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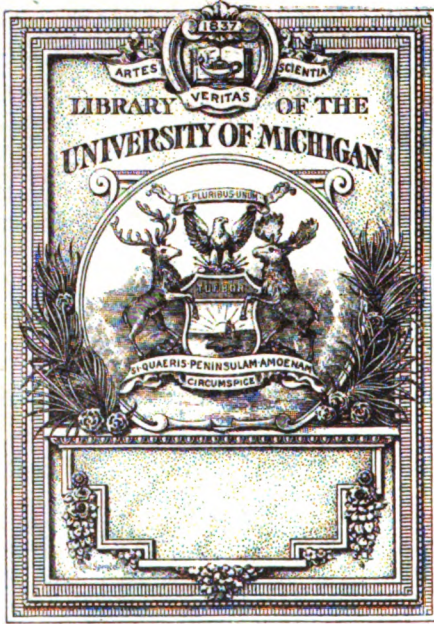
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[No. 1.

Original Lectures.

CLINICAL CASES USED IN ILLUSTRATING LECTURES ON MATERIA MEDICA.

BY PROF. CHAS. H. EVANS, M. D., OF HAHNEMANN MEDICAL
COLLEGE, CHICAGO.

BELLADONNA IN CEREBRAL HYPERÆMIA.—The instance that I am about to relate occurred in a man twenty-nine years of age, weighing 185 pounds, full-blooded, a high liver and of active disposition. For some time he had been under high mental tension, owing to domestic and business perplexities and the requirements of executive ability in several directions. Increasing headache through three or four days was neglected and finally culminated one afternoon. His face was puffed and of a deep uniform redness, the conjunctivæ were intensely congested, and there was a brilliant, sparkling appearance of the cornea. The pupils were greatly dilated. The carotid and temporal arteries pulsated visibly. At times he became violent and could scarcely be controlled. His skin was hot and dry. The head was thrown backward and his hands were clasped from time to time across his forehead. Alternating with violence were moans forced from him by the severity of the pain in his head. Bowels constipated; urine dark and scanty. The diagnosis of hyperæmia of the brain was readily made out; the diagnosis of the remedy to relieve this individual is another matter. It is not sufficient to select an anti-congestive drug, or employ what is known as antiphlogistic measures with which to combat this state. There must be found a drug specific for the in-

dividual now under discussion; specific for this case of cerebral hyperæmia, under the law of similia. But there are more than twenty drugs that produce cerebral congestion and the precision of homœopathy will not permit the random use of any of them. An exact selection must be made in order to cure the case just detailed, *tuto, cito et jocunde*.

In the light of the provings of belladonna that have been taught in this lecture you cannot have failed to perceive the similarity of the action of this drug to the case under discussion. It was accordingly administered at short intervals. In an hour's time the patient became quiet, and there was less moaning, and he steadily progressed toward recovery, in *all* respects. The word *all* is emphasized as several organs in the body are sometimes involved in consequence of a definite disease, and to which they have a certain relation, either through common or direct distribution of nerve filaments. Drug force is directed along the same nerve paths in its action upon the healthy body and consequently is distributed to the same organs and tissues that become grouped in natural disease. As a result all outlying disorders disappear at the same time the central one is effaced.

BELLADONNA IN PHRENITIS.—Here is another case to illustrate the specific drug effect upon natural disease. I recall a case of phrenitis occurring some years ago and one which I have never forgotten. It was that of a married woman about twenty-eight years of age to whom I was called for the purpose of signing a certificate for her commitment to the insane asylum. Her screams and shrieks had for three days and nights excited the wondering awe of the neighbors, several of whom were grouped upon the sidewalk in front of the house on my arrival. The woman was perfectly naked, she having repeatedly torn off all clothing that had been placed upon her. The torn fragments of a sheet that had been thrown over her an hour before were scattered over the floor. Her hands were bound together at the wrists, and her legs at the knees and ankles, and yet in this helpless condition it required the strength of a muscular man to restrain her within bounds, as rolling, twisting, turning and biting with her teeth she kept in incessant motion, while a torrent of raving, screaming oaths, and foul language poured continuously from her lips.

The action of belladonna upon the nerve centres of the cerebrum, which has been shown you in this lecture, presents a striking analogy to the case of phrenitis just related, and you readily perceive the similarity of the natural disease to the artificial drug disease, and how it is that under the operation of a natural law, the latter evanescent disease extinguishes the former. The indications for the use of belladonna were so plainly marked that I explained to the family how such cases might be curable, and did not require to be consigned to the hopelessness of an asylum, and convincing them I prepared some belladonna in water. The first teaspoonful was scarcely in her mouth before she spat it directly in the face of the attendant who had just given it to her. Her nose was held for another dose and her jaws forcibly closed together compelled her to swallow it. All this time she was writhing and struggling, and her ravings sounding the more horrible for being muffled. If Dante had beheld such a spectacle as this, it would have served to illustrate a new feature in his *Inferno*. After two hours' time, during which the remedy was repeated frequently, the patient became less violent, though strong restraint was still necessary, and later on there were intervals when it could be relaxed. Improvement continued, until in seven hours it became possible to place her in bed, put a night dress upon her and cover her with bedclothing. At lengthening intervals, however, it was necessary to use some restraint upon her movements, but these were of short duration. Entire recovery followed in a few days. There are quite a number of drugs that derange the functions of the encephalon, but each one of these has an effect differing from all the others. Some of these have common action upon certain groups of cells, but differ in their effects upon other cerebral ganglia, by which the total result presents another picture than those of other drugs, also having a marked action upon the brain. It is in the careful differentiation of these effects that the proper remedy can be selected. * * * * *

PULSATILLA IN RHEUMATISM.—From the foregoing pathogenesis of pulsatilla upon the muscular and tendinous tissue, in synovial membranes, it will be seen to be an important drug in the treatment of certain forms of rheumatism. The following clinical case will illustrate it.

A young woman aged twenty-four years, unmarried, spare figure, brunette, of delicate constitution, presented

the following condition. Pain in the left arm and hand, greatest in the left upper arm and extending over a portion of the pectoralis major. The pain was very severe and of a constant, aching character. The next day this pain was much easier, but had appeared upon the right side. The third day the left arm and side were free from actual pain, though soreness remained, and the right-sided pain had become more bearable, but both ankles and one knee had now become involved. Examination showed a peevish, complaining disposition; a feeling of weight and tenderness in the region of the stomach, especially so after eating. No appetite. Temperature, 102°. Very little thirst. Urine dark. A history of constipation, menstruation always irregular, scanty and light red, with some pain. Mucous membranes pale. Tongue coated white. She complained of a putrid taste in the mouth, which was so much worse in the morning that her nurse had to wash it out before she could eat any breakfast. An almost constant headache in the frontal region. Pulsatilla cured this case, and though there has been much damp and unpleasant weather, there has been no return of rheumatism during many months. * *

PULSATILLA IN HEMICRANIA.—A little girl eight years of age, of sad and gentle disposition, suffered for six months with a one-sided headache, usually upon the left side. The pain was situated in the left antero-temporal region, throbbing and stitching in character, especially worse early in the morning when rising from bed, and in the evening on going to bed; is worse when in a close room, when lying down and when the head is stooped over. When once established the pain continued for several hours at a time and was almost unbearable. Pulsatilla was the remedy indicated and cured the case. I have selected this case of migraine on account of the clear-cut indications pointing out the remedy, and free from the many hysterical, reflex and utero-ovarian conditions which accompany this disease in women. This variety of neuralgia has a long list of medicaments for its relief, but the concomitants as well as the direct pain single out the remedy.

Sometimes disease subsides in the organ in which it has been primarily established, and leaving this organ attacks another, often dissimilar and remote. It may do idiopathically or in consequence of the suppression of a discharge of long standing. This is known as metastasis. Here is an instance where the latter has taken place:

PULSATILLA FOR SUPPRESSED VAGINAL DISCHARGE.—A girl, five years of age, the subject of abnormal vaginal discharges, had an attack in which the discharges, mucus at first, at a later period became purulent. At the same time there was redness and swelling of the genitalia. At this time she took cold and the discharge was suppressed. A violent chill took place, which was followed by high fever. Accompanying this was headache, nausea and vomiting of sour, bilious liquid. Twenty-four hours later there was intense heat of the head and dryness of the skin, and the patient was unable to hold up her head.

The urine was scanty, and there was constant drowsiness together with frequent starting of the limbs. The vaginal mucous membrane was dry, swollen, red and excoriated and the patient constantly kept her hands upon the labia. The *status præsens* indicating pulsatilla, that remedy was given and the suppressed vaginal discharge was reëstablished after which the patient soon recovered. Although the report ceases here, it would seem as if persistence in the use of pulsatilla would have cured the catarrhal inflammation of the vaginal mucous membrane, to which it was also homœopathic. Perhaps it did so eventually, after its force had once been initiated, resolution took place slowly in consequence of abolition of the original disturbing force.

RHUS TOX. IN RHEUMATISM. You will recall what I have told you about the causative influence and aggravation of rhus symptoms by the patient having become drenched in a rain storm, and of the effects invariably produced by the approach of a storm or during a period of damp or wet weather. I will relate two clinical cases illustrating this peculiarity possessed by rhus. The first case is well authenticated. The patient, a lad seventeen years old was three years previously in the woods helping his father to load wood. While warm and perspiring there came up a rainstorm on the way home by which he was wetted to the skin. On reaching home, the right leg and hip were stiff and painful. Although every manner of means was used for relief there was no improvement, and indeed it became aggravated as time went on. When he presented himself for treatment there was a drawing pain in the hip joint with crepitation in the hip joint. Pain increased when rising from a seat after remaining seated for some length of time; it was also aggravated by cold and by any change of weather. The pain was relieved when sitting near a

warm stove, or in the sun, and by making continuous gentle motion of the leg. The leg and hip were so lame that he was obliged to take hold of the leg of his trousers so that the limb could be lifted and advanced when he desired to walk. The knee joint was flexed and any attempt to move it caused pain and it was impossible to make complete extension of the leg. Rhus tox. was prescribed. In a little more than a week the patient presented himself at the doctor's office to which he had walked five German miles. He was vastly better although still limping somewhat. The rhus was continued and a complete recovery followed.

RHUS TOX. IN RHEUMATISM.—The next case that I shall relate possesses the additional interest that it was cured in one of the clinics of this college some years ago. The man was forty-seven years of age and a carpenter, and was much exposed to drafts of wind. Some eight years previous he had had erysipelas which was suppressed by external applications. About three years before presenting himself at the clinic of this college he had experienced a numbness in his left hip. This numbness crept on gradually and was felt mostly on going to bed at night. There was also a pain commencing in the left foot passing up that side of the body to the shoulder, crossing at that point to the other side and from there down on the right side of the body to the hip and then crossing over to the left hip. This pain was sometimes of the most intense character. He had become a wreck bodily and mentally under the long continuance of his condition. The pains, (now this is what the prescription was based on), had always been relieved by gentle motion, they were easier in dry, clear weather and were always worse just before a storm, so much so that he knew two or three days before of its coming. Rhus tox. was administered and a steady improvement set in, which continued until there was perfect recovery. * * * *

LACHESIS IN DIPHTHERIA.—The disorganizing effect of lachesis upon the blood and tissues, producing a state analogous to sepsis is apparent in the throat as just detailed, and to illustrate this your attention is now called to a typical clinical case of the disease known as diphtheria. As pathology teaches to-day, this disease is not the local one it used to be considered, but is general, reaching every tissue and cell in the body with its poisonous touch. The

patient a child eight years of age of previous good health, was attacked with fever, to relieve which, I was called.

The temperature was found to be 103.2°, F. On examination the throat was seen to be greatly swollen and the tonsils were enlarged.

The color of the mucous membrane was dark red. There was a patch of pseudo-membrane on the left tonsil, and one of smaller dimensions on the right one. The odor of the breath was foul. A thin watery fluid was discharged from the nostrils which were reddened and sore. The child seemed tired and languid. Slight glandular enlargement in the neck externally. The tongue had a heavy, yellow coating. Some thirst, but water was swallowed with pain and difficulty. The skin of the face presented a grayish pallor, which is sometimes called earthy. Lachesis was prescribed and the throat ordered sprayed with a mixture of equal parts of alcohol and water to remove the foul secretions from the mouth and throat as these collected. In forty-eight hours there was a slight fall of temperature and the patches of membrane in the throat had not increased in extent or thickness. The day following there was another slight fall in temperature and the margins of the false membranes were observed to be slightly loosened around the edge. Improvement continued from day to day until entire recovery ensued.

APPENDICITIS.

A CLINICAL LECTURE DELIVERED AT THE HAHNEMANN HOSPITAL, OF CHICAGO, DECEMBER 23, BY DR. HOWARD R. CHISLETT, ASSOCIATE PROFESSOR OF SURGERY AND CLINICAL SURGERY.

REPORTED BY CHAS. E. KAHLKE, '04.

The first case which I shall present to you to-day is, as many of you may have already suspected from the history, one of recurrent appendicitis. Following out our plan of study I should have spoken to-day of chronic diseases of the joints, but as this case serves so nicely as illustrative of a very common affection, you will I am sure, pardon me for the deviation, if I give you a clinical lecture on appendicitis.

By appendicitis we mean an inflammation of the ap-

pendix vermiformis. Under this heading are now considered those conditions which in your older text-books are described as typhlitis, perityphlitis and paratyphlitis; terms which are seldom used at the present day by physicians and surgeons who are willing to depart from established precedents where pathological facts are clearly demonstrated as they are in the present subject, both by operative surgery and post mortem investigation.

You may judge still more of the frequency of this disease from the facts that most of the cases formerly treated as "inflammation of the bowels," and about nine-tenths of all cases of peritonitis in the male, are due to inflammations having their beginning in the vermiform appendix. We are told also that about fifteen per cent of all post-mortem examinations show evidence of appendicitis in some degree.

Causes.—As in all inflammations having an origin in the mucous membrane of the intestinal canal this inflammation of the appendix is of an *infective* character and is due most commonly to the action of the pyogenic microorganisms. This is just as true in those cases where a foreign body is demonstrable as in others where there is no evidence of such either present or past. The presence of a foreign body (be it a grape seed, an orange seed, or, what has been more frequent in my own experience, a ball of hardened fæces), unquestionably acts in most cases as a localizing factor, producing the abrasion of the mucous membrane through which the infection takes place. I wish, however, to impress upon you the fact that this inflammation may and does occur irrespective of foreign bodies, and that the essential factor in its causation is the introduction of microorganisms. As predisposing causes we may mention catarrhal conditions of the cæcum which produce a partial occlusion of the opening into the appendix and a consequent retention of discharges; obstinate constipation with an impacted cæcum, and possibly in some few cases traumatism.

Varieties.—You will see in current literature descrip-

tions of appendicitis under many different headings. I believe as evidencing the pathological conditions most commonly present, the division into the *catarrhal*, the *perforative* or *suppurative*, and the *gangrenous* will prove the most satisfactory to you.

While giving this classification I wish to remind you of my belief that the difference is of degree and not of kind, and that it depends not upon any essential difference in causation, but upon the virulence of the infection and the rapidity of the extension of the inflammation.

Pathology.—Let us take as a typical example for illustration one in which enlodgement of a foreign body has taken place. The foreign body excites a spasmodic contraction of the muscular fibres of the appendix—the action of the muscles may be sufficient to cause the expulsion of the offending matter before pathological conditions have developed. The extreme pains incident to such violent muscular exertion are referred to by Dr. Robinson as *appendicular colic*. When the foreign matter cannot be expelled, the firm muscular contraction upon it is the starting point of the pathological changes. There is first an active hyperæmia soon followed by a markedly slowed blood current through the greatly distended vessels and large quantities of leucocytes and serum are exuded both into the substance of the mucous membrane and into the lumen of the tube. This infiltration, together with the pressure excited by the foreign body, so interferes with the nutrition of the mucous membrane that it undergoes degenerative changes. The epithelial layers becoming destroyed allow the entrance of infective matters, thus starting up a superficial suppuration or ulceration. If resolution takes place now, while the mucous membrane is alone involved, the condition comes under the heading of *catarrhal appendicitis*. The cicatricial tissue formed by nature in her effort at restoration, particularly if the ulcerative process, has been circular, often causes a sufficient constriction of the lumen of the tube to retain semisolid or even liquid contents of the intestine which may have gained

entrance. No doubt many cases of recurrent attacks of inflammations are due to such retention and the secondary changes thus induced.

Suppose nature has not been so kind. The ulceration does not stop at the mucous membrane, but the muscular coat is attacked and then the peritoneal. The infiltration becomes extreme, the whole appendix greatly swollen. Simultaneously with the involvement of the serous coat, there is a plastic inflammation of the peritoneum surrounding the area—both of the visceral and parietal layers. Not uncommonly the appendix becomes virtually rolled up between coils of intestine and omental adhesions. At any rate the adhesions of the intestines to the abdominal wall and to each other, are such as to completely separate the inflamed appendix from the general peritoneal cavity. As the inflammation extends and the intra-appendicular tension becomes too great for the resistance offered by the peritoneal layer, perforation results, and thus an abscess develops in the cavity formed by the plastic adhesions. This is the *perforative* or *suppurative* form. When the perforation occurs before the surrounding adhesions are properly formed, as it quite frequently does, the peritoneum becomes involved in a diffused infective inflammation.

When the inflammation is very virulent and spreads rapidly, the infiltration becomes so extensive that the circulation is completely obstructed. The nutrition being completely arrested, the parts die before they have time to undergo the softening process of suppuration, and the gangrenous appendix drops off into the cavity prepared for it by adhesions, or more frequently into the general peritoneal cavity. This is the *gangrenous* form, or as it is sometimes termed the *fulminating*. Not infrequently the dead appendix is found, detached, in the abscess cavity during the operations done for the relief of such patients.

You will see different opinions expressed in relation to the frequency of *retroperitoneal* abscesses in perforative appendicitis. I never have seen one, and while not denying the possibility of such, this termination must for an-

atomical reasons be extremely rare. From the specimen which I show you, and for which I must thank Prof. Bailey, you can see that both the cæcum and the appendix are completely invested by peritoneum. The only two ways in which pus can find its way behind the peritoneum are these: when the perforation occurs exactly at the mesenteric attachment and separates the two layers of this membrane, and when extensive adhesions in front offer greater resistance to the tension than the posterior peritoneum. In such a case the pus formed is diffused between the peritoneum and fascia, and either reaches the surface at the outer third of Poupart's ligament or passes up and back and simulates perinephritic suppuration.

Symptoms.—The first symptom in most cases is pain. This usually comes suddenly, though it may be preceded by a sense of discomfort for several hours, or even days. It varies, of course, in kind and severity, but is almost invariably aggravated by coughing or a deep inspiration. The pain may, as in the present case, begin in the right inguinal region and radiate throughout the abdomen, or it may be a general abdominal pain from the beginning. Many patients refer the most extreme pain to the epigastric region.

Associated with the pain there is always tenderness upon pressure. This tenderness is, of course, at the site of the appendix, usually in the right inguinal region, but may be almost any place in the abdomen. The most frequent excursions it takes are to the left inguinal region and into the pelvis. In this latter situation it is found more often in women than in men, and then vaginal or rectal examination will be more satisfactory than the abdominal. A common point of great tenderness is midway between the anterior superior spine and the umbilicus—the so termed McBurney point. It has been present in most of my cases prior to abscess formation. Another important, though less frequent symptom is swelling—less frequent because in the catarrhal cases there is seldom if ever a tumor formed. This swelling may be of any shape and

varies greatly in size and sensitiveness. I have already told you the method of its formation. To me the presence of any considerable swelling, whether the constitutional symptoms are mild or grave, indicates perforation and at least a few drops of pus. The tumor is as a rule in the normal situation of the appendix—still as in the case of; the sensitiveness it may be anywhere in the abdominal cavity or the pelvis. The region is dull upon deep percussion, though superficial percussion may elicit a tympanitic note due in part to surrounding intestines, in part to gas formation in the abscess cavity. In the later stages if general peritonitis develops, the tumor may escape even close observation. The local symptoms enumerated are of course your main guides, still the general symptoms are of great importance also. These may be ushered in with a chill as in this patient, but this is not usual. There is always some elevation of temperature varying from one-half degree to six degrees F. above the normal. The condition of the bowels is no index whatever, as the evacuations may remain normal throughout the attack. Sudden collapse indicates perforation into the peritoneal cavity. This may occur as early as the second day in aggravated cases, but as a rule the onset and course are more gradual, the height of the attack being reached sometime during the second week, or even later. These cases are very treacherous, even those apparently mild ones being in constant danger of perforation and its consequences. Recurrence in those cases that have gone on to resolution is the rule.

Diagnosis.—This is not always easy you may be sure. Pain in the right inguinal region, sudden in its onset and followed by tenderness and the formation of a tumor accompanied by an elevation of temperature and an increased rapidity of the heart's action, is pretty positive evidence of appendicitis in the male. If with these symptoms there is a history of former attacks, the presumption becomes positive in my mind. In the female it is not so certain. Some of you may remember the case I reported

at a recent meeting of the clinical society: A young lady eighteen years of age with no abnormality in her menstrual history was suddenly attacked with all of the symptoms of appendicitis including the sensitive tumor. The operation revealed a strangulated ovarian hæmatoma. This condition is extremely rare but an abscess of the right tube or ovary might give rise to the same symptoms. The history of the case must then guide you and if it gives but negative results, the exploration is not only admissable but demanded. Another condition which is apt to mislead you is inflammation of the cæcum itself from impaction with fæcal matter. I call to mind now a case of this character: Mrs. R., age, twenty-nine years. She had been treated for five days prior to my first visit for peritonitis. The symptoms were excessive pain and tenderness, high fever, rapid pulse and obstinate constipation. Careful examination revealed a round tumor the size of an orange in the right inguinal region rather doughy to the feel and easily indented by deep pressure. The real condition was fæcal impaction and consequent inflammation of the cæcum. This patient soon recovered under treatment by oil enemata and small doses of saline laxatives; the tumor disappearing in two or three days. Such a condititon, however, if neglected, may result in a perforation of the colon and thus to a retroperitoneal abscess. I have had one such case involving the descending colon. The patient refusing operative measures died, and the post-mortem disclosed three distinct perforations of the gut.

Treatment.—Appendicitis is to my mind a surgical disease always. I do not mean to advise you to operate upon every case which you have so diagnosed, for a large percentage of these cases called catarrhal get well under appropriate medical treatment.

The exact conditions should be explained to the patient or to his friends—they should be told of the dangers of the operation, and also the fact that one can never tell what moment a catarrhal appendicitis may become perforative. They can then make their selection. That the nonperfor-

ative form is not free from danger is nicely illustrated by the following :

Case. Miss C. —, aged twenty-four years. Has had three similar attacks, the present one beginning three days prior to my first visit. There was no tumor, but intense pain in right inguinal region, and McBurney point was well marked. Slight fever. Diagnosed catarrhal appendicitis and the patient chose the operation. As it was a typical case I will describe the operation to you. A three inch incision at the outer border of the right rectus muscle extending from the level of the umbilicus downward. The appendix was found enlarged and deeply congested but not adherent. After ligating the mesenteric attachment with fine silk and stripping the appendix loose, I made a circular incision one-half an inch from the cæcal extremity, through the serous and muscular coats. Reflecting this flap as you would the skin flap in circular amputations of an extremity, I ligated the mucous membrane with fine silk, and after scarification of the flap, stitched up the defect by means of two layers of Lembert's sutures. This not only buries the stump, but causes its inversion into the cæcum. The patient reacted very nicely for two days, but on the third day developed all of the symptoms of acute progressive septicæmia. There was great pain in the hepatic region and the patient died on the fifth day very much jaundiced. The post-mortem revealed a somewhat enlarged and deeply congested liver, and in the absence of peritonitis or of inflammation about the cæcum, or the stump of the appendix, I am persuaded that it was a case of progressive septicæmia due to the ulcerative condition we found in the mucous membrane of the removed appendix. The microorganisms extended into the small veins about the cæcum and thus reaching the venous radicals of the liver, continued developing, and ultimately overpowered the system with toxines. Had the patient lived a few days longer there is no doubt in my own mind that we would have found numerous minute foci of suppuration in the liver.

The medical treatment of these cases consists essentially of rest, hot applications for the relief of pain, and small doses of the saline laxatives to create free, but not violent movements of the bowels. The thorough evacuation of the colon and cæcum often causes a diminution in

the swelling of the mucous membrane at the orifice of the appendix and enables the extrusion of the retained foreign body or fœcal matter.

As I have already said, a decided tumor is to me an indication of suppuration, and while occasionally such cases recover either by a rupture of the abscess externally or into the cæcum I always advise surgical operation. The time to operate is *immediately* you are assured that pus is present. The difference between the early and late operations is nicely illustrated by these two cases:

Mr. C. J., age twenty-three years, German. This patient has had two typical attacks in the past three months. The present one began thirty-six hours prior to my first examination, which determined a small sensitive tumor in the right inguinal region. Operation revealed a tumor consisting of omentum intestine and appendix rolled and matted together. Adhesions separated and disclosed a small cavity containing a drop or two of pus. Perforated appendix removed after method above described. Cavity cleansed with hydrogen peroxide. Drainage. Recovery.

Mr. F. J. B., age seventeen years, English. This boy had been ill for eighteen days before operation. His case was a typical one of perforative appendicitis with a temperature ranging between 100° and 104.6° F., but he steadily refused operative measures until the eighteenth day. The abdomen was then greatly distended and examination revealed two tumors instead of one, the original one occupying the right inguinal region, and due to a perforated appendix. The other to the right and above the umbilicus and due to a perforation of the small intestine. Both abscess were thoroughly evacuated, irrigated and drained. The appendix removed, the perforation sutured. Poor reaction. Death on the third day from general peritonitis.

Whenever it is possible the appendix should be removed, but there are cases where the safety of your patient seems best served by a partial removal, or by simply evacuating the abscess and supplying good drainage with the utmost expediency. I have operated upon two cases during the past few months where I made no search whatever for the appendix, as the condition of the patients did not war-

rant prolonged anæsthesia. They made nice recoveries. Remember always that the interests of your patient should be your surest guide, and decide each case upon its own merits. As illustration of the difficulty of removing the appendix allow me to cite this one case:

Mr. M., age twenty-five, German. It was the first attack and the history was sudden pain and tenderness, followed by fever, and in four days by a decided tumor. Operation two weeks afterward. Abdominal incision over prominent part of swelling, passing directly into abscess cavity. Appendix found firmly fixed in bottom of cavity. The body was easily separated, but the distal extremity was so firmly attached between two coils of intestine that I feared its separation would entail an entrance into the general peritoneum. Under these circumstances I excised one and one-half inches of the appendix after ligating both ends with fine silk. Both stumps cauterized with pure carbolic acid, cavity cleansed and loosely packed with iodoform gauze. Recovery.

The after treatment should be conducted on general principles. Abscess cavities can be drained with tubes if you prefer. My own choice is loose packing with iodoformized gauze, to be reapplied daily after irrigation and cleansing with peroxide of hydrogen.

The catarrhal cases where the appendix is removed and the stump buried, require no drainage, and little after treatment, save rest and careful attention to nutrition and bodily cleanliness.

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

DECEMBER MEETING, 1893.

The regular monthly meeting was held in the clinical amphitheatre of the new Hahnmann Medical College building, on Saturday evening, December 30. A very general and decided interest was taken in hearing and discussing.

I. THE REPORT OF THE BUREAU OF MENTAL AND NERVOUS DISEASES, BY DRs. H. B. FELLOWS AND O. L. SMITH—This report, consisted of seven clinical cases of which the first three, being alike, were read in a group and then "talked over."

ANTERIOR POLIO-MYELITIS.—*Case 1.*—Ruth B., æt. three one night some eighteen months since suddenly became feverish, commenced to vomit and the head began to draw back, accompanied by some delirium which gradually gave place to an extreme drowsiness from which it was very difficult to arouse her. The fever gradually subsided, but several weeks later she began to complain of her back hurting her. Soon it was noticed that the right limb was powerless, the flesh soon becoming very loose and flabby. The knee reflex is absent and the foot is slightly inverted. Under the use of causticum and massage of the affected limb and the spine, the child has been restored to almost though not a perfect use of the limb.

INFANTILE HEMIPLEGIA WITH ATHETOSIS.—*Case 2.*—Monto R., æt. five. When eighteen months of age, she had a convulsion which lasted nine hours, involving principally the left half of the body. The attack was preceded for two days by a "burning fever" which abated somewhat with the onset of the convulsion. Soon the limbs of the left side became contracted and the mouth was drawn to the left. Some four or five weeks later the left limbs began to be cold and flabby, and it was but a short time until

it was noticed that these limbs were wasting. Six months succeeding the initial attack she began to improve very slowly until now she has modified use of that foot and leg, albeit they are much smaller and more illy nourished than the corresponding members. Upon straightening the wrist the fingers would contract and could not be straightened again until the wrist was flexed. The fingers also showed the athetoid movements. On attempting to walk the everted foot drags.

In two months time, causticum, from the 6th to 200th, coupled with massage has practically restored motion and the use of the limbs, and the improvement in color, size, and general appearance of the limbs is quite marked.

FACIAL SPASM.—*Case 3.*—Mrs. ———, æt., sixty-two. Sixteen years ago the right eyelids and the surrounding muscles began to twitch. This twitching was aggravated by reading, but for a time it was corrected by glasses, soon to become worse than before. It now is worse when she becomes tired, but is unattended with pain. The spasms recur at intervals varying from ten to thirty seconds. She is entirely unable to exercise volitional control over the spasms. She has had a chronic cough for some time, accompanied by raising of much mucus, all of which symptoms disappeared under phosphorus 3, and she became better in a general way, but the face continued to twitch.

Causticum in dilutions from the 6th to the 30th inclusive, has brought about marked improvement in this case. Now she is able to hold the muscles at rest for periods varying from one to five minutes, and for hours at a time is wholly free from the annoying symptom.

CHOREA.—*Case 4.*—Alice S., æ. ten, about one year ago began to shake her head and to put her hand to her forehead as if pushing her hair back. It was but a short time until the eyelids began to twitch and the corners of the mouth to jerk, also the hands and feet, so that within the last week or so she is in continual motion; has always been well heretofore; oftentimes passing urine, scarcely recognizing it, and is very restless at night; has been completely restored under causticum 6.

DISCUSSION.—Dr. H. B. FELLOWS said: These cases have been selected principally because I do not think causticum is properly appreciated. In the provings we find that the causticum subject is weak and trem-

bling, complaining of a sense of heaviness and easily wearied. It is often indicated in paralytic and chronic choreic cases. Here you find the weak vesical sphincters, the urine oftentimes escaping unconsciously almost, or when the patient coughs or sneezes. I usually begin with the lower potencies and subsequently employ the higher ones.

Dr. W. A. DUNN: I have had considerable experience with causticum. It is absolutely necessary that you discriminate between the aphonia for which causticum is indicated and the hoarseness for which we prescribe phosphorus. I recall a case of aphasia which was sent to me, in which the child had not uttered a word since she had an attack of what would seem to have been meningitis about six months previous. I prescribed causticum for the case, promising them very little, but in a short time they returned and the child could talk as well as any one, except that the voice was somewhat squeaking.

Dr. B. S. ARNULPHY: The beneficial effects ascribed to causticum in the cases reported, would seem to establish a sort of parallelism between that drug and phosphorus. The dual action of phosphorus, comparable in that respect to that of our best curative agents, is well known. It is a clinical fact that the stimulating effects upon the cerebro-spinal system following the administration of full doses of phosphorus, is soon succeeded by signs pointing to the impairment of the vitality of the nervous centres, in short by signs of paralysis. I think that phosphorus is truly homœopathic to all forms of paralysis, at the root of which lies some degenerative process in the cerebro-spinal axis, especially when resulting from a drain on the system, sexual or otherwise. Causticum, in my opinion, is more decidedly adapted to functional disturbances of the innervation than to organic alterations of the nervous centres.

Dr. H. P. SKILES: I am very much interested in the papers which have been read because they are not of the every-day class. That remedy is not very frequently prescribed, and I have not been in the habit of thinking of

causticum as very prominent in the treatment of cases of paralysis. But this report brings to my mind a case which was brought to me from the Kankakee Insane Asylum, one year ago last summer, and was taken to the Baptist hospital. She was very quiet, and indeed, had not spoken for about two years. She was partially paralyzed on the right side, and had a hacking cough; was twenty-five or twenty-six years of age, and before going to the asylum had been a school teacher. For the cough and for some other symptoms, which I cannot now recall, I gave her causticum. It helped her more than any remedy that she had had, and she regained her sanity and also her speech. A few months later she died of tuberculosis, but retained her sanity to her death.

Dr. L. D. ROGERS: The case which Dr. Skiles has reported was certainly an interesting one. I saw her daily and her recovery was certainly a marvel. I think Dr. Skiles should have mentioned that there was also some orificial work done in the case. That patient could write perfectly when I first saw her, but could neither walk nor talk.

Dr. R. LUDLAM expressed himself as very grateful for the excellent report of the evening thus far given, and also for the discussion. The nib of Dr Skiles' very interesting case is in Dr. Rogers' statement that she could "write perfectly." For, by Charcot's rule, without agraphia, her mutism and her paralysis also were undoubtedly hysterical.*

Dr. A. K. CRAWFORD: If it would be in order, now, Mr. President, to tell of the failures under causticum, I should like to relate a case that Dr. Dunn and myself

*The Russian correspondent of *La Medecine Moderne* for December 23, cites a very interesting case from Dr. Vorotinski: Hysterical mutism of two year's duration occurred in a young woman whose parents were both alcoholics. It began with a convulsive fit with loss of consciousness that lasted an hour and a half, after which she could neither speak nor utter a sound. The fits recurred for six weeks, but the mutism persisted for two years. Three *seances* with verbal suggestions while awake and intense faradization of the vocal chords, entirely cured the mutism as well as the other hysterical symptoms. EDITOR.

treated. The patient was a young lady blessed with excellent health, a good constitution, and an easy running digestion. Her sole trouble was with her voice. A member of the Apollo Club and a lover of singing, she wished to accomplish more in the art than simply singing in chorus, but her voice could not be depended upon. She could produce a strong tone of good vibrant quality, but in the most unexpected places the voice would crack, emitting a harsh, strident sound, which was both embarrassing and disheartening to pupil and tutor.

We took her in hand to *cure* the defect. By laryngoscopic examination the throat tissues were found to be perfectly healthy looking. The only thing remiss appeared to be the lack of tension in one vocal cord when phonating.

The mirror showed one cord responding straight as a line, while the other was slightly bowed, the concavity being toward the aperture. In repose both cords had an equally normal look.

This did not seem to be much of a flaw to remedy, but I assure you that the administration of causticum, and of phosphorus, and electrical stimulus, and the application of the magnet at different times resulted in absolute failure. Yet this is a case which, according to Dr. Dunn's differentiation, should have responded at once to the action of causticum.

Dr. G. F. SHEARS: Now that we have arrived at the point in the discussion at which it is proposed to relate cases in which causticum did *not* cure, I feel that I am warranted in reporting the following:

Case. Mrs. B., aged thirty-seven, sent to me by a brother practitioner for the treatment of a bladder trouble, accompanied with the following symptoms: urination frequent and somewhat painful; whenever the patient coughed there was an emission of urine. This latter symptom was supposed to be a strong indication for the prescription of causticum, and it had been given in the different potencies, but had proven of no service, so my friend informed me. Upon examination of the patient I found that the bladder

was never thoroughly evacuated, there being at all times a certain amount of residual urine. Although the history of the case was not very clear, the trouble seemed to date from a pelvic inflammation, from which the patient suffered two years previously. Under persistent catheterization and vesical washing, the irritation was subdued and the bladder regained its tone, and the symptom for which causticum was prescribed, disappeared.

I do not relate this case to in any way detract from the value of the symptom mentioned as an indication for causticum, but rather to emphasize the fact that in the prescription of a remedy, a single isolated symptom is not sufficient. A symptom derives its value from its association, and must be considered in relation to other symptoms, either subjective or objective.

Dr. SMITH continued the reading of his report:

SHOCK AND HÆMORRHAGE OF THE SPINAL CORD.—*Case 5.*
—Charles G., æt. forty-eight, while at bridge work last August fell backward, striking spine in lower lumbar region. Immediately he was deprived of both motion and sensation in the lower extremities, but suffered excruciating pain especially in the knees. The bladder and the bowel wholly inert. He was entirely conscious and his mind was unaffected by the fall. Since the accident, under the direction of the attending physician he has taken morphine daily in varying quantities, but now takes only from $\frac{1}{4}$ grain to $\frac{1}{2}$ grain daily. Ten days after the accident he began to improve very slightly, noticing first a slight return of sensation in the toes. He soon found himself able to move the toes slightly. There was much pain in the feet and legs which was worse at night and of a piercing, burning character. On first appearing at the clinic, he was barely able to get about, even with the aid of crutches. The knee reflex is exaggerated; the ankle clonus is developed by striking the leg with the foot resting on the ball, but this symptom was not elicited by the ordinary method of flexing the foot.

He was given hypericum 3 and advised to "cut off" the morphia. Upon his return he reported that he had taken but one dose of morphia and had no further need for it. He also claimed improvement in every way. He has failed to report at subsequent clinics.

LOCOMOTOR ATAXIA.—*Case 6.*—Mr. C. *æt.* fifty-two, when fifteen years old had inflammatory rheumatism, but made a nice recovery. Has had syphilis. When about thirty-seven years of age he commenced to have shooting pains in the lower limbs, which have increased ever since. Of late years the pains have extended to the arms and the fingers. For several years now he tires very easily when walking, although the limbs seem well nourished. Experiences great difficulty in walking after dark, and unless he is so situated that he can keep the feet under observation. For, while washing his face in the the morning, he pitches forward toward the washbowl. The bowels have been constipated and control over the bladder has gradually been growing less. Is very despondent and taciturn. The pupils are much contracted and accommodate to distance but not to light, etc. Is unable to stand steadily with the eyes closed. Neither can he approximate the tips of the index fingers upon closing his eyes. They knee reflex is but slightly impaired. One year ago he gave up business, as he was wholly incapacitated for it both mentally and physically. Under the use of phosphoric acid and arsenicum album. in eight months the patient was sufficiently improved to resume business but was carried off by acute intestinal obstruction, so we were informed by his attending physician.

II. ZINCI SULPHAS IN CONVULSIONS.—BY DR. M. HOUSTON, OF JOLIET, ILL. *Case.*—The patient a child fifteen months old, which had been well the day before, had a convulsion shortly after midnight lasting two hours and confined to the right side. Dr. O. C. Davis, of this city, saw and prescribed for the case at this time, and shortly after returning home was again called, the convulsion returning as before on the right side, and lasting one and one half hours. Very shortly after its subsidence, a third spasm occurred, this time on the left side; and it was then seen that the entire right side was paralyzed. After about one and one half hours, the convulsion disappeared on the left side, and reappeared on the right, where it remained when I saw the case with the doctor about 11:30 A. M. The child was wholly unconscious, the face pallid and dry, the pupils symmetrical and immovable, temperature $102\frac{1}{2}$, pulse 160, the respiration rapid and jerky. The muscles of the entire right side, including those of the face, were contracted, and in rapid chorea-like action. Those of the

left side were motionless. The bowels had been unloaded, and cuprum, passiflora, and such other remedies given as the symptoms called for, but nothing availed, and the prognosis was gloomy enough, though not hopeless. While the trouble was central, it was thought best to unload the stomach of any possible reflex cause. The emetic chosen was zinc sulphate, of which eight grains were given in a little water by the mouth. Directions were given to repeat the dose each ten minutes till three doses were given (twenty-four grains in all,) unless vomiting should occur. In five minutes after the first dose was given, the convulsive movements suddenly and entirely ceased, and never returned. The remaining two doses were given but no vomiting occurred. Consciousness gradually returned, and when last seen, November 19, the paralysis was much improved, and the child in other respects perfectly well, and active.

DISCUSSION: Dr. CRAWFORD: I should like to ask Dr. Fellows if hypericum cured case five by the superficial or the deep action of the remedy?

Dr. FELLOWS: The action of this remedy in this case was upon the cord and the membrane. As to the presence of the knee reflex in this case of locomotor ataxia I have had three or four such cases where other symptoms marked them undoubtedly as tabes.

Concerning Dr. Houston's case (No. 7), we know that zincum is oftentimes indicated in convulsions. In depressed nervous states it arouses the normal activity and controls the excessive irritability of the nervous system. The action here corresponded with zincum, and the base of these compounds is the element that has the predominance in their action.

VOLUNTEER PAPERS. III.—A CASE OF PURPURA. By Dr. A. E. BAILEY, of Hyde Park, Chicago.—*Case.* November 24. I was called to attend a patient suffering apparently from an attack of acute articular rheumatism. The patient was a man fifty-five years of age, of exemplary habits, he never having used tobacco or alcohol in any form. He was, however, possessed of a syphilitic heredity, which manifested itself from time to time by successive crops of ulcers

which appeared upon the lower extremities, and which, he assured me, healed readily under mercurial treatment.

The patient had been confined to his room for several days previous to my first seeing him, by an attack of diarrhœa, which he finally controlled by means of a cholera mixture obtained at a neighboring drug store. On the preceding day, in the hope of shaking off his indisposition, he took a sponge bath and subsequently shaved himself, standing by an open window, clad only in his night shirt. This performance was succeeded by a well marked chill, and when I first saw him his temperature was 103° F., pulse 80°, remarkably full and strong. The wrist, shoulder, knee and ankle joints were exquisitely sensitive, only moderately swollen and presented no unusual redness. Chloroform liniment was used locally and bryonia and aconite were the remedies administered.

The following day the patient appeared somewhat better. He had perspired freely during the night and his temperature had receded to 102° F. His appetite was good. His skin now, however, was dry and harsh, and he complained of great thirst. The urine was abundant in quantity and passed at frequent intervals. He was allowed to drink freely of Londonderry Lithia water and weak lemonade. His diet consisted of rice, milk and broths. During the day there was a slight hæmorrhage from the nose which recurred occasionally during the subsequent course of the disease. Bryonia was continued.

November 27. The patient presented a marked appearance of jaundice; and the following day, no movement of the bowels having occurred since November 24,—a copious injection of warm water was given, the Allen pump being used, and the bowels being thoroughly flushed. From November 25 to 28 the temperature remained at 102° F., and the pulse at about 80. The patient appeared cheerful, would read the paper in the morning and converse freely with the attendants during the day. The joints remained sensitive and the slightest motion occasioned severe pain. Rest was broken, but the patient declined to take narcotics. November 28. Podophyllin 2x was given in alternation with bryonia, in hope of rousing the liver to activity, and continued without effect until December 1.

November 30 an injection was given with unsatisfactory results. Upon this date a free hæmorrhage occurred beneath the conjunctiva of the left eye.

December 1, a marked change was apparent in the condition of the patient. He had passed a restless night and complained of having been disturbed by unpleasant visions. Prostration was marked. He desired to read his paper as usual, but was unequal to the effort. He became drowsy and passed urine involuntarily during the day. The following morning, December 2, an abundant crop of purpura of minute size appeared upon the head and face, the chest and trunk being only moderately involved. Drowsiness had merged into a semi-comatose condition, but the patient could be aroused to take nourishment, and recognized and attempted to converse with his attendants. Half-grain doses of calomel were given every two hours throughout the day, and stimulants were freely administered.

In the evening Drs. Arnulphy and Oughten were called in consultation. At the suggestion of the former, drop doses of phosphorus were administered every half hour; and by advice of the latter, elaterium in one-eighth grain doses were substituted for the calomel, one-half grain being given without result; one-sixth grain pylocarpin was administered hypodermically and induced a profuse perspiration which was, however, only transitory, the skin soon again becoming harsh and dry. Temperature at this time was 103.5° F., pulse 120, respiration 30. By morning of December 3, the patient was in a state of profound coma, and there was paralysis of the entire left side. Handling the joints even now would occasion evidence of pain. Temperature was 104° F., pulse 138, respiration 28 and very much embarrassed. Patient sank rapidly throughout the day and died at 4:40 in the afternoon.

Throughout the course of the disease the lungs were clear and resonant and the heart's action apparently normal. An examination of the urine made December 2, yielded negative results, the specific gravity being 1010, reaction acid, no sugar being present and albumen only in slight quantity, due undoubtedly to the presence of blood.

No post-mortem was permitted. I was, however, present during the embalming of the body and had an opportunity of examining the contents of the abdomen. The intestines presented ecchymoses of large size, coalescing in many instances and forming an almost continuous chain. These ecchymosed spots presented a varied appearance, some being dark, others bright red, indicating that effu-

sions had been constantly occurring. The omentum and the surface of the stomach and liver presented a similar appearance, but to a slighter degree. The gall bladder was distended to bursting.

I believe that the case was one of purpura pure and simple from the beginning, and that the rheumatism was merely a manifestation of purpura, rather than that purpura was superadded to a rheumatic condition. The case is, however, unusual in several particulars. Elevation of temperature in purpura, according to the authorities whom I have consulted, is rare. Bartholow, however, says that "although a very large proportion of cases of purpura, whether simple or hæmorrhagic, are entirely free from fever, there are cases of both in which fever is present." The temperature in this case averaged 102.5° F.

The pulse of purpura, when any deviation from the normal occurs, is ordinarily described as small, wiry, irregular and frequently dicrotic. In this instance the pulse was unusually full and strong.

Again, purpura ordinarily manifests itself externally. Effusions from the mucous membranes are not rare, but a case in which the serous membranes are involved is almost unique. The primary cause of death in this case was cerebral apoplexy.

DISCUSSION.—DR. ARNULPHY: This case was very remarkable in its general behavior, and I am sure that our society is greatly indebted to Dr. Bailey for having given us an able and trustworthy report of it.

From the well marked tendency to cutaneous, mucous and visceral hæmorrhage evinced in the case, no doubt can be entertained that this was an instance of purpura rheumatica, or peliosis rheumatica, an affection in which the purpuric symptoms as revealing a peculiar condition of the blood and of the nervous system, very little known yet in its essence, are the predominant factors, the rheumatic symptoms barely deserving to be considered as a complication.

The danger to the patient in this affection does not arise from the pseudo-rheumatic condition present, as threatening involvement, for instance, of the heart or of the brain. In this case death resulted from slow hæmorrhage into the

meninges, possibly into the brain tissue itself. The hæmorrhagic determination to the head became very pronounced only toward the last three days, as evidenced by the conjunctival hæmorrhage, epistaxis, and copious petechial development over the neck, face and scalp. The comatose condition of the patient, which set in gradually, in a measure as the purpuric appearance of the integument became more marked, could only be satisfactorily explained by an extension of the hæmorrhagic process to the meninges.

There was certainly no need of resorting to the hypothesis of uræmia in order to explain the oppression of the brain so apparent during the last days. This same hæmorrhagic determination existed in the abdominal cavity, as shown by the hasty post-mortem examination which Dr. Bailey cleverly managed to perform. The peritoneal covering of the liver was infected, and so may have been the liver tissue, and the biliary ducts, which would explain the presence of icterus in this case, a very unusual symptom in this disease.

The specimens secured from the liver, including the gall bladder, I have delivered to Dr. Halphide for microscopic examination. I am sorry the doctor is not present to-night as his report on the matter cannot fail to be very interesting.

I must say that the feverish condition observed in the case has no peculiar significance. Some of the worst cases of purpura, with or without rheumatic pains, are apyretic; some other cases, though slight, are attended with a rise of temperature. In fact we know precious little about the true nature of this disease. From personal observation and cases that I have seen reported, I am inclined to think that sexual excesses, and possibly other forms of nervous exhaustion, are an important etiological factor.

I remember the case of a wealthy Brazilian whom I knew in Paris some twelve years ago. He was about fifty years of age when he married. Three days after his marriage he was attacked by purpura, from which he slowly recovered after six weeks' treatment.

Phosphorus was my main remedy then, and it served me well. I also prescribed it in the present case, though the condition of the patient at the time I saw him was quite hopeless.

My reasons for the prescription are the well known pathogenetic effects of phosphorus on the blood, on the liver and on the nervous system, all of which were conspicuously involved in the case. Hamamelis and lechesis also had claims to my attention, but I gave the preference to phosphorus as covering the ground more thoroughly.

I must say, to the credit of Dr. Bailey, that the correct diagnosis of the disease, though comparatively easy at the time of my visit, must have been extremely difficult, if at all possible, during the first days, the purpuric manifestations having supervened unusually late in the course of the affection, so that the only practical hint thrown out was the early appearance of epistaxis.

Dr. CRAWFORD: Some knowledge of this case came to me through meeting Dr. Arnulphy one morning with the post-mortem specimens of the liver in his hand, and I am more than gratified now on this account to hear the full report from those who attended it. At that time Dr. Arnulphy will recall my cross-questioning him with reference to the diagnosis. Whether there had been any evidence of a previous fever like unto typhus or malignant measles. Whether there were any inguinal enlargement and suppuration such as cases of the plague exhibit; whether any signs of acute yellow atrophy of the liver had manifested themselves; and whether there was any likelihood of meningeal inflammation being the cause of the purpuric display. But these interrogations were answered so concisely that I could not but agree with him in his diagnosis.

It is a great pity that we are so obstructed in the scientific investigation of a case like this, through inability to obtain permission to make a thorough *post-mortem* examination. There is a point for instance, in the history given

by Dr. Bailey, that suggests the inquiry, were the kidneys involved? The specific gravity of the sample of urine he tested was only 1010, which is the very opposite to the weight of urine in rheumatic disease. On the other hand such a light specific gravity in urine is common in advanced cirrhotic kidney, and the subjects of this disease often develop a petechial rash before the fatal ending.

With reference to the remedies mentioned by Dr. Arnulphy I have but one suggestion to offer of the three chief snake poisons we use. Lachesis, crotalus and naja, although they all have many indications in common, the virus of the rattlesnake is the one which exhibits the greatest tendency to hæmorrhages. The gums, nostrils and mucous surfaces generally, as well as the skin, show abundant signs of hæmorrhage, resulting from the bite of this reptile.

The cobra poison develops a greater proportion of the nervous phenomena, and lachesis holds a balance between the other two.

As I expect shortly to receive a full-blooded "rattler" for a pet, if any of the members of this society would like to verify these indications I will be able to furnish them with a bite.

Dr. R. LUDLAM had not a doubt that the case so well reported by Dr. Bailey was one of rheumatic purpura. A few years ago he was called in consultation by one of our members, Dr. E. E. Gwynne, of this city, to a similar case that recovered, and which Dr. Gwynne had promised him to report to this society. He had also had two cases of purpura occurring at the climacteric, in his hospital clinic, both of which had recovered under the use of hydrocyanic acid, 6 and 30. One of these was sent to him by Dr. C. T. Canfield, the details of which are reported in *THE CLINIQUE*, volume VI., 1885, pages 31-32.

IV. THERAPEUTICAL SUGGESTIONS. By ASA S. COUCH, M. D., of Fredonia, N. Y. *THE CLINIQUE* is essentially what its name implies. Contributions to its columns, through this Society, therefore, should be clinical in character, or be derived from clinical observations.

Assuming, however, that well qualified practitioners will receive with little interest and less benefit, remarks upon "*Confirmation*" and "*Keynotes*," the writer begs to depart a little from this beaten path.

Nothing is known of the rationale of so-called homœopathic cures. It is assumed, probably with truth, that they come from the law that like forces destroy one another. A phenomenon of symptoms, called disease, is met by a similar phenomenon of drug symptoms and lost balances are restored. But just how these antagonizing peacemakers find their way to the arena has not been ascertained. In any event, in the application of the rule which is to bring them together, science disappears. There is, and must always remain, too much uncertainty in drug types (provings) in the discrimination of practitioners and the mixed and conflicting symptoms of disease. Wise homœopathic physicians feel this embarrassment, and most of them will endorse the somewhat humiliating confession. Can nothing insure a broader scope to professional operations?

Outside the adjuvantory field, can no rule be deduced whereby progress can be made other than that under the homœopathic law? Replying to this interrogatory attention is called to the mineral remedies. Many of them act curiously and most beneficently, and yet apparently independent of and outside of the law of similars. The enthusiasts on behalf of the "tissue remedies" have undoubtedly achieved results through their employment which justify their faith but the supposition that these drugs are "nutritive to some tissues and thus act upon their function" must be received with caution if not rejected as altogether untenable. Nature advances by sequences from lower to higher. The vegetable is organized from the mineral and the animal from the vegetable kingdom.

If organization into *protein plasma* is essential to assimilation and nutrition in animals, minerals when they produce results as medicines must achieve them either through chemistry or catalysis. That calcarea phos. can be organized into cells for the repair of fractures; or that iron can be assimilated so as to actually *nourish* the hæmoglobin, is yet *sub judice* in the volume of conservative thinking; but that these, and other minerals, are indispensable remedies is established beyond dispute. That they act chemically (in the broad sense of the term) is improbable, for this is opposed to what is known of the laws of biology, and the inference remains that results from them largely come through catalysis.

Tellurium, even in minimum doses, procures disgusting and lasting exhalations from the body, and it is confirmed of its proving that it will cure otorrhœa having a discharge "smelling like fish-brine"—an odor unlike any of its chemical compounds. In this instance is the cure strictly homœopathic? through chemical changes in the remedy? or through catalysis?

In 1886 the writer reported to the Homœopathic Society of Western New York a cure of diabetes mel. by antimony crude. The case was a typical one and the cure absolute, for the patient is still living and free from all traces of the disease. From the *resumé* of the symptoms in the case, the cure might be claimed to be homœopathic, and it is admitted that the remedy was selected from the "totality of the symptoms;" but, if so, does it not at least involve a hint as to the action of remedies under the law?

In many cases of gastric disturbance with (or without) acidity, flatulence, constipation or diarrhœa, many of the minerals, simple or composite, and especially the phosphates and sulphates, act with great promptitude and emphasis. Often when *nux vomica*, though indicated, proves insufficient, and especially when there is much flatulence with a tendency to anæmia, a combination with *ferrum phos.* is blessed with striking results.

Combinations with *insoluble carbo veg.* are also frequently beneficial. Changes most marvelous follow the administration of *ferrum pic.* for some of the new formations. In one instance, a lady from whose breast an adenoma had been removed and who had also a small, benign formation on the face, was afterward attacked by diabetes mel. Digestion, assimilation, and, as a necessary sequence, nutrition were poor. She was growing thin and anæmic. Remedies selected homœopathically were of no avail. *Ferrum pic. pt. x* trituration produced a prompt and wonderful transformation, and what is better, reduced the sp. gr. of the urine from 1040 to 1017!

Other minerals might be referred to and cases cited where relief following their administration was clearly not homœopathic and, almost as certainly not from chemical changes in themselves, but it would encroach upon the pages of THE CLINIQUE without adequately enhancing the intent of this paper to do so. They will be suggested to the minds of experienced practitioners. The purpose of the article is simply to invite attention to its subject matter, in the hope of stimulating observation and discussion in the direction, to the possible end of broaden-

ing the scope of those who call themselves homœopathic practitioners.

A starting point may be made from the declaration that crude minerals are never assimilated in the higher animal organisms; that their excessive presence, in parts, after administration—e. g. iron in the red globule—is only proof of its *presence*, and that good results when obtained by them come from this *presence* and not because of direct and actual *nutrition*. If this be so, it would appear to open up a valuable field for exploration.

The husbandman supplies materials of which his fields have been exhausted. In this instance nature assimilates it into the golden grain. Why should not physicians supply minerals which, through dialysis, shall permit restorative changes in many parts of the organism ?

IN MEMORIAM.

Dr. Shears announced the recent death of Dr. G. H. Morrison, of Winnetka, Ill., from typhoid fever, and after paying a tribute to his many excellent qualities offered the following resolutions which were unanimously passed:

WHEREAS, This Society has learned with regret of the death of Dr. George H. Morrison, a member of this Society, an alumnus of the Hahnemann College, and a former interne of the Hahnemann Hospital, and

WHEREAS, In his death we lose a loyal member of this Society, a valued friend and an earnest supporter of the Hahnemann college, therefore be it

Resolved, That this Society desires to express its appreciation of his many good qualities as a man, a physician and a citizen.

Resolved, That we express our sincere regret at his death, and that we tender to his family and friends our deep sympathy in their loss.

Hospital Notes.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

REPORTED BY CORNELIA S. STETTLER, M. D.*

THE CALCAREOUS DEGENERATION OF UTERINE FIBROIDS. —
December 18 a laparotomy was made before subclass 12, and a uterine fibroid, larger than the foetal head at term, removed. In showing this tumor to the general class, on the next Wednesday, Prof. L. said:

You will remember that the patient in this case, 21,074, was fifty-six years old; that she had been married thirty-two years without having conceived; that she passed through the "change" three years ago without any serious trouble. But her health had been wretched since that time; she had grown weak, very nervous, pale and anæmic; had spent the last winter in California, and traveled considerably in the hope of regaining her strength. She first noticed this growth about two years ago.

Observe that the surface of this tumor shows evident signs of disintegration. Its vitality must have been very low. It is low enough in all cases of fibroids, but we often find that the cutting off of their feeble blood supply after the climacteric is a special source of danger, because they afterward degenerate more rapidly. For this reason it is very unwise to promise any woman who has a fibroid of any considerable size that it will diminish or disappear after the menopause. It may become more or less atrophied, but even that retrograde change is beset with danger. Here is a case in point. The first step in the calcareous degeneration of these growths is a post-menstrual atrophy. It may not affect all portions of the tumor at the

* Continued from Vol. XIV., page 565.

same time, but commencing here and there in its interior, or upon its capsule, or both, the tissue becomes condensed, its vascularity diminished, and the process of petrification begins. In one case there will finally be a more or less complete shell, or incrustation about the tumor; in another the internal transformation results in cretaceous deposits of various sizes scattered through the growth. Sometimes these formations are so hard and dense that they can only be cut through with a saw; again, they are smooth and polished like bone, or ivory. In very rare cases, according to Virchow and Lebert, the deposit is truly ossific. Bostock gives their composition as consisting of the phosphate, the carbonate and the sulphate of lime, the former salt predominating.

The extra-uterine fibromata are most prone to undergo this rare form of degeneration; but it occasionally happens that a sub-mucous fibroid, which is as hard as a stone, is expelled from the uterus. These fibro-calcareous changes are mischievous because they involve other forms of degeneration, such as the gelatinous, the cystic and the hæmorrhagic. It may happen, as in this case, that the earthy deposit shall involve the pedicle of the tumor so as not only to starve the growth, but finally to amputate it. Here is a hard mass which I could not cut with the knife or the scissors, that extended half way across the pedicle. And here are scattered foci through the growth, and its capsule, which you can feel and examine for yourselves, as it is passed around.

THE CONSERVATIVE TREATMENT OF CERTAIN CASES OF ECTOPIC KIDNEY.—Wednesday, December 20. *Case 21,077*, brought to the clinic by Dr. Helen M. Lynch, of Highland Park, was that of a woman æt. thirty-two, mother of two children. Both labors were normal, but during her getting up after the last one, she noticed a growth in the right hypochondrium. It has never entirely disappeared but is more prominent at certain times and especially on standing or walking; has never been painful; the urinary secretion is not impaired or changed; the bowels are regular and she can lie upon either side indiscriminately. Local exami-

nation shows that the tumor has considerable latitude of motion; is non-sensitive; can be pushed toward and partially into the right renal region; a certain portion of its surface is elastic and slippery, and glides from the grasp of the fingers like a movable kidney.

This position upon the back with the knees flexed is the best one for examination in cases of this kind. If you place one hand posteriorly, thus, for counter pressure, and the other one beneath the free border of the ribs while the patient takes a deep inspiration, you will feel the mobile kidney to descend so that it can be palpated. Then, on expiration, it will rise again toward the thorax, as the air is forced out of the lungs. Those about me can apply this test in the present case, and you can all see how it is done.

Now we will turn this woman on her left side and the tumor will fall toward the mesian line of her abdomen. While it is there we apply percussion to the normal site of the right kidney, and the resonance elicited shows that it is away from home. However, if the organ were not so enlarged as almost to fill this space when pushed into it, the converse of this sign might fail us as it often does, for we cannot always find dullness on percussion in the renal region when the kidney is in its proper position.

The shape and texture of the displaced kidney are sometimes so well preserved that we can identify it wherever we find it; but here it is different, and there only remains the peculiar propensity to slip from between the thumb and finger, like a melon seed, that we find in most cases of floating kidney.

I have already spoken of the importance of remembering that a displacement of this organ may serve to complicate obscure diseases of the uterus and the ovaries.* You cannot have forgotten the clinical points already made in several cases of the kind. All we have to do for this poor woman, who in all other respects is so well and so useful in her home relations, is to refrain from doing anything in a surgical way, unless this erratic tumor should directly or

*THE CLINIQUE, vol. XIV. p. 121.

indirectly impair her health and her comfort more than it does at present. It will be time enough to resort to nephrorrhaphy or nephrectomy when her symptoms and her sufferings warrant it. But the case should be watched and examined from time to time, and the patient should refrain from all violent exercise. Nor should she wear anything like a corset, which habit, according to Mathieu and Bouchard (1884) next to child-bearing is the most frequent cause of a displacement of the kidney. It is well also to avoid the causes of gastric dyspepsia and distension of the stomach which often occasion and perpetuate these renal deviations.

THE EXPOSURE AND STUDY OF THE APPENDIX VERMIFORMIS IN CERTAIN LAPAROTOMIES.—Before closing the abdomen in a recent laparotomy, Prof. L. said to the class: I have several times referred to the possibility of confusing the local signs of ovarian and tubal disease with those of appendicitis. As a means of aiding our students in this matter I have formed the habit whenever it is possible, and not harmful to my patient, to expose the appendix for a brief observation and study. These opportunities are not infrequent, and now that you have seen this troublesome organ, you can readily understand that by its size and length it may hang down into the iliac region, and, becoming diseased, might involve the integrity of the uterine appendages.

This one is five inches long; while the one which I showed to the class a few days ago was not more than half its length. Both being healthy there was no justification for their resection; but you will remember that while tubo-ovarian disorders cannot complicate appendicitis in men, neither can they in women excepting in the right iliac region.

OVARIOTOMY FOR INTRACYSTIC HÆMORRHAGE WITH GELATINOUS AND COLLOID DEGENERATION OF THE OVARY. RECOVERY.—Wednesday, January 3, 1894. *Case 21,080.* Miss —, æt. forty-eight, sent to this clinic by Dr. O. N. Hoyt, of Pierre, S. D., menstruated regularly for thirty-four years, when there was a suppression during an acute illness of two months, since which time the periods have been regular but scant. The only exception to this rule occurred

three months ago, after being much upon her feet during the Columbian Exposition, when she had a severe hæmorrhage which lasted six weeks, ceased gradually, and was followed by the appearance of a growth at the left and just above the pubic bone. In ten days it was as big as a tea-cup, in ten more twice that size, and so it has continued to grow rapidly. Ten years ago she received an injury in the left iliac region, which was immediately followed by a profuse hæmorrhage from the rectum. Until recently her general health has been pretty good, but now she is failing in strength and looks badly. She has no pain and the only inconvenience is from pressure, especially on reclining, and the lower extremities are sometimes numb.

Having considered the chief points in this case, and after a careful physical examination, you may be disappointed in my failure to give you a final and satisfactory diagnosis. We ought to be able to say whether this tumor is uterine or ovarian, solid or cystic, but we are not certain. The growth is big enough; there is a large area of dullness on percussion; its first appearance was in the iliac region; it has filled or grown very rapidly; and the surface of the abdomen is very tender to the touch; but there is no change in the volume or the texture of the cervix, the depth of the uterus is not increased; nor is there any fluctuation in the tumor, except such as would indicate a layer of ascitic fluid over its exterior. To the touch the tumor is elastic, or semi-solid, which sensation is confusing and not diagnostic, for it may indicate the presence of a thick walled cyst of the ovary, or of a uterine sarcoma, or it may be due to a very deep rubber-like deposit of fat in the abdominal parietes. We shall know what it is to-morrow.

Operation—January 4. An ovariectomy was made before sub class 1. The abdominal wall was very thick from adipose. The tumor proved to be a large multilocular cyst of the left ovary; the parent sac was filled with blood and large blood clots, some of which were old and bronzed; while the other cysts of which there were a great many, were all colloid and gelatinous. The entire growth was friable and rotten, and came away in chunks and masses as large as the fist. There were no adhesions excepting to the mesentery, which points were badly congested and almost

ulcerated. The pedicle was broad and not twisted. The abdomen was flushed, cleansed, and then closed with silver sutures. The weight of the tumor was estimated at twenty-five pounds.

Now you can understand why some of the usual signs of ovarian dropsy were absent in this case. With several condensed tumors composed of these masses, and in the larger sac, of these big blood clots, not to speak of the thick intervening wall of the abdomen, it is no wonder that we failed to detect anything like deep fluctuation.

The rapid increase in the size of this tumor must be ascribed to the hæmorrhage into this large cyst, which, judging from its contents, had been going on with interruptions for about three months. There is nothing in the remaining portions of the tumor to indicate any rapid or very recent change in its size. And, so far as the intracystic hæmorrhage is concerned, it is worthy of note that its usual cause in cases of this kind was lacking, for the pedicle was neither long nor twisted. Bad as the case is, if there is no development of septic peritonitis from those points of adhesion and abrasion on the mesentery, I believe that this woman will recover.

I have abstained from the use of drainage not because the case was not "nasty" enough, but because thorough flushing with hot water, if the discharges are sticky and gelatinous, is much better; because there were no extensive adhesions from which a large amount of capillary oozing might come; and also because with such a fatty abdomen the wound will almost always suppurate, and we ought, therefore, whenever it is possible, to close the peritoneum perfectly against all extraneous sources of infection.

Wednesday, January 10. The only care needed in the after treatment of this case has been to avoid intestinal paresis and the accumulation of gas. The highest temperature has been $100\frac{1}{4}^{\circ}$ and the highest pulse 107. The only complaint has been of hunger; and she has had milk, and mutton and oyster broth. The dressings were removed this morning, at the beginning of the seventh day, and the wound has closed perfectly by primary intention.

Clinical Reviews.

THE THEORY AND PRACTICE OF MEDICINE, PREPARED FOR STUDENTS AND PRACTITIONERS. By JAMES T. WHITAKER, M. D., LL. D., Professor of the Theory and Practice of Medicine in the Medical College of Ohio, etc., etc. With a chromo-lithographic plate and three hundred engravings; 8 vo., pages 840. New York: Wm. Wood & Co. 1893.

This is a well printed, beautifully illustrated, comprehensive and intensely practical book, written by Prof. Koch's first American student. On every page there is evidence that the author has not followed the too common habit of those medical writers who fill their books with nothing except the omission to say something that would be of real service in the sick chamber. We commend the volume as the freshest, brightest and most satisfactory of its kind. Here is a sample of directness of style and statement that the busy doctor will appreciate, at page 151:

The diagnosis (of pulmonary tuberculosis) may be established, in a case at all advanced, by the discovery in the sputum of elastic tissue. For this examination no particular skill or apparatus is demanded. A morsel of sputum, preferably a grayish or reddish yellow particle, is pressed upon the slide by the cover-glass, to reveal at once, best after the addition of a drop of a thirty per cent solution of caustic potash, the curled fibre of elastic tissue, usually, on account of its incompressibility, near the edge of the glass.

In all other cases of tuberculosis, of the skin, glands, bones, testis, etc., as well as in all concealed, latent, or quiescent cases, the diagnosis may be declared in the course of a few days by the subcutaneous injection of tuberculin—one milligramme of the diluted 1:100 solution—which will produce fever in tuberculosis, but will have no effect in other diseases or in health.

At page 438 this latter diagnostic test is emphasized: "The author has never yet been deceived or disappointed with this method in this disease. In one case the diagnosis thus established was verified by laparotomy." Concerning the curative value of this agent we read at page 158:

As a therapeutic agent tuberculin has stood the fire of trial, so that its value may now be definitely stated. The use of it is contra-indicated

in hectic and hæmorrhage, and in serious affection of the intestinal canal conditions due to sepsis, and best controlled, if controllable at all, by creasote and cognac. Tuberculin cures only pure tuberculosis. It is therefore of especial value in incipient cases of lung disease, before sepsis has set in, and in deep seated or secreted latent cases of gland and bone affection. In these cases it soon puts a new phase upon the disease. Cases of anæmia, amenorrhœa, dyspepsia, cryptogenetic fevers, "colds," bronchial catarrh, so-called rheumatism—in reality beginning bone caries—recurrent or obstinate laryngitis, or other of the multiform manifestations of tuberculosis, whose real nature was only disclosed perhaps by tuberculin, gradually yield under its continued and judicious use. The beginning dose should be small—one-twentieth to one-tenth milligramme—and gradually increased, avoiding fever, slowly at first, more rapidly later, up to ten centigrammes. The remedy should be introduced subcutaneously about the back of the trunk, not oftener than every other day, and always in the morning, that the effect upon the temperature may be studied during the day.

A SYSTEM OF DISEASES OF THE EAR, NOSE AND THROAT, edited by CHARLES H. BURNETT A. M., M. D.; illustrated. J. B. Lippincott Co., publishers, Philadelphia. Two volumes.

There is a decided reason for the publication of this treatise. The close anatomical and pathological relation existing between the ear, nose and throat renders it necessary that diseases of these organs be treated by the same hand. Diseases of the one region are so commonly the cause of results in the neighboring organs that the study of the related diseases is necessary, and for reference a systematic treatise is of especial value.

For years the treatment of diseases of the eye and ear have been associated, but it is an unnatural relation, as the diseases of the ear depend so much more upon nasal and naso-pharyngeal causes; of late so much more stress has been laid upon this relation that the field of the aurist and rhinologist is now more commonly covered by the same practitioner. I believe that in no field is the era of preventive medicine more clearly shown than in this. There will not be the excuse for the development of so many incurable cases of deafness, after the thorough study of this generation.

Another special feature of this system is that it is encyclopedic in form. The various chapters and subjects are written by men who have some peculiar fitness for the task, and we have here summed up the latest and best of the specialists of this country and England. There are about

forty contributors who have given us practical conclusions rather than theories, and the sixteen hundred and forty pages of the work cannot fail to be of value to those who will make reference to it.

C. G. F.

ESSENTIALS OF HOMŒOPATHIC MATERIA MEDICA; being a Quiz Compend upon the principles of Homœopathy, Homœopathic Pharmacy, and Homœopathic Materia Medica, arranged and compiled especially for the use of Students of Medicine. By W. A. DEWEY, M. D., late Professor of Materia Medica, Hahnemann Hospital College of San Francisco, Cal., etc., etc. Philadelphia: Boericke & Tafel, 1894; pp. 270.

"When I was young," said Jules Simon, "we prepared students for life, but now we prepare them for examination." While this little book might be adapted to the "cramming" process its author claims for it a higher and a more honorable function; and its compensation lies in the smallness of its size, its compactness, directness and thoroughly practical and non-partisan character. The title shows its scope. Chapter I. is devoted to general considerations, principles of the system, symptoms, provings, action of remedies, nosodes, aggravations and ameliorations, local measures, palliation, isopathy, prophylaxis, relations of drugs, alternation, etc., all within twenty-four pages and without preaching or scolding.

Chapter II. is devoted to Pharmacy, and is equally clear, sharp and satisfactory. Chapter III. quizzes on the Essentials of drugs derived from the Vegetable Kingdom. These drugs are grouped into their botanical families and the clinical cream of their therapeutical action is given in such a form that it may be utilized at the bedside. Chapter IV., the Essentials of drugs derived from the Animal Kingdom, such as *moschus*, *lachesis*, *crotalus*, *naja*, *sepia*, *spongia*, *apis mel.*, *cantharis*, etc. Chapter V., the Nosodes, is fittingly brief; while Chapter VI., which properly includes the "tissue remedies," is extended and very clever.

The author deserves great credit for putting so much information into so condensed a form, or rather, perhaps, for bringing it forth in response to a set of questions that are not fanciful and theoretical merely. For there is an art of putting questions that not only tests the knowledge of the pupil but the tact, learning and good sense of the teacher also. Surely such study of the materia medica as will be stimulated by this book is greatly better than the old trick of memorizing a lot of isolated and disjointed symptoms as a preparation for prescribing.

CORRESPONDENCE.

SYMPHYSEOTOMY TO DATE.

The following letter from one who is an acknowledged authority in this matter will interest our readers and we are glad to publish it.—EDITOR.

PHILADELPHIA, January 8, 1894.

Dr. SHELDON LEAVITT,

Dear Sir:—I am very glad to learn of your symphyseotomy, and to be able to congratulate you upon its result. Be kind enough to fill up and return the enclosed postal card.

Your case gives thirty-four to the United States, eight for 1892, and twenty-six for 1893. In order, it is case twenty-nine. There was one woman lost, out of the last eighteen in order.

The first operation in America, was in Alabama, on March 12, 1892. I have fine pictures of mother and son.

The first operation in Chicago was on May 3, 1893. Mother and daughter now living. Fœtus weighed twelve pounds.

The average weight of the fœtus in this country, delivered by pubic section, has been eight pounds. The C. V. should be at least two and three-quarter inches, or the baby will probably be lost in delivery, as twice happened in this city.

I will correct some of Varnier's errors:

Morisani revived symphyseotomy in 1866. Pinard operated first on February 4, 1892; Coggin's case in Alabama was thirty-six days later; Germany's first case was on April 29, 1892; Austria's first case was on August 4, 1892; Russia's first case was on September 5, 1892; England's first case was on February 12, 1893. England operated the thirteenth country, and not until France had had forty-three cases, and we twelve. There were eighty-one operations in the world in 1892—and probably 200 in 1893—Varnier is much behind Neugebauer and me, in his record.

Yours very respectfully,

ROBERT P. HARRIS.

 THE "OLD HAHNEMANN."

MR. EDITOR:—I have several times observed a disposition on the part of some of our Eastern friends to rob your college of the above title and to settle it upon the school in Philadelphia. Being a graduate of the latter prior to 1869, and when it was still known as the Homœopathic Medical College of Pennsylvania, I want to say that the Hahnemann of Philadelphia was started in 1867 by Dr. Hering, in consequence of a row between himself and Dr. Lippe. Both schools continued for two years and then the old one ceased to exist under the old name. So, as a simple matter of fact, the Hahnemann of Philadelphia dates from 1867, while your Hahnemann College and Hospital, of Chicago, as I am credibly informed, has been in active operation ever since 1860. If you think it worth while to put this statement on record in the interest of fair play, you will do a good thing for your school and hospital, which were the first in the world to be named after the immortal Hahnemann.

Yours very respectfully,
MATERIA MEDICA.

SHOULD VALVULAR DISEASE OF THE HEART
BE A BAR TO MARRIAGE?

AURORA, ILL., Jan. 12, 1894.

MR. EDITOR:—I was greatly interested in Prof. Arnulphy's recent paper to the Clinical Society upon Heart Disease and Pregnancy.* But his remarks upon the important question of marriage in the case of young women who are already the subjects of cardiac valvular disease, attracted my especial attention, as it certainly did that of many of your readers. In this view of the subject may I send you a brief translation from a very recent issue of the *Semaine Médicale* that will, perhaps, be suited to your pages?

*THE CLINIQUE, VOL. XIV., page 405.

Ought a young lady or a woman afflicted with heart disease, to marry and to assume the risks of maternity? It is very well known that pregnancy and labor exercise an unfavorable influence upon such subjects. Certain clinicians, as the late Dr. Peter, expressly forbid marriage, pregnancy and lactation to all women who have valvular disease of the heart.

The experience of Dr. Vinay, physician to the Hotel Dieu of Lyons, has taught him that this rule is too general, and that pregnancy is much less hazardous for these cardiac subjects than is commonly supposed.

During the years 1891-92 he invariably auscultated all women who came to the Maternity to be delivered. Of a total of 1,700 women who were thus examined, he found that 29 or 1.70 per cent had various heart troubles.

The most frequent lesion was mitral insufficiency, which occurred eleven times without complication, seven times along with bicuspid, and once with aortic insufficiency. In the whole twenty-nine cases, pregnancy was normal eighteen times; three times there were accidental ailments, as influenza, etc.; four had œdema resulting from varices of the lower extremities; but in only four was there any perceptible effect of pregnancy upon the heart lesion. One of these latter had hæmoptysis with dyspnœa; another had a sense of suffocation with serous effusion; and finally two, who were pregnant with twins, had dyspnœa with swelling of the legs and feet.

In twenty-four cases delivery was at term, one being a twin labor; only five were premature, two being twin cases. It is worthy of remark that only two women had albuminuria; all the others were exempt from it.

Dr. V. divided those pregnant women who were ill with cardiac troubles into three groups. In the first he includes those in whom the heart trouble, latent before conception, continued during pregnancy, labor and the lying-in. His cases of this kind were more frequent than is generally supposed.

The second group consists of cases in which the cardiac function was but slightly impaired, and for the first time during gestation, delivery and the puerperal state. While the prognosis in this class is more serious than in the former one, it is, however, benign. In fact the cardiac insufficiency was not very marked, besides it was mitigated by rest and proper treatment and disappeared in due time after delivery.

The third group concerns those cases in which the gravido-cardiac symptoms are most severe and in which, at a period more or less remote from the date of conception, the result is fatal.

The existence or absence of albuminuria is an important element in the prognosis. The presence of albumen in the urine of one who has heart disease signifies a valvular insufficiency that has advanced to the state of compensatory disorder, and is always a bad sign, but especially in a pregnant woman.

The practical conclusion deducible from the facts furnished by Dr. Vinay is, that with young women and also with older ones who have heart disease, marriage and maternity should, according to the circumstances of each particular case, be sometimes permitted and sometimes discouraged. It may be allowed, but not without reserve, when the cardiac affection is well compensated (in mitral narrowing or aortic insufficiency) if there is no albuminuria, and when there has never been any serious asystolic trouble.

But if the patient has already had such attacks; if, for example, she has had very distinct symptoms of cardiac insufficiency, such as pulmonary congestion, hæmoptysis, and especially albuminuria, we may be certain that pregnancy and the future of the infant will be seriously compromised, and we will therefore do well to forbid marriage and maternity.

Very respectfully,

C. S. S.

The proposal to ask the doctor's advice concerning the propriety of marriage between parties who are ill, or who are threatened with some serious disease, is a very old one. If we grant that certain affections of the heart on the part of the woman should be a bar to matrimony, we ought to be able to decide what degree of involvement and what complications should determine this very delicate question. This can only be done by the collection, compilation and careful digestion of reliable statistics obtained in hospital service, and from those general practitioners who are sufficiently conscientious and competent to do this kind of work. The facts brought out by Dr. Vinay, for the clever

rendering of which into English we are indebted to our correspondent, are pertinent and suggestive. They will help us to decide intelligently, which is no small matter. For to interdict marriage because of a trifling functional disorder of the heart through an error in diagnosis, or through ignorance of such rules as he has laid down, would be almost criminal. And so also would it be if we failed to advise against marriage in such cases as those which he has so carefully eliminated from the lighter and less serious members of the same general class.

To leave this question for the family physician to decide might arouse a personal prejudice, or clothe his professional opinion with undue importance. For the heart specialist it would perhaps be an insuperable incentive to find just what he was looking for. To deprive such women of the liberty to marry might through psychical influences react upon the heart to its detriment, or drive them to immorality and desperation, because the doctor's stigma had been put upon them. So that, in any event, we should be careful in a case of this kind, not to be swayed by sentiment at the expense of good judgment and experience ; but to give to heart affections as they concern the proposed marriage relation the same consideration that we would to renal disorders, or to the tubercular predisposition, and nothing more.—EDITOR.

Miscellaneous Items.

The winter term is progressing in a very satisfactory manner, most of the out-clinics being held in the new college building.—The new library is a great success already. Dr. Charlotte W. Cushing, of Hinsdale, has given it thirty more volumes.—Prof. Bruce has removed his office and residence to The Ormond, 144, Fifty-fourth Street, and Prof. Vaughan to the Marshall Field building, Washington Street and Wabash Avenue.—Dr. W. M. Thompson has left Crystal Lake and located in Chicago.—The *Revista Homœopatica*, of Barcelona, Spain, publishes, with credit to THE CLINIQUE, the late Dr. Fischer's Clinical Hints or New Remedies.—Prof. Bailey has gone south with a patient.—The Illinois State Homœopathic Medical Association will hold its next meeting in Quincy, May 15–17th, and communications concerning the same should be sent to Prof. W. A. Dunn, Secretary, Marshall Field building, Chicago.—Prof. Bailey has resigned the office of Registrar of the College and Business Manager of THE CLINIQUE, in which service he has been so long and so honorably engaged, to be succeeded by the election of Prof. Cobb to the same post.—Prof. Chislett takes Dr. Cobb's place as the College Superintendent.—Prof. Crawford is giving a short, special course on the physiological anatomy of the thorax.—The course of lectures in the trained nurse department of the Hahnemann Hospital was opened January 2.—Two more of our beloved Alumni have been removed by death: Dr. Geo. Parsons, '74, November 27, at Kerrville, Texas, and Dr. Geo. H. Morrison, '81, at Winnetka, Ill.—Dr. F. W. Root is now associated in the practice with Dr. Isabella S. Hotchkiss, at Riverside, Ill.—Everybody is urged to renew his own and his friend's subscription to THE CLINIQUE for 1894, and to do it at once.—Especial attention is directed to the article entitled Therapeutical Suggestions, by our old friend, Dr. Couch, at page 30.—Prof. Crawford will present a report on Vaccination at the next meeting of the Clinical Society, January 27, and if the vaccinophobists don't want to sit on the pins and needles of impatience they had best remain away.

THE CLINIQUE.

VOL. XV.]

CHICAGO, FEBRUARY 15, 1894.

[No. 2.

Original Lectures.

CHRONIC PERITONITIS.

SYNOPSIS OF A LECTURE GIVEN BY E. STILLMAN BAILEY, M. D.,
PROFESSOR OF THE MEDICAL DISEASES OF WOMEN, IN THE
ANATOMICAL AMPHITHEATRE OF THE HAHNEMANN MEDICAL
COLLEGE, DECEMBER, 1893.

Before going into the subject of this evening's lecture, permit a word of explanation. Those of you who have attended my lectures this winter have noted the arrangement of subjects to be as follows: First we discussed the present theories concerning the physiology of menstruation, then the disorders and anomalies of the same, then the inflammatory diseases of the genital tract from without inward, finishing with the subject of endometritis. Now we take up peritoneal and pelvic inflammations.

Thus far it has been easy to illustrate these lectures, by showing you cases from my clinic and sub-clinic. With the new subject of intra-abdominal inflammations, I must hunt for a different form of illustration and as there is none so good as the body itself, I am glad to be in a position to demonstrate some of the facts that will interest you all.

Pelvic peritonitis is three times more common in the woman than in the man, and the abdominal form is twice as common. The anatomy of the peritoneum is difficult to describe and almost as difficult to demonstrate. There is

no way of obtaining a clear idea of the peritoneum except through a knowledge of its development from the embryo to the adult, and just here let me recommend for your earliest reading and study, the little monograph by Dr. Dexter.*

The body of the woman before us came from the insane asylum, after remaining unclaimed, and not a word of clinical history do we know, yet it is an excellent subject for illustration of peritonitis. Having made the incision from the ensiform cartilage to symphysis pubes and also transverse incisions through the abdominal parieties and turning the flaps backward, completely opening the abdominal cavity, I ask you to observe the position and relationship of these presenting parts. They are too instructive to be hurriedly disturbed.

The omentum is entirely absent; its framework is only visible at the lesser peritoneal cavity. What we see is the enormously distended ascending colon, part of the transverse colon, part of the sigmoid flexure and just a coil of the small intestine. The parts are not normal in size or position, the intestines in sight are distended with gas, the width of the colon is an inch more than the flat of my hand and its calibre is six times what it should be.

It would have been a difficult matter on the first inspection to have determined with accuracy, the identity of these parts, had it not been that the longitudinal muscular fibres that form a continuous band on the wall of the large intestine came immediately in view on opening the abdomen in the median line. This I should tell you is a well known and much used landmark for finding the much sought vermiform appendix. Let us see where the appendix is in this case. In tracing it by this band we find it, though small in size, resting on the pelvic brim and one-half of it over in the pelvic cavity. The stomach and liver are crowded upward and so is the diaphragm to a very marked degree. Such displacement must have very materially in-

* "The Anatomy of the Peritoneum."

terfered with the heart's action and also that of the lungs.

At the splenic flexure of the colon, we find a firm fibrinous band the width of my little finger, making a decided constriction of the colon, and the visceral covering of the intestine is anchored by adhesions to the parietal fold of the peritoneum; and the evidences of inflammation are also present in the muscular tissues over the region of the spleen and kidney. Such a pathological condition has brought on intestinal obstruction by bands. The lumen of the gut is so occluded as to nearly restrict the advance of the faecal matter and the gases are confined above the constriction. As the politicians are saying, "It is a condition and not a theory that confronts us." Whatever other lesions shall develop in this autopsy, we can say that here the patient has had a circumscribed chronic peritonitis, adhesive form, probably of traumatic origin, and the plastic lymph effusion becoming organized, has formed this constricting band.

This obstruction to the intestine is very productive of symptoms all along the digestive tract. These bands are usually slow in forming and the calibre of the intestine very gradually diminishes, but there is a time, as there was in this case, when the occlusion becomes a very serious matter.

The physical signs of chronic circumscribed peritonitis vary greatly. In a case like this there is great distention of the abdomen. This sign will vary according to the tightness of the constricting bands. The rise and fall of the abdomen during the respiratory act would scarcely be noted; the peristalsis of the intestine is sometimes very plainly visible; on percussion a full tympanitic note could be elicited; the normal dullness over the liver and spleen is greatly diminished or absent entirely; auscultation is of little service, revealing only the sounds produced by the movement of the fluids in the stomach and bowels.

The symptoms are usually confined to certain areas. Pain, one of the foremost in acute peritonitis, may be ab-

sent entirely, or irregularly present, or present all of the time, any irritation, hyperæmia or inflammation causing its return. The pain usually subsides with the inflammation. Vomiting may be present but is not urgent. The temperature is not a certain sign, it runs up sharply but may fall as suddenly and for long intervals remains scarcely influenced. The pulse is usually rapid, the circulation is so altered as to cause cold extremities. Fluctuations of encysted or encapsuled effusions of lymph or pus, can sometimes be added to the physical signs and they cause the symptoms to be pronounced, especially if the purulent matters undergo absorption. Constipation of an obstinate or habitual character is often present; sometimes there is an alternate diarrhœa and constipation.

The meteorism developed, is from the formation of gases in the intestine and not between the layers of the peritoneum. I know this is debatable ground but the evidence of experiment gives sanction to the statement. The facial expression is usually of pallor and the features drawn, pinched or haggard. Marasmus may be marked. The first abnormal thing we saw in this autopsy was the absence of the omentum. This is a very common thing in this disease and reliable reports also show that the intestine itself becomes shortened, materially so sometimes, and its lumen greatly contracted. This is the result of atrophy through constriction of nourishing vessels.

Bands and adhesions.—This division of my subject is not frequently discussed. It is understood best by those who have a clear idea of the anatomy of the peritoneal parts involved. No better time can come than the present, in which to make this clear. It is a physiological fact of great importance, that a certain range of motion is necessary to the welfare of the organs contained in the abdomen and the pelvis. To grant it, nature has provided a number of suspensory ligaments, nineteen in all in the human, holding the organs in a position that is normal for the performance of function, and to the noninterference with other neighboring organs. To further facilitate movement, the one tissue

covering all the other organs, is a serous tissue, having a smooth and slippery surface. This is the peritoneum. One surface lines the containing cavity and the other is thrown over the contained viscera.

The inner surfaces are smooth, polished and lined by squamous endothelium; all surfaces having an endothelial covering are bathed with moisture or fluids, the external surface of the peritoneum is composed of areolar connective tissue and connects with the internal layer of the invested viscus, or to the abdominal parieties. On the right side of the abdomen I have dissected up the parietal layer of the peritoneum and hold it up for your inspection. The parietal side is rough and irregular in appearance and the visceral side is smooth and shining. The peritoneum itself is thicker than normal and very opaque, a common condition resulting from inflammation. There exists nothing between the two visceral layers of this sac, save the moisture of the surfaces. The abdominal viscera are all more or less outside the sac, some lie altogether behind it as the pancreas, kidneys and suprarenal capsules, others as the lower parts of the duodenum, cæcum, ascending and descending colon are only partly covered by it, while others, as the stomach, liver, jejunum, ileum, and some parts of the large intestine are completely invested.

It is well known that in peritonitis a fibrinous exudation appears upon the surface of the inflamed membrane and that any two surfaces so affected, may through the medium of the exudation, become adherent if they be brought into contact with one another. This adhesion may be over an extensive surface, or only over isolated points. As the inflammation subsides there is no doubt that a good deal of this exudation is in time absorbed, such as remains becomes organized into fibrous tissue and so adhesions are produced, as in bands and false ligaments. It is also probable that some of these adhesions, owing to their flimsy structure and to the altering position of the intestines, disappear even after they have become organized into connective tissue. Mr. Treves in his masterly work

on intestinal obstruction, paints this picture of how these adhesions and bands are formed. "During the progress of peritonitis, the intestines are relatively still. They are moreover more or less distended from some paralysis of their walls. As a result of this distention, coils of bowel may be brought together that were hitherto far apart, or a certain loop may be placed in association with a comparatively distant point on the parieties, when the inflammation has subsided the parts return as far as possible to the status *quo ante*, coils that were close together tend as a result of those movements, to become separated and adhesions that attach the intestine to points upon the parieties are persistently dragged upon. It follows from this almost constant tension that the still soft adhesions yield, become elongated and thinned, ultimately giving away and are absorbed. Movement has great influence upon the future physical characters of the adhesion. If two distant coils of small intestine have been brought together during peritonitis and have become attached to one another by means of the exudate, or if a like attachment has taken place between the intestine and the parieties, then as movement is restored in the bowel the adhesions which may be quite membranous, are dragged upon and as a result become elongated. As they increase in length so must they become attenuated in width and thickness. The constant tension, moreover, probably interferes with the already feeble nutrition and renders a further wasting. The wide membranous adhesions may thus become narrowed and ribbon like."

The adhesions we must also understand are subjected to the rolling movements of the intestines over one another and are subject to frequent torsion, now in one direction and now in another and the adhesions are often rolled out into false ligaments. We might spend a long time upon this interesting phase of the disease, but enough has been given to assist in the remaining portion of my lecture. What are you going to do for these conditions in the living?

Treatment.—Chronic peritoneal adhesions circumscribed, are not so difficult to determine as you might at first think. The patient in the clinical history and the presentation of physical signs and symptoms will point to the facts. You will have to make the interpretation and application for relief. What about treating symptomatically, ignoring the pathology you are able to demonstrate? Will the minimum dose and usual time of waiting do? Resolution may take place from causes already indicated, but was it the dose or the potency or the unaided or unhindered action of nature herself that liberated from obnoxious bonds? Take the case where prescriptions and untrammelled natural action has not availed. The patient is still ill and your best prescriptions have failed, what next? I certainly recommend that you try the very best similitimum most carefully chosen, first and last and all the time, but even physicians of greatest reputation fail to cure with these means alone.

Postural treatments, such as will tend to elongate and thin the adhesions, are to be persistently tried. This is practiced when the adhesions are at a fixed portion of the abdomen, like the hepatic, splenic, cæcal or sigmoid flexures. The exaggerated Sims' genu-pectoral or modified Tendelenburg positions are excellent and often give not only immediate, but long lasting relief and the gravity expressed is in the line of helping to attenuate the adhesions. Many, many treatments may have to be given, but results are satisfactory. Emollient external applications are very grateful and useful.

Massage is only an exaggeration of the natural peristalsis. It is a fact known to the laity, but does not seem to have reached the profession in a practical way, that kneading, rolling and rubbing the bowels in a skillful manner, is an excellent cure for chronic constipation. It is known among surgeons that passive motion and friction aids materially in restoring joints that have lost their usefulness through exudations; and it is equally well known in some places that fæcal impaction and knotted intestines are re-

moved and straightened by this kindred science of medicine. The peritoneum has been likened to a joint tissue. It has its concave and convex surfaces meeting with an intervening fluid. Flexion and extension help to break up the adhesions.

Electricity.—It is much to be regretted that so little is known of the circumstances that favor the absorption of adhesions after peritonitis, but this therapeutic agent very difficult of explanation as to how it does the work, certainly should receive considerate attention and application. It is easily demonstrated that the rectal electrode with the abdominal or lumbar attachment will excite a very rapid and violent bowel peristalsis. This is directly in the line of tearing apart the adherent parts. The relief of symptoms from galvanism or faradism is very grateful and often is so effectual that many inconveniences resulting from adhesions are overcome. While I am aware that no one of these methods can do all that is necessary, yet a happy combination of them all is where the patient is set free from suffering and from progressive pathological changes.

THE TORCH VERSUS THE SPADE.

AN EVENING LECTURE BY B. S. ARNULPHY, M. D., PROF. OF THEORY AND PRACTICE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

"When graveyards yawn
"And hell itself breathes out contagion on this world,"

[—*Shakespeare.*]

What shall we do with our dead? This is the question I propose to study with you to-night. And I consider it eminently proper that such an earnest and progressive body of students as forms this class should give some thought to a problem, which though it apparently concerns the dead is nevertheless of vital importance to the living.

A problem, the solution of which becomes more imperative every day, considering the rapid increase in our population and the growth of our large cities; a problem unfortunately which seems to encounter the profoundest indiffer-

ence on the part of the great public. Such is the force of habit and routine!

In a paper recently read before the Detroit Medical Association, the following statements were made:

A number of years ago a commission of medical men was sent from the United States to investigate yellow fever in Central America and report on some method of lessening its spread. Among other investigations they examined the earth from a cemetery in which eighty years before many dead from yellow fever had been buried. They found the surface of the earth filled with yellow fever microbes, and unanimously recommended that all who died from yellow fever be cremated as the only sure method of stamping out the danger of recurring epidemics. In Charles Darwin's work on the formation of vegetable mould through the action of earthworms, he teaches that these worms bring up mould from every depth to thirteen or fourteen feet below the surface. Pasteur has recently demonstrated that earthworms may become infected with tuberculosis or the bacilli which are found in consumption. They digest the soil, bringing it to the light and, after passing it through their bodies, deposit it on the surface of the earth, where it is ground into powder by the action of the atmosphere. Should these worms have come to the surface from the grave of one dead from consumption they deposit the tubercle bacilli, and these, when blown through the air and inhaled, as dust is constantly being inhaled, bear their legitimate fruit when deposited on suitable soil.

But it is not only through contagious diseases that earth burial does its deadly work. Air, earth, and water are contaminated, as witness the fact that in all settlements in close vicinity to a cemetery, diphtheria, typhoid, and kindred diseases pointing to a depraved condition of the system are almost perennial. During the months of June, July, and August, when other parts of a city seem exempt, diphtheria and typhoid are to be found in the neighborhood of its cemeteries. Washington Square, New York, is a delight to the eye with its lovely lawns and shady walks and beautiful flower beds. Almost ninety years ago it was the potter's field, and to-day New York physicians say that no child can thrive who lives on the first floor of any dwelling in its vicinity and many succumb to its fatal beauty. Down to this day a thick blue haze every tranquil morning rests a pillar of death several feet thick over the green sward. Trinity church yard crowded with graves is a distillery of death in the midst of the mightily throng surging along Broadway and eddying down Wall street.

In support of these facts it can be shown that the graveyards, all the world over, have won for themselves the most unenviable reputation. And why not say so, when it is true? A more murderous institution, under the protecting banner of Church and State, could not be devised.

The proof is ready at hand for him who cares to elicit. Let any one go to a cemetery, take a handful of earth and hand it over to an expert chemist; the chemist will extract from that earth a subtle septic substance which injected into a pigeon, a cat or a small dog will kill it outright.

It is the great fault of mankind to be satisfied with a film-like knowledge of things. Few people, even among

the best educated, ever dive below the mere surface of the host of disquieting problems which encompass our lives. I make bold to affirm that there are millions of refined, cultured, intelligent people in this land and abroad who have never given a single thought to this subject.

It is not my intention to sing the praise of the medical profession. But it is safe to say that of all recent attainments in the scientific field, none are more glorious nor more widely beneficent than such as are due to the labors and genius of men like Pasteur and Koch, the practical lesson of which comes home to every one of us in this way: that the most acute, the most deadly, the most widespread forms of disease are those which spring from living germs.

Such is the case with tuberculosis which annually kills five millions of our fellow-beings; with diphtheria, pneumonia, scarlet fever, influenza or grippe, erysipelas, yellow fever, typhoid fever, Asiatic cholera, smallpox, etc.

Since the knowledge of the nature and origin of disease has become a science, there is no possible excuse for any one even superficially acquainted with its recent attainments who does not loudly protest against the method of burial to-day in vogue.

A large percentage of the mortality results from the infectious diseases cited above. The physician knows it, the minister knows it, the lawyer knows it, and the general public ought to know it. Still what do we see? Every day thousands upon thousands of persons who have succumbed to the inroads of infectious and contagious diseases are quietly buried together with the deadly germs they harbor under a few feet of earth, in the very heart of our crowded cities, under the indifferent gaze of the busy community, nay under the patronizing approval of the city authorities, and with the serene endorsement of the State Board of Health.

Now if the researches of modern bacteriology teach anything, they teach that those specific germs are endowed with tremendous vital power; that they may be drowned in water, or dried up in sun heat, or buried for years, and that still when accident or neglect brings them to light again they may fasten on the unsuspecting passer-by with unabated power to breed disease and death.

It is a well-known fact that nothing short of prolonged ebullition, or actual fire is capable of destroying those destroyers. Still, do we see around us any signs that this terrible lesson is being understood and acted upon? We notice some faint efforts on the part of municipal legislation

toward protecting the food we eat and the water we drink; but how about the air we breathe? Is this an unimportant item?

I repeat it, in view of the disquieting facts adduced at the beginning of this essay, pointing to graveyards as permanent sources of infection, as the kindergarten of the most deadly germs of disease, how shall we protect that most important factor of our lives, that *pabulum vita*, the air we breathe?

One of the most urgent measures is to stop the threatening growth of the graveyards. Look at the great cities of the world, on this continent and on the old one. What do we see? That everywhere the public cemeteries have outgrown their former limits; the empire of the dead, encroaching, day by day, as it were, over the abode of the living; day by day recruiting strength and swelling the volume of the pestilential emanation which is being poured forth upon the indifferent herd of its worshipers. London seeking relief from its overcrowded cemeteries, has founded a few miles from the heart of the city her new necropolis. Paris is trying to remove the growing tide of her cadavers to Méry-sur-Oise, thus instituting a new centre of infection for the benefit of the neighboring population. Genoa has had to forsake her famous "Staglieno," filled to overflow.

In this country the same spectacle is offered the observer. New York, Brooklyn, Boston, are struggling with the same difficulties. In this city the situation will soon be worse still. A few years ago the Oakwoods cemetery was considered out of the way, at a safe distance at any rate; nowadays it is right in our midst, surrounded with a fast increasing zone of population, and if the tide of prosperity which carries the World's Fair city on the crest of its wave shall continue onward, ten years more will locate it in the very core of our beautiful southern division, an abiding source of ruin and desolation.

Such is the situation as it must appear to every sound mind, alive to the comfort and welfare of his fellow citizens, abreast of the discoveries of the age, and unbiassed by religious prejudice which has not crystallized into a stultifying routine.

Such a situation reminds one of the man, in Lafontaine's fable who nursed a deadly serpent in his bosom. We may fairly ask ourselves, in all sincerity, whether we are better off than the natives of the Oriental Indies, where luxuriant vegetation and a gorgeous climate are but poor compensation for the innumerable venomous reptiles and

swift man-eaters which the country breeds and harbors.

We know that we are encompassed by shoals of deadly germs; we know that every person dying through their agency becomes a ripe source of propagation of the same infection. Still what are we doing right along? We carefully and tenderly lay away in the ground, near our homes, the plague-laden corpse, as if we were anxious for the disease germs to multiply *ad infinitum*, and at stated intervals we go to work and tear up certain allotted portions of the cemetery thus letting loose upon the people seeds of destruction whose name is legion.

Far from me the idea and even the remotest suspicion of being disrespectful to the dear departed ones. If presence of their bodies, under the existing circumstances, constituted a real and undoubted danger, it certainly is no fault of theirs. And surely of all men it ill behoves physicians to cast reflections upon the dead, people as a rule only being too apt to look upon them as so many silent and inglorious witnesses to the progressive methods of the healing art.

I repeat it, all the odium of the present state of things rests with the living, and is rooted in the incurable carelessness and happy-go-lucky habits of the human race.

It takes a succession of dire calamities to teach man how to see danger and to cope with it. In that respect, mankind may be said to be in a constant state of childhood.

No doubt the terrible mortality from infectious diseases, in the guise of cholera, or otherwise, coupled with the rapid decomposition of the dead bodies arising from the high temperature of those regions, is the real cause which accounts for the prevalence of the custom of incinerating the dead in India, a custom which history traces back to the dawn of time.

It naturally followed that when the Buddha Cakya Mouni died he was incinerated, and ever since the process of incineration, which prior to that event had been enforced upon the Hindoos as a sanitary measure, assumed in the eyes of the Buddhist devotees the proportions of a holy rite; and is so regarded to this very day.

Much as I approve of cremation as a means of disposal of the dead, I must confess that those good people of India are rather apt to overdo the process; for we are told on good authority that some of the high personages of the land, not content with the privilege of taking their wives with them on the funereal pyre, occasionally insisted on the

attending physicians joining them also through the last sad rites.

That is what we call in this country "too much of a good thing."

Many object to cremation on religious grounds. "Christian burial" is to them a matter of as grave importance as Christian living. But is it Christian? Cremation does not lessen the respect paid to the earthly tabernacle of our loved ones. No Christian ceremony or rite need be omitted. The most devout Christians have been cremated from the time of the martyrs down, for burning at the stake is but one form of cremation. Prof. Max Muller, the famous linguist, writes; "I often regret that the Jews buried and did not burn the dead, for in that case the Christian idea of the resurrection would have remained far more spiritual." Canon Liddon says; "The resurrection of the body from its ashes is not a greater miracle than the resurrection of an unburnt body. Each must be purely miraculous. Faith in the resurrection would have been as clear and strong if the Jews had burnt their dead as it is when, as a matter of fact, they buried them."

The truth of the matter is that Christ happened to be born among a people who used to bury their dead. So that at his death he was buried also, as a matter of course. Hence the spread of this Jewish custom throughout the length and breadth of the Christian world. So that, if the head of Buddhism seems to stand for cremation, against the head of Christianity who seems to stand for burial, both of them in reality were made to conform to the already established custom among the people about them.

The Hindoos had been driven by sheer necessity to burn their dead; the Hebrews buried them simply because they did not know any better. Placed under very different climatic conditions, the Persians had only to expose their dead out of doors, and in a few days a regular process of dessication of the body had taken place, rendering it perfectly innocuous. This was the work of the extreme dryness of the air in those regions.

A like result obtained in Egypt, and the secret of the art of mummification which the Egyptians practiced so well and so long mainly resides in the dryness of the air of their country.

The Greeks and the Romans, as is well known, were in the habit of burning their dead, and we are safe in concluding that in doing so they must have obeyed some imperative need of self-preservation. This need we find to have arisen from the warlike habits of those people. All through history we see that cremation follows in the wake of war or of pestilence, as the only sure means of protection against the stench of the dead and the withering touch of death.

In times of war the question of disposal of the dead becomes one of extreme importance. And we need not go back to the Athenians for testimony. The first epidemic of spotted fever on record was caused by the emanations due to unburied bodies on a battlefield in Spain. After the battle of Waterloo 4,000 bodies were incinerated on piles of resinous wood. During the Crimean war typhus ravaged the French and English armies, leaving a record which is still engraved in the memories of men. It would fill two columns of a newspaper to record the evils to the living wrought by the hastily buried dead of the Franco-Prussian war alone.

After the battle of Sedan more than 40,000 human beings and animals were hastily and superficially buried. All the Belgian villages in the neighborhood suffered frightfully from infectious diseases and epidemics. So serious was the evil the government sent Col. Creteur to remedy it as far as possible. The report of the conditions he found is too revolting for repetition. Suffice it to say, that the heavy rains, bears, foxes, dogs, and crows, had uncovered many of the trenches, the latter feeding on human flesh to satiety. He found it difficult to procure men to help him, as the effluvia produced a severe eruption as well as serious symptoms of poisoning on all those who remained near the place. Finally he secured a sufficient number of men to carry on his plans. He had large quantities of tar poured into the pits. Then he heaped on chloride of lime. On this he had thrown bundles of hay saturated with kerosene, which being lighted, ignited the whole mass.

In this way some 45,000 human and equine bodies were reduced to harmless ashes and the neighborhood once more rendered habitable.

Of late the French government has created a very efficient system of ambulatory crematories, the duty of which shall be to accompany the army in time of war, so that the dead may be decently incinerated. No doubt the example will be contagious. During the brilliant campaign which Gen. Dodds recently conducted against the Dahomey savages, incineration of the dead has been strictly enforced, with the result that the health of the troops, in spite of a murderous climate, remained good all through.

In presence of such facts does it not stand to reason that in time of epidemics the incineration of every contaminated dead body should be compulsory. Take cholera for instance. Do you think the process of burial is safe when every buried victim is known to harbor millions of living

germs, which will lie dormant and bide the chance for mischief at the first opportunity? And what is true of cholera is still more true of other epidemic diseases like smallpox, diphtheria, scarlet fever, etc., and true also of that insidious foe, consumption.

If we have been lucky enough to have escaped the visit for a long time of one of those dire plagues, such as humanity has known in the time of Pericles, and of Antoninus, also as our modern world was afflicted with when in the course of the 14th century fully a third of the whole population of Europe, according to the historian Froissard, was swept away by the black pest, we can see no definite assurance that the future has not in store for the human race similar calamities.

And while we might confidently believe that the appalling scenes of which so many large cities like Florence, Paris, London, Marseilles, and so many others, were once the theatre, would never be enacted again, still, short of systematic cremation, we fail to see any efficient remedy against their possible recurrence.

I trust that the religious argument against cremation has been sufficiently refuted, but I repeat there is nowhere to be found a written law, human or divine, against cremation. True, we have the opinion of more than one bigoted bishop or narrow-minded theologian, against that mode of disposal of the dead; but such opinions do not make law. Likewise it has been the pleasure of some well intentioned people to call the graveyard, God's acre; with much more reason does science step in and call it the *devil's acre*, thus relieving God from an odious and undeserved responsibility and reflection.

From another quarter it has been urged against cremation that if it were generally adopted it would soon be conducive to total neglect of, and disrespect to the dear departed ones. Nothing is further removed from the truth than such an assertion. Look at the ancients. Who would venture to state that the Greeks and the Romans did not have a high regard for their dead, when they took pains to build altars in the very heart of their homes, which they consecrated to the names of their ancestors? Were they disregarding of their dead, those Athenians who pronounced the penalty of death against the generals who had neglected to render the last rites to those under their command when they had fallen on the battle-field; or those Romans who surrounded their funeral processions with so many touching and impressive demonstrations of grief and

feeling? Were they disrespectful of their dead those Romans whom Scipio knew he was wounding cruelly, when he directed, at his death, that his ashes should not be brought back to rest in the soil of his ungrateful country, but should be left in peace at Linertum? And has, to any one's knowledge, the cult of the dead been banished from those oriental Indies, where from time immemorial incineration has been practiced, and is practiced to this day?

The advocates of burial against cremation on the plea of feeling and sentimentality had better apply their resources in that line to some more worthy object. They seem to forget that a very strong argument in favor of cremation is that it prevents entirely the danger from resurrectionists. At all events cremation would have obviated the necessity of guards patrolling night and day for many months at the burial places of our lamented Presidents, Lincoln and Grant.

And those beautiful and realistic words—*ashes to ashes—dust to dust*—it is only when the priest shall pronounce them over the cinereal urn that their full weight and their true meaning will be revealed to the mind of the mourners.

We are of the belief that the cinereal urn, wherein the family ashes will be sacredly preserved, whether kept within the precincts of the home, or deposited in the church, or in the special edifices provided for their safe-keeping, is bound to be a higher and purer source of inspiration to the coming generations than the moldering slabs of the cemetery. It will surely be found that the urn is better calculated to spiritualize the idea of death than the putrid graveyard, and that it will better cultivate in the human breast those nobler and unselfish emotions which grow from the cult of the dead.

After all, the true philosophy of the question is that the destiny of the human body after death is only a secondary matter. The only true, the only lasting effigy of himself which man can hope to leave behind, is the one that remains engraven on the memory of the living. Whether his flesh rotten under the sod, or his ashes rest in the urn, or his body be buried at sea, the only thing of importance to man is that he remain present in the heart of those with whom he has suffered and loved and hoped. For, aside from this, all else is ignorance and superstition.

From an æsthetic point of view, I need only ask the question: Who without shuddering, would dare, after only the lapse of a few months, to face the result of an exhumation and gaze upon the remains of the beloved one? The

details of such a spectacle are too horrifying for description, and I know you will thank me for omitting any further reference to them.

After all says Prof. Fornari, what becomes of the corpse? It is changed into grass, most of the time; into that tall, vigorous grass which grows in the country graveyards. And now the question arises: What becomes of that grass? Well, in some places it is mowed down, then burnt. So well, so good; though this rather smacks of a diluted cremation. Sometimes however it happens that cattle are turned loose in those lonesome places and feast on that grass. Now this grass is transformed into butcher's meat and we Christians do eat it afterward. If this does not savor of a sort of mitigated cannibalism, a manner of homœopathic anthropophagy, of what does it savor?

Two arguments remain to be met: One is from an anthropological point of view, and runs thus: suppose cremation should be universally adopted, how shall the scientists of say 1,000 or 2,000 years from now, manage to study and appreciate the anatomical characters of the cranium and bones of the present race of men?

Is this serious, I ask? Even if such a calamity should occur are we not going to leave behind us, as a legacy to posterity, more valuable tokens of our state of civilization, in the way of imperishable monuments of art and literature, than a pile of dried up bones? When we have the Venus of Milo by which to judge of the type of beauty of the Athenian women, and of the excellence of the Greek sculptors, what do we care for the bones of all the Greeks put together? Suppose the cranium of Homer should be unearthed to-morrow, do you think we would understand the immortal poems of the Iliad, or enjoy the Odysseus any better?

If by reason of some awful catastrophe nothing should be preserved for the remotest posterity to form a judgment of our attainments but the Montana silver statue of Justice, would not such a relic be better qualified to impress the connoisseur of the day with the merits of our art and of our women, than even the skeleton of Chicago's Cinderella.

The last argument, and the only one that has some foundation in fact, is derived from a legal standpoint. Some bright legal mind one day urged this point: the adoption of cremation will be tantamount to putting a premium on crime, as the proof of poisoning or of foul play would thereby have been forever removed. Without denying that

there is some truth in the argument, the answer is not difficult. Even if the proportion of crime were to increase tenfold, and the criminals go unpunished, the total loss of life were cremation adopted, would still be incomparably less than it is now, owing to the improved state of the public health and the low rate of mortality from infectious diseases which would then obtain. A few hundred rogues would escape the gallows, but millions of innocent creatures would be preserved to society.

It is hardly needful, however, to state that it would be comparatively easy to cope with the difficulty. Let our solons devise some means of protection. I see fit to declare right here that the system of such death certificates, such as are in vogue at the present day, offer but scant guarantee of safety. Death certificates signed by irresponsible names are accepted by our health authorities. No effort at verification or control is seriously made. Through the sieve of such a lax system, crime filters unheeded and unobserved every day of the year.

Let cremation be adopted and some stern measures of verification of each and every case of death will have to be applied, were it only to give satisfaction to public opinion, so apathetic to-day on this vital subject.

So that cremation shall not only have answered the argument, but supplied the remedy and thus will be inaugurated a state of things far superior to the present one.

Now, before closing, let us revert to nature and see what she does with the human frame when left to itself. When the pulsation of life has retired from the human organism, it becomes subjected to physical and chemical laws through the agency of which its component elements are gradually reduced to very simple combinations, such as water, carbonic acid gas, ammonia and a few mineral salts, chief among which are phosphates and carbonates of lime, magnesia, potash, soda and iron, the ultimate product being gases and ashes. The material part of man, therefore, returns to the mass of the planet and may eventually be utilized by vegetation or pass into the organism of the lower grades of animals; that is, its destiny is to go on through different forms of life.

Metamorphosis in the chemical sense of the word is therefore a natural law, demonstrated to the latest evidence. It is a beneficent law, which shocks no principle of morals or of religion. Surely if the spiritual world is only the counterpart of the natural world the same law of migration must hold good.

We have now seen what nature does with the human frame. What does man do with it? Instead of hastening by all possible means this return of man's material elements to the bosom of nature, actuated no doubt by respectable motives of affection, or impelled by mistaken religious principles, or by misguided hygienic preoccupations, he strives hard to guard his mortal remains from the agency of the providential laws of nature, with a view to postpone as much as possible that necessary disintegration of its elements; he seems to take a sombre delight in prolonging the agony of putrefaction with all the evils attached thereto, thus making of his cadaver a source of desolation for the living. Thousands upon thousands of acres uselessly sacrificed, pestilential effluvia scattered broadcast over the cities, the drinking waters poisoned to their very sources, such are the fearful results of the process of inhumation.

No doubt a lonely body buried in a lonely plain will in the nature of things injure nobody. But the new conditions created by the agglomeration of millions of human beings in the busy lives of modern civilization, has rendered necessary the application of new methods, and of all methods that have been proposed, that of incineration is the only one which seems to answer all possible requirements.

By means of the modern crematories a body can be consumed in the course of forty or sixty minutes without giving rise to any offensive or deleterious gas. At the end of the performance a small heap of ashes varying from six to nine pounds is gathered from the vessel and deposited in the cinereal urn prepared for the occasion.

Now, if we are candid with ourselves we may well wonder why such a process, which after all is only the eptome of the process of nature, while it does away with the slow, awkward, disgusting and eminently dangerous aspects of the process of decomposition; we may well wonder why such a method of disposal of the dead is not already in universal use at least in and around the great metropolises of the world.

No satisfactory explanation of the favor with which inhumation meets on every side can be found except in prejudice and routine. Still laudable efforts are being made in this country and abroad in favor of a much needed reform. In England, in Italy, in Germany, influential cremation societies have been founded, which keep up the

agitation. Crematories have been built which have demonstrated the practicability of the method.

Chicago is not lagging behind in this matter. We have in this city a cremation society, doing very good work. It was owing to its exertions that a crematory was erected in one of our cemeteries a few weeks ago, which promises to be well patronized.

Among the many signs pointing to an awakening of opinion respecting this great problem of the influence of graveyards on public health, it is comforting to see that the subject has been earnestly considered by the Mississippi Valley Medical Association.

The formulated conclusions of that body emphatically declare that the method for disposing of the dead should be founded on reason and not on custom or sentiment; that the interment of the dead in the earth was never enforced by a statute, Jewish or Christian being merely incidental to both dispensations, that no law, human or divine, requires any such disposal of the dead as is prejudicial to the health and comfort of the living, and while it may be an open question as to the right of the State to decide on the manner of disposing of the dead, unless in exceptional cases, it is clearly the province and duty of the State to prevent any such practice as will in any wise jeopardize the interest of the living. As a final declaration, in view of all the facts attainable, the opinion is expressed that the graveyard, as a constant menace to public health, should become a thing of the past and that incineration is the method most in accordance with science, sanitation, reason and religion.

Let the medical organizations of this vast continent keep up the agitation. Let these salutary notions spread among the people and a revulsion of feeling be thus created in favor of cremation. In other words, let the *Spade* yield to the *Torch!*

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

JANUARY MEETING, 1894.

The regular monthly meeting was held in the Clinical amphitheatre of the new Hahnemann Medical College building on Saturday evening, January 27. A very large attendance of physicians and students had assembled to hear the reading and the discussion of the following paper:

THE PROS AND CONS OF VACCINATION.

By. A. K. CRAWFORD, M. D.

It would seem as though at this late day, an address before a society of educated physicians in support of vaccination must be a truly superfluous task. Nor would I have thought of such a thing had it not been for the recent publication in one of our daily newspapers of an article championing certain tenets and practices which have reflected a stigma upon the whole homœopathic profession. This doctor more desirous of notoriety than of good reputation, flaunts his presumable methods before the public under the guise of it being homœopathic, and in the mind of the public each one of us is held responsible for his assertions. He states that, "for the last ten or fifteen years many homœopathic physicians in the United States have used the potentized virus prepared as all homœopathic potencies are, both in the treatment of smallpox and as a protective measure by vaccination. The potentized virus is used on the arm in the same way as the crude vaccine virus is, and at the same time is given internally as we give belladonna or sulphur to prevent scarlatina. * * *

"This method of course, may be novel to those who have not investigated it, but to those who have put it into actual practice far better results are claimed and that without danger. The effect when the potentized virus is used in this way is, in some cases, a slight fever, as most cases have when vaccinated with the crude virus, but the arm is rarely sore and never erysipelatous."

"Far better results are claimed by those who have put it into actual practice." Upon what ground is such a *claim* based? Have any scientific investigations ever been made by this doctor, or any of his ilk?

Away back in 1809, in the town of Milton, Mass., twelve children were inoculated with smallpox lymph, in October, to test the efficacy of their vaccination, which had been performed upon them in the month of July previous. Not one of them took the smallpox, and, therefore, this severe trial was offered to the world simply as "additional evidence of the power of that mild prevention, the cowpox, against smallpox infection."

Have the advocates of this refuted internal vaccination any such testimony as this to offer in favor of their mode?

It was a matter for congratulation that the answer to the newspaper article by Dr. Allen should come from an eminent allopath, Dr. W. E. Quine, President of the State Board of Health, and Professor in the College of Physicians and Surgeons, of Chicago. Listen to one or two things he says:

"Internal vaccination is an absurdity," said Dr. W. E. Quine, President of the State Board of Health, yesterday, when his attention was called to the interview on that subject with Dr. H. C. Allen, published in *The Sunday Tribune*. "It is an absurdity; but I do not mean by that to reflect on the respectability of Dr. Allen, nor of the Hering College of Homœopathy of which he is the Dean. The college has been in the hands of the State Board of Health for some time, and has not yet been recognized by it.

"The truth is the Hering College was started to promote the cause of Hahnemannian, as distinguished from modern homœopathy, and Dr. Allen is what you might call an ultra Hahnemannian homœopath. The whole faculty of modern homœopathic physicians would repudiate his opinions on almost all questions of homœopathy. Certainly they practice vaccination in the arm, just as allopathic physicians do. Still, while internal vaccination has been advocated by some homœopathic physicians for a long while it is not required by the principles of homœopathy, modern or otherwise.

"What is more to the point, Dr. Allen himself, it appears from this interview, does not practice it. That is, he does not practice it alone, but combines it in every case with vaccination in the arm. This, you see, makes it impossible to discover whether it is of any value or not. If the people whom Dr. Allen vaccinates internally escape it may be in consequence of the vaccination in the arm. But another feature of his vaccination, whether internal or external, is that he uses the virus in such an attenuated form that when used on the arm it produces no sore. So that his vaccination in either way is, in my opinion, worthless.

"In his attack on vaccination by the regular method his statements and reasoning are extremely fallacious and misleading. I will speak first of the alleged danger of death by vaccination. I have not time to review his figures, but I will answer them all by the most recent

and significant statistics that have reached the profession. I refer to the fact that in the German Army, out of 400,000 soldiers that were vaccinated, not one died. Now, I will admit that vaccination as now practiced is attended with some danger of double infection. But I also claim, as statistics prove, that where absolutely pure virus is used, and where reasonable antiseptic precautions are taken there is no danger.

"Now I will speak of the efficiency of vaccination which Dr. Allen so positively denies. Here, too, I might rely not only on statistics but on history. It is a historical fact that since the introduction of vaccination smallpox has almost disappeared from the world. One or two centuries ago it was the most dreaded and pestilential of all epidemic diseases. It would decimate whole communities or sweep away whole tribes of Indians. Even in the Crimean war more of the troops died of smallpox than were killed in battle. But in our day the disease makes no such ravages and excites comparatively no alarm. It is not unreasonable to expect that, if vaccination is persisted in, it will, within one or two more centuries, disappear from the world like the plague and the black death and be known only in history. It is therefore mere nonsense for any one to charge that vaccination is no protection against smallpox.

"Dr. Allen's array of smallpox figures from Chicago are rather amusing. He says that the number of cases of the disease in this city increased from 109 in 1851 to 1,292 in 1882, and considers that a proof that the disease is on the increase despite vaccination. I happen to know that the population in 1851 was 59,000 and in 1882 it was probably 800,000. But he seems to think that that does not affect the argument." —*Chicago Tribune*, January 8, 1894.

In the same issue of the *Tribune* is published an interview with Dr. Kippax, an eminent member of the faculty of the Chicago Homœopathic College, and his views are set forth as follows:

"Dr. Allen does not at all represent the rank and file of homœopathic physicians. We all practice vaccination in the arm just as the allopathic physicians do. We are not a little annoyed by the impression to the contrary made by Dr. Allen. My own patients are constantly coming to me to inquire about internal homœopathic vaccination and I am compelled to tell them that it is all moonshine.

"The truth is that while this method of taking the virus has been believed in by some homœopathic physicians for fifty years, it was not according to any homœopathic principle. Moreover, it was never administered in that way as a preventative, but as a cure, and has generally been given only to patients who had been exposed to smallpox, and did not have time to wait for the effect of vaccination by the arm.

Of course, this method did not originate with Dr. Allen, but if any of the members of this society wish to know something regarding so called homœopathic vaccination I would refer them to the January number of the *CLINIQUE* for 1882, wherein will be found a contribution by Dr. Meissler on this subject, gleaned from his German works. Dr. A. Ritter is there referred to as using in 1850 a 6x trit. of vaccine virus internally instead of vaccinating the usual

way. At that same meeting of the Clinical Society, twelve years ago Dr. E. S. Bailey presented an excellent essay "On Compulsory vaccination*," and the discussion at that time was led by Drs. A. E. Small and Geo. A. Hall.

The smallpox cycle has made its revolution, and its threatened outbreak brings us again together to reconsider our defenses against it, and we note the changes that have meantime taken place in both persons and things.

Were those good doctors here now they would join me in refusing to be saddled with such vaccination nonsense as Dr. Allen has tried to heap upon the back of homœopathy.

This same article of Dr. Allen evidently raised the ire of that most equable gentleman, Dr. J. P. Duke, of Nashville, Tenn., than whom no one in the South stands higher in the profession for his clarified knowledge, ethics and culture. Here is the letter, &c.:

NASHVILLE, TENN., Jan. 10.

Editor of The Tribune.—In reading the *Tribune* of January 8, I came upon an article by Dr. H. C. Allen, Dean of the Hering Medical College, discussing the "Virtues of Vaccine," in which a method was set forth as being followed by "many homœopathic physicians in the United States," against which I desire to enter an earnest protest. That Dr. Allen and some others, who claim to be homœopaths, may be in the habit of trying to prevent the smallpox by the use of "the potentized virus" (vaccine), I do not question; but that "many" resort to such a method, comparing the number with those who do not, I must surely deny. I raise no objection to the practice of Dr. Allen and those of similar views. So far as I am concerned they are quite at liberty to take their own course in that, as in all other medical matters, in which and for the effects of which they alone are responsible. My protest is against his bringing before the public, in a daily newspaper, such a species of practice as a thing favored or largely followed in the homœopathic school.

Homœopathic physicians generally are well educated persons, not ignorant of medical discoveries in all the departments of medicine and not unacquainted with matters of natural science and mechanics, so far as related to the art of healing. They know that the disease following vaccination, that may anticipate and prevent smallpox, is caused by the introduction of living germs, that in due time are reproduced in the virus of the vesicle and crust on the arm of the person vaccinated. Virus, in which the living germs have perished by fermentation or other cause, is not capable of producing vaccinosis or the vaccine disease which prevents smallpox. It may generate erysipelas, blood poisoning, or a destructive inflammation, as sometimes witnessed. And the process of trituration or grinding in a mortar with some neutral substance or shaking in a bottle with alcohol so as to become "potentized virus" most effectually destroys the minute organisms upon the integrity and life of which all virtue depends.

This product, dead and disintegrated vaccine germs, put into the human arm could no more produce a disease that would substitute or prevent smallpox than a handful of superfine flour sown upon a field

*See THE CLINIQUE, Vol. III, p. 18.

could yield a crop of wheat for the farmer. And the same "potentized virus," introduced by the mouth into the human body, is devoid of all power as a preventive of smallpox. The homœopathic school does not favor a practice so in violation of the plainest facts in etiology, pathology, pharmacy, and therapeutics. With some exceptions, it adheres to the method introduced by Jenner, and has confidence in it for the prevention or modification of smallpox. For myself, I must say that after a medical experience of more than forty years, in attendance not infrequently upon cases of smallpox, I must bear witness to the great value and importance of cowpox vaccination and say also that I have never known anything to compare with it as a substitute.

J. P. DAKE, M. D.

The accumulated observations of a century reveal the fact that there are but two forms of smallpox, to wit: humanpox and sheep pox. They both attack the multitude, they both assume pandemic range; one is a genuine epidemic, the other a genuine epizootic.

All other varieties of pox, that of the horse, cattle, (including cowpox) of swine, goats and dogs—constitute as Bollinger proves, no distinct individual disease. They are to be regarded only as irregular forms of the primary human or sheep pox modified in different animals. Whether man got the pox from sheep or sheep from man is a question that may never be determined, but the best authorities (Bohn and Bollinger) unreservedly maintain that the virus is identical in the two cases—identical and interchangeable. The corollary of this fact determines the origin of smallpox. Cowpox is in its essence variola vera. It is variola modified in the body of the cow. If vaccine be but an attenuated or modified variola its protective action ceases to be a mystery. It protects by the immunity of previous attack.

It protects by the immunity of inoculation—i. e., variolation: for vaccination is variolation with virus robbed only of its virulence, Dr. Allen to the contrary, notwithstanding: for he says, the cowpox comes from dirty stable boys infecting the cow from "the grease" of the horse.

If you will allow me I would like to repeat to you a pen picture of the *then* and *now* of smallpox and vaccination. It covers much ground that other writers have done, but it is so humanized, it carries more conviction than any bare argument. Dr. McVail, a countryman of mine, is responsible for the following facts and figures. In the first place he believes that smallpox when allowed to pursue its natural course, unmodified by vaccination, is essentially a disease of childhood, and that this is illustrated in a most forcible manner, when the smallpox statistics for Kilmar-

nock in the last century are grouped together. Of the 622 persons who died of smallpox in that town between 1728 and 1764, 586 or 94.2 per cent were five years of age or under. Seven only were over ten years of age, and the oldest was but twenty-six.

In the different epidemics which fell upon that community the time from the height of the first epidemic to that of the second was but four years and eight months.

The principal point shown in a table of the mortality from smallpox during this period of thirty-six years, nine epidemics, is that, on an average over eighty-eight per cent of those who died in one epidemic had been born since the previous one, that ten per cent who died had passed safely through one epidemic; and that only one per cent had lived through more than one outbreak.

Another table shows that these epidemics to nearly nine-tenths of their extent did not practically occur in the general population of the town, but in an average population of 475 people, who were born since the previous epidemic, and the average number of deaths in this population was at the very high rate of 126 per 1000 living in each epidemic year.

He goes on to say: "These two tables show that, as regards smallpox, there were, in fact, three Kilmarnocks, one, a Kilmarnock that had no fear of its attacks. These had already met and battled with the disease fiend. On many were to be seen the marks of the conflict. Some were blind, some had lost their hearing, many were permanently injured in constitution, and very many were scarred and disfigured for life; and, for every one that conquered, another had fallen, never to rise again.

"There was indeed a second Kilmarnock under the green sod of the kirkyard. The Kilmarnock which had reason to dread the epidemics approach was a Kilmarnock the least able to meet it. It consisted of a band of little children, numbering less than 500 in all. Every such group that came into existence had to face, within four or five years of its birth, the most terrible physical enemy that it would ever meet; and having fought the battle, some were added to the maimed and distorted who formed so large a portion of the population, and others were laid beside those who had been destroyed by former epidemics. One can barely imagine what must have been the feelings of a mother regarding these fearful visitations. Even when the town was free from the pestilence, there would be the constant foreboding of its all too certain coming; and when at

last the first case occurred—when the doctor was called in, and pronounced the disease to be the dreaded pox—his words would be heard as a sentence of death, to some member of almost every family containing little ones; and as the news spread from house to house, with what a despairing clutch would each mother press her darling to her breast and beg almighty God to command the destroying angel to pass by her door. After the lapse of a hundred and fifty years one can have little conception of the real meaning of a smallpox epidemic. But the old parish register has enabled us to apprehend something of its horror, and I venture to say, that, if the anti-vaccinationists had their will, we would, ere many years, be again experiencing somewhat of the awful visitations which were so familiar in old Kilmarnock."

Dr. McVails' practical conclusions are: 1. Smallpox was epidemic every four and one-quarter years. 2. Its death rate per 1000 per year was nearly twenty times as great as now. 3. Its death rate under five years of age was thirty-five times as great as it is now. 4. The mean age at death from smallpox was two and one-half years in the last century, and is now nearly twenty years. 5. The death rate in the second half year of life is now only a fourth of that in the first half year, while formerly it was nearly five times as great as in the first half year. 6. The smallpox death rate has improved about twelve times as fast as the death rate from measles, whooping cough and fever.

In regard to the degree of protection furnished by vaccination Corbally reports that the vaccinated children of Sheffield had, as compared with the unvaccinated children, a twenty fold immunity from attack, and a four hundred and eighty fold security against death by smallpox.

But the duration of this protection is not established. It certainly varies in different cases. If revaccination "takes" the person was certainly liable to take smallpox. No case of smallpox contracted within seven years after a successful vaccination stands upon authentic record. The Health Office in Germany extends this immunity to twelve years. After this period of absolute protection revaccination should be performed upon every exposure. No doubt whatever now remains as to the possibility of transmitting syphilis from one subject to another through vaccine lymph. Dr. R. Cary, an officer of the Local Government Board of England, underwent three separate inoculations from pronounced syphilitic subjects without

evidencing the least disturbance or sign of the specific malady, but the fourth time, although the vaccination did not take, a papular eruption appeared on the twenty-first day, the subsequent history of which left no doubt as to its nature. Bovine vaccination, as now generally practiced, precludes the possibility of such an accident to a vaccinee.

We are now just as absolutely certain of the fact that tuberculosis has never been transmitted in this way, so that even if Dr. Jenner's son did die of phthisis, it was not because of vaccination that he so died, as Dr. Allen would have us to infer. Such pathology has a "very ancient and fish-like smell" in these times.

The streptococcus of erysipelas may be introduced with vaccination or may fall later upon the broken surface. The accident is rare in any event.

With reference to the general question of irregular phenomena, it may be taken as a rule of practice that any vaccination which presents a deviation from the perfect character of the vesicle, and the regular development of the areola, should not be relied upon as a protection against smallpox.

Extensive inflammation as dermatitis or destruction of tissue indicates mixed infection. Revaccination should be insisted upon as being just as necessary as primary vaccination. Dr. Hardy was the first to advocate revaccination strenuously in 1823. The belief that vaccination became weakened by the lapse of time gave him willing adherents, and governments ordered revaccination in their armies from 1831 on.

It should be performed on all persons after puberty and with the same care as primary, and also with fresh bovine lymph. According to Seaton, Robertson, and Coey insusceptibility is akin to a myth. The first named had but one case in a series of over 9,000 vaccinations which did not take on second trial. A third attempt was made but the child was not brought back for inspection. The last named says that in his experience of several thousand cases he had never met with a case of insusceptibility in any child under ten, and with only one case above that age.

In a conversation with Commissioner of Health, Dr. Arthur R. Reynolds, to-day, I learned that the total number of cases of smallpox in the city of Chicago during 1893 was 136, of which number sixty-four occurred in the month of December. There were twenty-one deaths out of

the 136 cases, and it is an item worthy of note that twenty of these were persons who had never been vaccinated. The remaining one thirty-eight years of age had been vaccinated in childhood, and possessed only a dim scar. That we have been fighting a smallpox *scare*, and not a smallpox epidemic, is evidenced by the facts just stated, and the additional ones that the highest number of cases in the pesthouse at any one time has been 123; that there are only eighty-six there to-day, and of this number only thirty patients are confined to bed. So that when we consider that there is no smallpox outside the pesthouse, and that these are all the cases in a population of 1,600,000—the disease in our midst has not attained to the dignity of an epidemic.

In the 1880-82 outbreak there were 8,856 cases of smallpox in this State and 2,978 deaths, and this epidemic cost this city and the State of Illinois the sum of \$4,500,000.

In Philadelphia during the epidemic of 1870-72 there were 20,065 cases of smallpox reported, and 4,464 deaths, which is said to have cost that community some twenty-one millions of dollars.

Compared with either of these epidemics the present visitation is a mere bagatelle, and whatever modification is witnessed can be placed to the credit of vaccination and re-vaccination, which has been so urgently advised, and so generally practiced by the City Health Department, and by the whole fraternity with the exception of a few cranks. Up to date the city authorities have gratuitously vaccinated nearly 150,000 persons this winter, and I think it would be quite within the mark to claim that more than 1,000,000 of the inhabitants of Chicago had undergone vaccination this season. All this has been done without the coercive force of the State law, for none such exists relative to vaccination in Illinois. The State Board of Health has upon its own authority, issued an order excluding unvaccinated children from the public schools. And the City Board coöperates with the State Board in the endeavor to carry this rule out perfectly.

The city physician says he is working under city ordinances in regard to the performance of vaccination, and to the removal of a patient from his own home when smitten with smallpox. As to the validity of these ordinances he cannot say, nor does he desire that they shall be tested in the courts. He much prefers persuasion to force, and he says that, thus far, arguments have won. He points out to an afflicted family that not only is it for public safety that the member who is sick had better be removed, but also

that it is a safeguard to themselves personally, for the public if roused is more to be feared than the police. A mob might set fire to their premises, or pull the roof down over their heads for harboring a pestilential disease in their midst.

Assistant Corporation Counsel Zeissler gives it as his opinion that under the city ordinances a man cannot be vaccinated against his will, notwithstanding the ordinance reads that the city physician's duty is to order the citizens to be vaccinated when he deems it necessary, and in case the order is disobeyed a fine shall be imposed of not more than \$25.

The same legal authority says that the Health Department has the right to forcibly enter and carry off to the pest house any individual found suffering from smallpox. But, as Dr. Reynolds says, this reading of the law has never yet been proven valid. The way to overcome this difficulty and avoid a conflict with "the powers that be," in the event that a case of this disease occurs in a family living in their own home, and where you feel perfectly certain that you can do better for the case and for the community than the Health Department can, is to *neglect to report it*. In doing so you need not fear prison bars nor large fines. The authorities are not at all anxious to interfere where there is no exposure of the community in consequence of your little act of forgetfulness.

As long as they are not informed of the existence of a case they are not called upon to act, and they know as well as many of us here do, that this mode of saving our families much misery has been practiced many times.

When I asked Dr. Reynolds about Dr. Allen's notions on vaccination he smiled and said that he was requested by a daily journal to make a reply, but that he would not dignify it by any such notice.

DISCUSSION: DR. J. E. GILMAN said: There is no one subject in the whole range of medical topics or procedures in which the general consensus of opinion is so well settled as it on the advisability of vaccination. I have seen personally a great deal of its working both in a collective form and individual instances.

Dr. Ludlam will bear me out in the statements I am about to make, as he was a member of the committee on sick and hospitals of the Relief and Aid Society, of which

committee I was the Secretary in the months after the great fire, when we did such a great work in vaccinating among the class of people where smallpox gains its start and burrowing spreads from them throughout the community. During the winter following the great fire an epidemic of smallpox broke out. The hospital committees prevailed on the central one to pass a resolution that no aid should be granted to any one not having a certificate of vaccination. So we established at each of the distributing depots, where the people came for their supplies, a corps of physicians who vaccinated all applicants filling out a certificate to that effect and at the end of a week examining each case and if the vaccination was a failure repeating it until insusceptibility was certain or the vaccination was successful.

Very careful statistics were made of these cases and I do not think in the whole range of operative vaccination that any such thorough and accurate statistics have ever before been kept. These records are on file in the Relief Company's books. We vaccinated 30,746 cases among the people that are so hard to reach ordinarily. Of these 26,549 cases were tabulated in their entirety and 4,197 cases incompletely. From them we learn that the number of cases of smallpox occurring after recent or remote successful vaccination and revaccination was 726. General average time of occurrence after a first successful vaccination was seven years; After a second successful vaccination eleven, and five-sixth years and after a third fifteen and three-fourth years.

The number of cases occurring after unsuccessful vaccination was 658. The statistics of smallpox include cases occurring previous to the winter of 1871 and '72 and of which the evidence was satisfactory to the observers. Now what was the result of this wholesale work. The next winter variola raged in the cities all about Chicago—Milwaukee, St. Louis, Cincinnati, Louisville, Toledo and Cleveland, and Chicago was free from it with but here and there an imported case and no soil ready for its propagation to make

an epidemic for us. The school authorities by their rules enforced vaccination among the school children, and the better class of citizens were vaccinated, and the result was we were freed from danger. As the city grew and new elements entered we were again in danger, as the prophylactic measures faded out until the conditions are again present for many cases of variola to occur.

It is a surprising thing when we look back at the history of smallpox and see what vaccination has done that there should exist any opponents of it. Taking the annual mortality from the disease and the immunity from its ravages that now exists we can safely say that it has added three and one-half years to the average longevity of the human race. In England, the annual mortality from variola was 3,000 to every 1,000,000 of inhabitants. In France 30,000 persons perished annually. Within the years 1783 to 1799 one-tenth of the total mortality at Berlin was due to smallpox. In Sweden, before vaccination, the annual death rate from smallpox was 2,050 out of every million of inhabitants, while during the forty years from 1810 to 1850 it was but 158.

In Westphalia, where the deaths from smallpox were formerly 2,643 per million, between the years 1816 to 1850 it fell to 114. In Bohemia, Moravia and Austrian Silesia it was reduced from 4,000 to 200; in Copenhagen from 3,128 to 286, and in Berlin from 3,422 to 176. We have in Boston a striking example of what vaccination has done. In that city from 1721 to 1792 there were 2,609 deaths from variola. In the year 1800 vaccination was introduced, and in 1810 compulsory laws were passed for vaccinating. Now from 1811 to 1836 there were but thirty-seven deaths—thirty-seven deaths only in twenty-five years. In 1836 the compulsory law was repealed, and in the next twelve years there were 533 deaths. The prophylactic power of vaccination was exhibited in the Franco-Prussian war of recent date.

In the medical history of that war we learn that the smallpox prevailed to an alarming extent and both armies

were fully exposed to the contagion. But the German mortality was only 268 men, while the French lost 23,468 from smallpox, although the latter army was at no time more than half the size of the former. In Germany every soldier is vaccinated on entering the army, and again and again until insusceptibility is obtained. In the French army neither vaccination or revaccination is compulsory.

Now there are many cases where smallpox occurs in individuals that have at some previous period been vaccinated but even then it has this influence that the disease is rendered less dangerous. In Bohemia it was discovered that the death rate among vaccinated persons who contracted smallpox was five and one-sixteenth per cent, while among the unvaccinated it was twenty-nine and four-fifths per cent. In Dr. Marson's thirty years in the London smallpox hospital there were 15,000 cases of smallpox treated. The unvaccinated died at the rate of thirty-five per cent—the vaccinated six and one-half per cent, the efficacy of the vaccination being sufficient to modify the disease to that extent.

In my individual experience since I have been in practice in the city of Chicago I have treated *eighty-four* cases of smallpox and I have never had a second case in a family resulting from the original case that I was called to treat. My method has been this: As soon as the diagnosis of variola was made I vaccinated every one in the house. The next day with fresh matter I vaccinated again. Every third day thereafter I repeated the operation until the vaccination took or the danger of contagion was over; and with all of the different families the result was the same, that no second case occurred from the original one. While without the safeguard it is unreasonable to suppose that out of the numbers that were enclosed in those plague spots there should not have been more or less victims.

Two instances of cases may be interesting. In one family consisting of the grandfather and grandmother, father and mother and two children, the smallpox appeared. One year before I had vaccinated the mother and

one of the children, the latter a girl of six years. From the history of the case I was satisfied that the mother had contracted the disease but in such a slight form that it was not at the time even suspected to be smallpox. She had not been incapacitated from any of her regular duties and had had but a slight ailment which would have had no further record but in the light of subsequent events. In one day three of the susceptible ones in the family came down with the disease. The grandfather never had been vaccinated. He had a case of confluent variola. He would probably have died anyway but he made it certain by going out and rolling in the snow and he died promptly after that. The grandmother had been successfully vaccinated twenty years previously. She had a light varioloid, not severe enough to prevent her from aiding the others who were ill. The father had in his youth had smallpox and his face was scarred with the marks of the disease. He had an attack of varioloid of some considerable intensity, was confined to his bed and suffered a good deal of pain. The girl that I had vaccinated one year previously was in the house continuously exposed and escaped without a trace of any sickness, while the unvaccinated daughter had a case of confluent variola and barely came through it alive. In this case the recent vaccination was a more powerful preventive than the previous attacks of smallpox. The logic of the prophylaxis was convincing to the mother for she had been in a great measure opposed to vaccination, but after such a proof she was so thoroughly converted that she brought two or three years afterward her infant son to my office to be vaccinated on her first day of outing after the confinement.

The other case was one of a family of four persons; the father, mother and two children. The father became ill with varioloid. The mother who was then five months advanced in pregnancy insisted upon remaining to take care of her husband. I vaccinated the three and satisfactory results were promptly obtained. The two children escaped the disease absolutely; counting from the time when the

infection was the strongest and, allowing for the period of incubation, the mother complained of the feverish action and tumultuous motion of the fœtus. This continued for awhile and then ceased and the mother declared that the embryo was dead. Two days later it was born covered with suppurating smallpox pustules. The fœtus had died in utero from variola leaving the mother untouched and unharmed as she had never had the disease and did not contract it. I reported the case to the health department. The superintendent, Dr. Reid, declared it to be impossible and sent an inspector to report on the case. The inspector confirmed my statement, as the evidence was so clear as to be unmistakable.

I have seen so many instances of the protecting power of vaccination that I have come to look upon it as a certain preventive and I fully believe that if every man, woman and child in the world were vaccinated every five years, that smallpox as a disease would be presently extinct, and its ravages as unknown as the black death through the plague and the sweating sickness of the middle ages.

I was glad to hear Dr. Crawford bring up the subject of the transmission of disease through the medium of vaccination. The enemies of vaccination have stated that as cows are very susceptible to tuberculosis vaccination exposes the community to danger of having matter from tuberculous animals inoculated in our persons. Koch has demonstrated positively that it is an impossibility to communicate tubercle by placing it upon any abrasion or open wound: with his strongest most virile tubercular poison he failed in reproducing it in this manner, so that disease need not be feared. Syphilis can be communicated, but animals do not have this disease, so we need have no fear of it. And in all of the cases that have come under my notice in private and public vaccinations I have yet to see any injurious effect remaining. The enemies of vaccination, like Dr. Keller, have to rely upon false statements to bolster up their denunciations. It was proved after Keller's death that in

his published statistics he had suppressed data that would conflict with his views and had actually altered the returns made to him to suit his convenience. Yet it is on such untrustworthy data that the anti-vaccinationists rely to prove their position.

And now what would be the effect in such a great city as ours without the protection of vaccination if variola should break out? A thrill of mortal terror would sweep over us; business would be suspended and all who were able would flee in haste from the doomed community as they would from a yellow fever outbreak. And those left would be stricken with the disease, perishing by hundreds and thousands and those recovering maimed and scarred with the disease to forever bear the marks of the pestilential conflict upon them.

Dr. H. B. FELLOWS: Two employes of the Relief and Aid Society who had previously had smallpox, one of whom had been inoculated with it and the other got it from contagion in the usual way, asked me to vaccinate them. It took vigorously in both. About the same time an elderly lady who had had smallpox from inoculation, was fearful that she had been exposed to smallpox and upon my advice was vaccinated. It also took vigorously in her arm. Since then I have advised vaccination to be performed on persons who had had smallpox the same as revaccination on others. If vaccination will take on this class of patients, we have reason to believe they would take smallpox if exposed to the contagion.

Dr. E. S. BAILEY: There are so many pros and cons to this question of vaccination, that it seems difficult to intelligently discuss it, unless we make each division a special study. One thing is certain that the great popular opinion is that vaccination and revaccination does protect against smallpox. Very few physicians practicing now have had an extensive personal experience in treating smallpox or in watching the prophylaxis of vaccination.

To a large extent then, I take it that personal prejudice enters as a larger factor than personal knowledge, concern-

ing this whole subject. These prejudices in favor of a given idea are quite as debatable as those against it. For my part I am prejudiced in favor of vaccination. In speaking of one phase of the subject, I should like to lay stress on the question of the technique of the operation of vaccination and the proper after-treatment.

The popular idea seems to be, that the more violent the inflammation and the larger the crust, the more thorough the vaccination. Again, the evil effects of vaccination are often referred to in after-life, and described by giving the appearance of the arm and the method of vaccination.

One factor that should be taken into consideration at the present time is, that in all probability the wound made in the introduction of the virus, became an infected wound, and very many of the after-troubles arising from vaccination, are really due to the bacterial infection of pathogenic germs and the fault is not with the pure virus. A filthy skin, filthy lancets, and filthy clothing and dressings go to make up a large cause of the evils of vaccination. Can not this cause be eliminated ?

The bacteria of the surfaces of the body are well known to the surgeons of the present day. Sternberg's Manual of Bacteriology* says : "Great numbers of bacteria of various species multiply upon the surface of the human body, where they find the necessary pabulum in the excretions from the skin and the exfoliated epithelium. Evidently the number will be largely influenced by the clothing worn, the atmospheric conditions as to heat and moisture, personal habits, etc. The writer has frequently inoculated culture media with a drop of sterilized fluid which had been placed upon the surface of the body of patients in hospitals and of healthy persons. By friction with a platinum needle at the point where the drop of fluid is applied the surface is washed and a little epithelium detached. Cultures may always be obtained by inoculating nutrient media from a drop of fluid applied in this way. Micrococci of various species, including the pus cocci, are very com-

monly encountered; sarcinæ and various bacilli are also frequently met with. Even the hands, which by reason of their exposure and frequent ablutions are freer from exfoliated epithelium than portions of the body covered with clothing, have constantly attached to their surface a considerable number of bacteria. This is shown by the experiments of Kümmel and Forster, of Fürbringer, and others, with reference to the disinfection of the hands with soap, water, and a brush; contact of the fingers with nutrient gelatine always resulted in the development of a greater or less number of colonies. Bordoni-Uffreduzzi, in his researches relating to bacteria of the skin, obtained in pure cultures five different species of micrococci and two of bacilli.

In his examinations of water from various sources Miquel found that "wash-water" from the floating laundries on the Seine contained more bacteria than water from any other source, even than the water of the Paris sewers. His enumeration gave twenty-six million germs per cubic centimetre.

Hohein has enumerated the colonies developing from underclothing worn for various lengths of time and made of different kinds of material. A piece of the goods to be tested was sewed fast to the underclothing, so as to come in immediate contact with the body; at the end of a given time a fragment one-quarter of a centimetre square was cut up as fine as possible and distributed in nutrient gelatine. Plates were made and the colonies counted at the end of five or six days.

In an experiment in which sterilized woven goods were worn next to the skin of the upper arm, the following results were obtained: Linen goods, at the end of one day twenty-eight, two days 4,180 colonies; cotton goods, end of one day 105, end of two days 1,870; woolen goods, end of one day 606, end of two days 6,799. When the material had been in contact with the skin for four days, the colo-

* Page 573.

nies which developed were so numerous that they could not be counted.

These experiments, startling as they are, can be verified over and over again in the bacteriological laboratories in this building. Simply denying such reports or repudiating them by expressions of unbelief, cut no figure in this form of scientific study. The virus, so-called, is also made the subject of microscopical research, but up to the present time the results are negative. The same author says :

“The etiology of smallpox still remains undetermined. The common pus cocci and various other microorganisms have been isolated from vaccine vesicles; but no one of these has been shown to possess the specific pathogenic power of unfiltered lymph from the same source. The experiments of Carstens and Coert show that the specific virulence of vaccine lymph is destroyed by ten minutes' exposure to the temperature of 54° C. And the writer's experiments show that various disinfecting agents tested—chlorine, sulphur dioxide, nitrous acid—destroy the infective virulence of lymph dried upon ivory points in about the same proportion as is required for the destruction of some of the best known pathogenic bacteria. But this does not prove that virulence depends upon the presence of a living microorganism, however probable this appears, for certain toxalbumins are likewise destroyed by a corresponding y low temperature and by the action of the various chemical disinfectants.”

The technique with which fewest faults can be found, is that used by the aseptic surgeons, washing the skin, clean instruments and protective dressings, of which carbolic gauze is the type. Improving the present haphazard and faulty technique will be one factor in eliminating an uncertain element in vaccination.

Throughout the world, the question of regulating by law the cultivation of pure virus, is receiving merited attention and the impure lymph of a few years ago will be unknown in the near future. A more hopeful day for the advocates of vaccination never dawned than the present, and smallpox, like cholera and yellow fever, will be found to be under the control of the scientist.

Dr. R. LUDLAM: Having been a member of the Medical Committee of the Relief and Aid Society, in its work after the Great Fire of 1871, I can verify Dr. Gilman's figures, and can endorse that experiment with compulsory vaccination as affording one of the most remarkable illustrations of its protective power on record. It is fitting, therefore that this Clinical Society, here in Chicago, should come to the defense of vaccination as often and whenever it is necessary. That some physicians should oppose it is natural enough, for there are those who antagonize anything and everything that is not in accord with their own ancient and peculiar views. There is no hope or expectation of making them all think alike; nor would it be well if we could. But when the public press goes wrong, in these days when everybody reads so much and thinks so little, we must come to the rescue of a prophylactic measure that has been such a blessing to the race.

My own idea is that much of the talk about the failure of vaccination to protect against the smallpox would cease if physicians realized, and would remember, that the vaccine disease and variola are not one and the same. We cannot reasonably expect that a single successful vaccination shall give immunity for a lifetime, as one attack of the smallpox *usually* does. It is not fair, or true, to say that it has failed and cannot be depended upon because it gives exemption for a few years only. We might as well argue that eating and sleeping and praying are failures because the performance needs to be repeated. There is a limit to everything we do, and to the protective scope of vaccination among the rest. Pasteur would not pretend that his inoculation against the rabies, with the virus that has been modified by transmission through the rabbit, gives *perpetual* immunity. It is enough that it acts and protects for a season against such a horrible disease as the hydrophobia.

The most important question to settle is the duration of the immunity given by proper vaccination. If it "runs out" and needs to be repeated, like the effect of our remedies, which is not everlasting, what is the limit of its protective

power? At first it was thought to be twenty years, then ten, then the old tradition of the seven-year-change was adopted, but the most recent writer that I have read proposes that five years shall be taken as the limit*. All of which indicates that the professional estimate of vaccination as a prophylactic of smallpox is developing in the right direction, for it is trying to determine the best rule of action by a practical clinical test, which is worth more to humanity than all the fads and fancies in the world.

DR. SHEARS said: The opponents of vaccination present two principal affirmations, viz.: (1) It does not protect. (2) It often infects the patient with some dangerous or loathsome disease. The first of these objections has been so completely met by the statistics presented in the paper of the evening and the leaders of the discussion that at this late hour I do not deem it necessary to add thereto, although much might be said. The second affirmation has been met with the statistics of the almost impossibility of transmitting tuberculosis by any method employed by the vaccinator. Syphilis has been transmitted, it is admitted, and yet I am convinced that many people take greater risks in the putting of coins into their mouths than are received in the attempts to protect themselves and the community from a loathsome disease, than by vaccination. The careful statistics of the German army show that out of 2,500,000 men vaccinated upon entrance into this army not one case of syphilitic infection was observed. Leaving out these two diseases, the other probability of infection may be prevented by care, and it is to the conclusions of Prof. Bailey's excellent paper to which I desire to add my emphasis, fearing that in the multitude of good counsel received you may forget to bear away with you that which in my judgment is one of the most important contributions of this evening and in the exercise of which instructions you may do more by your results, to remove one of the objections to vaccination than by any other. I refer to the

**L'immunite vaccinale*, par le Dr. Juhel-Rénoy médecin de l'hôpital Cochin, Paris, 1894.

proper execution of this slight operation. Dirty skin, dirty clothing, dirty instruments, or dirty fingers, are the causes of many of the complications which present. If a part of the care which is now observed in any well conducted surgical operation, however slight, were exercised in the act of vaccination, I am convinced that much of the erysipelas and similar complications would not be met. Antiseptic precautions, proper cleansing of the arm, the use of clean instruments, clean hands, protection from infection, are necessities if we wish for the greatest benefit with the least inconvenience. Do not understand me to say that no complication will arise if these precautions are observed. Patients with a syphilitic, scrofulous or eczematous heritage are at any time, under irritating influences, liable to have eruptions, inflamed glands, and limited ulceration, and vaccination may cause for a short time a reappearance of these constitutional difficulties, but it must not be claimed that vaccination produces these difficulties. They are dormant in the system. I have never observed any such manifestations in which I have not been able, upon careful inquiry to find a history which warranted me in believing that the trouble was not in the vaccination but in the patient. Even in these cases I have never seen any permanently bad results.

DR. CRAWFORD closed the discussion.

Hospital Notes.

FROM THE CHILDREN'S CLINIC.

SERVICE OF PROF. JOS P. COBB, M. D.

REPORTED BY MISS JAMES, CLERK OF THE CLINIC.

ICTERUS DUE TO CONGENITAL MALFORMATION. *Case 671.* Helen, age three months, was brought to the clinic by Miss H. M. Jackson, a member of the senior class, with the following history: At birth, she was bright yellow instead of red, the stool passed soon after birth did not have the usual color and appearance of the meconium. She has been subject to attacks of colic for which at one time she was given paregoric by the nurse. Aside from that one prescription she has always had homœopathic treatment. The stools were frequent at times, but always white or greyish in color; the odor was sour or fœtid, in consistency they were slimy, stringy, and tenacious. The child is fed at the breast; has a good appetite, and is regular in her habits of feeding. The urine has more staining capacity than normal; the child does not perspire any more freely than normal, but the clothes always smell strong. She is plump, fairly well nourished, and usually good natured; but does not, however, seem to pay as much attention to what is going on around her as a child of her years would be expected to.

Nothing in her parent's history was learned that would seem to have any bearing on the case except that the mother suffered with a rather severe cold for some time previous to the birth of the child. The child had been given podophyllum and chelidonium, and at times there was thought to have been some improvement in the color of the skin, but no change in the color of the stool had been noticed.

The differentiation between the normal icteroid condition of the first few weeks due to the destruction of the excess of red blood corpuscles present in the blood at birth; the icterus due to simple hepatic congestion or any functional disturbance of the liver; and the icterus due to malformation of, or obstruction in some part of the biliary apparatus, was carefully gone over and the opinion

advanced that the present case was an example of occlusion of the common bile duct due to a malformation. There were reasons for believing that this occlusion was not complete, viz., the meconium while not black and tarry had some color; the child was well nourished and gave evidence of the absorption of some fat; and the stools, at times white, were most of the time greyish.

The mother was requested to bring her to the sub-clinic in three days for a thorough physical examination, and she was given antimonium crud. 8, every three hours. She was also given six tablets of mercurius dulc. 1 x, to be taken one each night and morning for three days, to see if an extra *vis-a-tergo* in the bile duct would change the character of the stool.

The report given on her return was that the stools had increased in number but not in amount, the color was not apparently changed, and as yet there had not been any change in the color of the skin. She had, however, been less restless, had slept better, and seemed brighter.

Examination showed a liver of normal proportions for her age; a fairly well distended abdomen, at no point unusually sensitive; it failed to reveal any abnormality of the spleen or the gall bladder. An examination of the stool showed it to consist largely of fat and mucus; the proteid substances had been entirely absorbed; it was creamy white in consistency and color, and had a sour, rancid odor. The antimonium was continued. Shortly after this she went into the country on a visit, and we learned later that about two weeks after our last examination she had convulsions followed by coma and death.

MALNUTRITION. Case 642. This was a twin child six weeks old whose sister died at the age of nineteen days. The father is a consumptive. She is the youngest of ten children, all the rest of whom have died in infancy. At birth she weighed six and one-half pounds but now, September 27, 1893, she weighs less than when born. She is much emaciated, the skin lies in wrinkles all over the body and the face is pinched and has an aged appearance. At this time the bowels were moving ten or twelve times daily; the evacuations are light green in color, watery and ex-coriating. Pain precedes and accompanies the stool. She is extremely restless and cries continually. The appetite is voracious; she takes from seven to nine ounces of food every two hours. Her food has consisted of a diluted milk

preparation containing a large proportion of lime water. The abdomen is distended and she has a congenital inguinal hernia.

The case was taken to illustrate the subject of feeding babies, and the class was reminded that quantity and quality were just as important factors in successive feeding as frequency. This is an example of the many babies who are starved to death with a full stomach. An excess of lime water is a detriment to the child; the only good office performed by limewater is to neutralize the acid reaction of cow's milk.

Three or four ounces of food containing a proper proportion of the normal ingredients of milk, with only sufficient limewater to ensure an alkaline reaction, is, as a rule, the best food for babies of this age. The mother was given directions for preparing a milk and cream mixture and directed to feed but four ounces every two hours. The baby was also given calcarea phos. 6, four times daily. October 18, a marked improvement in the appearance was evident; the mother reported that the child was less restless, slept nearly all night; the stools are frequent but normal in color and consistency. She now weighs six pounds. Treatment unchanged October 25, weight seven pounds general improvement. November eight, weight eight and one-half pounds.

At this time she contracted a cold and was attended by a member of the class at the patient's home. December 6, the child again reported at the clinic showing evidence of further improvement, limbs well rounded out, face plump, and skin soft and smooth; and reports of continued good health were received during the following month.

INDIGESTION AND CONSTIPATION. *Case 675.* An infant girl, *æt.* 5 months was brought to the clinic Dec. 20, 1893. During the first month of her life the child was fed from the breast but as she was not doing well her diet was changed at the advice of a physician. Since then she has been fed Nestle's Food, Horlicks malted milk and is now taking a mixture of boiled flour, water and sugar; of this preparation she is given *two nursing bottles full* at each feeding.

She is poorly nourished and anæmic. The bowels are constipated stools large, hard, dry, sometimes yellow but oftener dark green, accompanied with pain and tenesmus. The urine is profuse, of a strong ammoniacal odor, stain-

ing and stiffening the napkin. The child is restless and fretful requiring constant attention both day and night. When it was about a month old the mother noticed an eruption on the back and buttocks in the form of watery blebs; at present there is a diffused erythematous condition over the same region. At the same time that the blebs were noticed there was a persistent hoarseness which has since given place to a constant dry stuffy condition of the nose. It was impossible to obtain any information in regard to the family history. The diet was changed to a milk and cream mixture diluted with oatmeal water, and she was given aurum mur. 3.

Jan. 3. Since the last report the child has been ill with gastro-intestinal inflammation which the mother thinks was due to contracting a cold, as there had been some improvement in the general condition. This may have come from such a cause but it is just as likely that it is a result of the indigestion and constipation together with a change of food.

The improvement in the general condition should be expected from the change of food and is not marked enough to warrant the supposition that the remedy has been of any value. Because of the new development and because we strongly suspect a syphilitic inheritance we shall give her to-day mercurius sol. 6. For two weeks there was a report of marked improvement. The mother said the child had never been as well; the bowels were regular, the stools normal, and the sleep quiet. The remedy was continued. No further report.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

REPORTED BY CORNELIA S. STETTLER, M. D.*

TUBERCULIN VS. LAPAROTOMY IN DEFECTING PERITONEAL TUBERCULOSIS.—Wednesday, January 10. *Case 21,084.* Mrs. —, æt. twenty-seven, married eight years, has never menstruated nor conceived. At ten, and again at twelve years of age she had dropsy of the abdomen, which became very large, but which yielded to medical treatment and entirely disappeared. If she sits long

*Continued from page 89.

she has a severe backache, and she also has pain in the left iliac region, and frontal headache constantly. For five years she has had a moderate bronchocele; there is no leucorrhœal discharge, and the bowels are regular. The uterus is normal and mobile, but undeveloped, the sound passing to the depth of two inches; and the conjoined examination finds nothing wrong with the appendages.

This patient was kindly referred to our clinic by Prof. Crawford. Failing to detect any malformation or defect in the genital organs, we naturally look for some other cause to explain the total absence of menstruation in this case. The clinical history of two attacks of abdominal dropsy in a young girl is doubly significant. Many years ago Cruveilhier described what he called the "dropsy of young girls," and one of the good results of modern gynecological surgery is that it explains the cause in many, perhaps most cases of this sort, and that cause is some form of peritoneal or genital tuberculosis. If it happens that the encysted dropsy is secondary upon the deposit of tubercles in the tubes, or the ovaries, the menstrual function will be delayed, deranged, or go by default.

There is a class of young lady students in boarding schools and seminaries, who being predisposed to phthisis, and whose diet and exercise are bad and neglected, often develop this condition. Such patients are certain to come under your care. If you remember the significance of Cruveilhier's dropsy, you will have a key to their proper diagnosis and treatment. For it is those very cases in which the tubercular deposit is accompanied by effusion that are most amenable to the proper surgical treatment. Where the incidental peritonitis is dry, or plastic, and not dropsical, hygienic, local and general constitutional means are usually sufficient for their cure, providing we can begin early enough.

In this woman's case we are embarrassed by the fact that the dropsy has been disposed of sometime ago, and that now there are no local signs of peritoneal inflammation. But her general condition of anæmia and pros-

tration, chronic ill health and thyroid enlargement, as well as the continued absence of the menses all betoken a dyscrasia of some sort.

Is there any test by which we might prove the existence of tuberculosis in this case? A laparotomy would settle the question, and it might safely be made; but it is a serious expedient and is scarcely justifiable unless the dropsy should recur, or if we cannot satisfy ourselves without a recourse to it. The proposal to detect obscure forms of local tuberculosis and to identify them by the injection of tuberculin hypodermatically is the newest and most promising expedient that we have for this purpose: It is said that the subcutaneous injection of one milligramme of the diluted $\frac{1}{100}$ solution of tuberculin will induce fever if tuberculosis is present, but will have no effect in other diseases or in health. Dr. Whitaker, of Cincinnati, claims to have had this diagnostic test verified by a laparotomy in a case of peritoneal tuberculosis, and if my colleague, Prof. Crawford, will apply that test to this woman's case, he may feel justified in sending her to us again for an operation. It is possible, however, that under his direction internal remedies may be sufficient to remove whatever remains of the morbid condition.

THE CLINICAL IMPORT OF MULTIPLE FIBROMATA. VENTRAL HYSTERECTOMY. RECOVERY.—January 20. One of the most practical lessons in recent times concerns the relative frequency of multiple as compared with single fibromata of the uterus. Péan's list of 300 cases upon which he had operated for their removal shows the proportion to be five to one. If this estimate is correct there is an important clinical significance in the fact; for not only does it argue against the futility of trying to dispose of one of these tumors which happens to be prominent by any sort of palliative treatment, or of waiting for the climacteric to cause its atrophy or to stop its growth; but it also shows the folly in most cases of removing a single one without taking the uterus along with the tumor. And since these multiple

growths are likely to be most numerous low down about the abdominal neck of the womb, out of reach, perhaps, from above and below, especially in fat subjects, we should

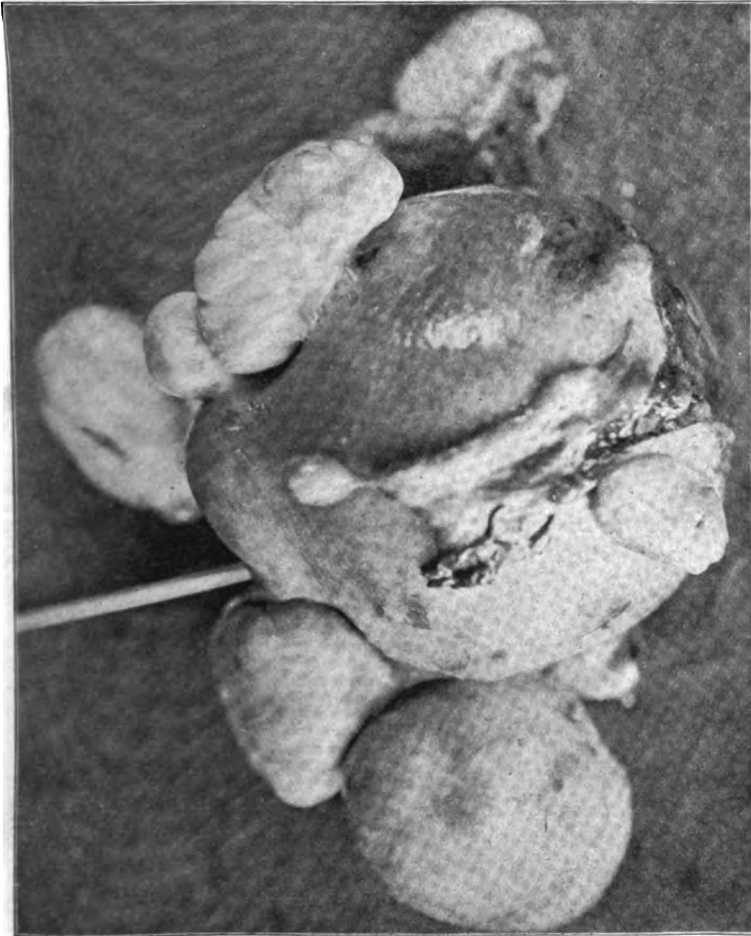


FIGURE 1.

remember not to conclude that because the upper one has subsided, or shrunken, or slipped away, or even been cut off, therefore the other buds and satellites that are almost

certain to be present and to develop in due time are of no consequence.

Here is a uterus that I removed from a patient of Dr. J. B. Dunham, at Wenona two days ago which presents some points of interest. (See Fig. 1.) The sound shows the direction of the uterine cavity. The bulk of the uterus at its left is due to an interstitial fibroid. There were eleven subperitoneal fibroids, all but two of which were attached to the inferior segment of the womb. The left ovary and its broad pedicle are thrown over the fundus uteri, and to this is attached the hydatid of Morgagni. Now suppose that one of these fibroids had been attached to the uterine body higher up and grown toward the abdominal wall while the others were below, what good would it have done to have removed it and left the others behind? Or suppose that in such a case the body of the uterus and one or more of the upper fibroids had been taken by vaginal section in such a way as to leave a portion of the matrix to which some small buds about the inner cervix were attached. Neither operation would be radical or successful and the trouble would recur.

Wednesday, February 14. This patient has made an excellent recovery.

HYSTERECTOMY FOR TWO HUGE FIBROIDS. RECOVERY.—
Case 21,087. Mrs. Spotted Bear, the wife of a Sioux chief, was sent to this clinic by Dr. O. N. Hoyt, and accompanied by her good friend and interpreter, Mrs. Riggs, of Oahe, S. Dakota. She is thirty-six years old and has had no children, although married fifteen years. Puberty at seventeen. The periods have been regular, scanty, sometimes dark and clotted. Three years ago she had a hæmorrhage from the uterus and œdema of the left leg; was ill for three months and has suffered more at menstruation since. She has a dull, heavy pain in the left side upon lifting. She first observed a growth in the left abdomen four years ago when she was supposed to be pregnant. The tumor has grown slowly since and the abdomen is very large.

January 11. A cœlio-hysterectomy was made before sub-class four, and two large fibroids were removed; the

lower one was interstitial and the uterus and ovaries were taken away with it. This was as large as the adult head, and was attached to the other one by a fibrous band an inch wide and two inches long extending from its fundus on the left side to the other tumor. The upper one was packed into the left hypochondrium and thorax as far as possible beneath the diaphragm. It had a sharp edge like the hypertrophied spleen, and was attached by adhesions beneath the short ribs. It was of an enormous size and the two taken together weighed forty-five pounds. The abdominal incision was seventeen inches in length.

Wednesday, February 17. The patient was carried into the general clinic and the wound dressed before the class. Except at the site of the pedicle it had closed firmly by first intention, and at that point it had almost entirely healed. The record shows that the woman has had a steady and uninterrupted recovery.

DOUBLE OVARIAN VARICOCELE. OPERATION. RECOVERY. —January 24. *Case 21,090.* Mrs. —, æt. twenty-eight brought here by Dr. A. J. Morris, married nine years, has had two living children and three miscarriages, the last of which was seven months ago. With that mishap she had a retained placenta, as she had had once before. She had been under treatment for about two years for ovaritis and endometritis, and was progressing nicely until the last miscarriage after which the placenta had to be taken with instruments, the patient being placed under chloroform. She was also curetted to arrest the hæmorrhage. Then paroxysmal pains in the right ovary became more marked, sending her to bed, especially at the month. After this there was quite a free discharge of sanious blood, with pain, tenderness, and throbbing and some fever, although her temperature did not exceed 102°. The uterus was again curetted, but this had no effect upon the discharge. A drainage tube was placed in the uterus and the sponge collected pus and blood. With expulsive pains blood clots would pass, and finally she became unable to move about, and at a consultation three physicians decided that an operation was necessary.

Operation.—January 25, a double tubo-ovariotomy was made before class nine. The right ovary was very adher-

ent, its tube and surrounding tissues were very congested, and of a livid hue. Its fimbriated extremity was badly broken down. The same conditions were present, but in a less marked degree, in the left appendages.

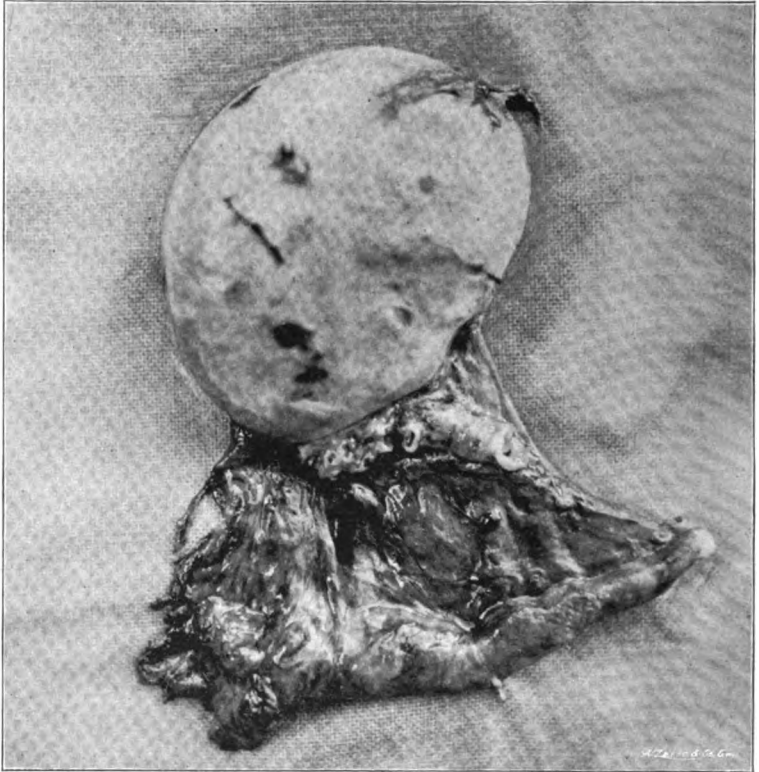


FIGURE 2.

The condition of these specimens (Figs. 2 and 3) explain the origin of the symptoms which neither our good friend Dr. Morris nor any one else could have cured in any other way than by their extirpation. The recurrence of retained placenta may have been a coincidence, or it might be ascribed to the early miscarriages; but the

inveterate uterine discharge, which was not changed by the curetting; the ovarian and tubal pains, the throbbing, and the increase of these symptoms until she was disabled and had to remain in bed, all point to an extra-uterine lesion, which at the beginning may or may not have been puerperal. But the lesion that was exposed when the

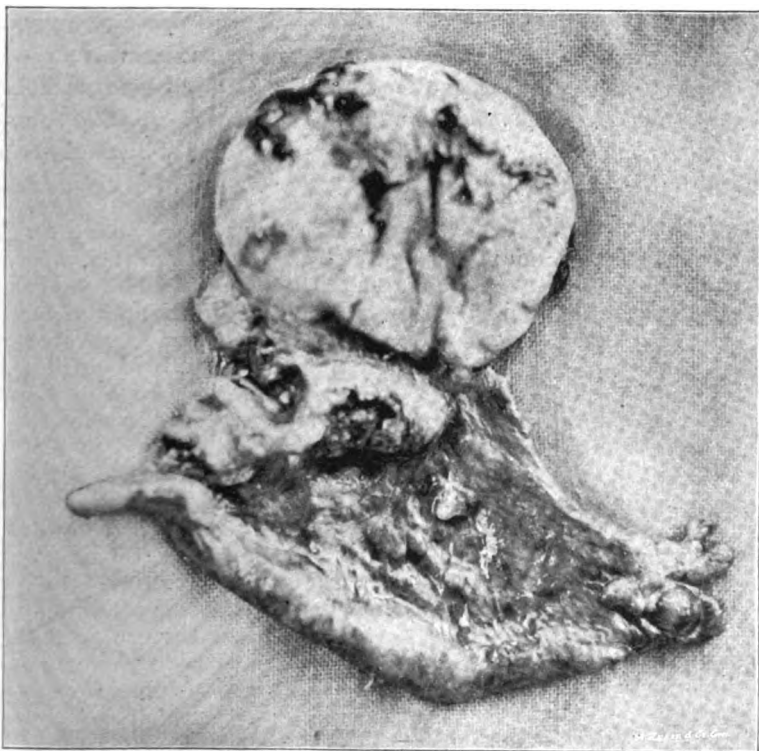


FIGURE 3.

ovaries were brought to light, and which you will verify in these specimens, as they are passed around, is the varicose condition of the veins of the ovaries, the tubes and the margin of the broad ligament. Those tissues were filled with these twisted veins which were dark blue in color, soft, knotty, and indolent. It being in the interval of the

menstrual period, no doubt they were smaller and less congested than at the month, but since this condition of the veins always goes with the hemorrhagic diathesis, we might readily expect that some form of hæmato-salpinx would accompany it. And doubtless this was the source of the flow which did not yield either to curettage or drainage. The changes in the ovary and in the tube confirm this theory most decidedly.

February 7, the fourteenth day. The sutures were removed on the ninth day; the wound had healed by first intention; the patient's temperature had not reached a hundred degrees, and she already expresses herself as feeling better than she has for years.

TRAUMATIC EXTRA-PERITONEAL ABSCESS. February 10. *Case, 21,098*, brought to the clinic by Dr. E. G. Keifer, was that of a married woman *æt.* 28, with one child now twenty months old. About three months ago she received a blow in the right iliac region; the next day the doctor discovered a lump there which was sensitive but not painful until a week later. She continued to nurse the baby for another month but then weaned it because of an abscess in the left breast. The breast was lanced and when it ceased to discharge the swelling in the right abdomen began to grow and became very painful. She has menstruated twice regularly and once slightly since she ceased to nurse the child; is anæmic and looks weak and ill. On entering the hospital yesterday her temperature was 103° and her pulse 115. Dr. K. says that since he first saw her ten days ago her temperature has ranged from 101° to 104° and her pulse has been as high as 120. For several weeks prior to that time she had been under treatment by another physician for enteritis.

You will naturally ask why operate upon this woman with such a temperature and pulse, and with such a history as she has presented for the last ten days or more? Why not wait a little? Simply because her life is in peril from a real pyæmic fever and infection. This tumor, five inches long by four in width and very prominent, is hard excepting at one point where there is a slight and shallow fluctuation; immobile, and of a reddish cast. Its trauma-

tic origin, increased rapidity of growth after the disposal of the mammary abscess, its pyæmic accompaniments, and the questionable diagnosis make the case one of more than ordinary interest. The possibility that it is intra-peritoneal and ovarian, or connected with the appendix vermiformis, renders it all the more serious, and suggests that we go very carefully in making the exploratory incision. We will deviate from the mesian line and cut directly over McBurney's point with the lower angle of the incision toward the right ramus of the pubis, not forgetting to avoid the epigastric artery. Our incision passes down through an inch of hard, infiltrated tissue, which cuts almost like a fibroid, at the bottom of which a dirty pus wells up and is sponged away. Here we find the necrosed tissue which is composed of broken down adipose and areolar structures. Evidently the lesion has not extended into the peritoneal cavity, which I prove to you by the conjoined touch as well as by other signs, and the thing to do is to remove this detritus by the curette, to secure drainage, and to close the wound. I prefer to pack the cavity with long strips of iodoform gauze rather than to use the ordinary drainage tube.

This woman was in a very precarious condition and now we know how to explain it. The exudate above the large pus pocket was so dense that the abscess had been weeks in trying to point externally. Meanwhile, however, it had not opened downward and discharged into the peritoneal cavity, else she would have died before this. The probable solution of the case was, first the traumatism and the extensive infiltration in the iliac region; next the mammary abscess, which was probably incident to nursing; then a local pyæmic infection at the site of the injury; and finally the systemic involvement of which the hyperthermic condition and the febrile pulse are the certain symptoms. In this view of the case the first source of the infection, according to Jaccoud's definition, was extrinsic whence it afterward became general.

Wednesday, February 14. The wound, dressed in the

general clinic, was healing kindly. The gauze drain was removed and replaced. Since the operation her temperature has not exceeded 99°.

CLINICAL ITEMS.—In cases of poisoning from bad mushrooms M. Poulet reports the best results from the internal use of atropine; but our readers are advised not to forget our experience with sulphuric ether as published in the CLINIQUE, Vol. I, page 340. The symptoms in that case were incessant and copious vomiting and purging, with violent cramps in the legs, which were relieved by standing, but when upon the feet almost immediate fainting ensued. There was also a paralyzed feeling in the muscles of the face, a locking of the jaws, and a sensation "as if a bag were drawn from the chin upward over the face as high as the ears, and over the ears, and a feeling as if so much of the head as was covered by this bag had been submerged in water." The mind was clear, but the pulse became thready and finally imperceptible. Half a teaspoonful of ether was put into half a glass of water and a teaspoonful of the mixture given every five minutes. The pulse becoming perceptible and the cramps less severe, ether was then given by inhalation and the attack passed off with one slight relapse of the cramps, which were soon relieved by its further use.—Concerning the mooted origin of tetanus, Le Blanc says: "I have seen a great many cases of it among horses, but despite the most careful researches, I could not always determine its source. But I have proven that the effect of cold plays a very important part in its development, at least in many cases; and Chauveau relates several instances in which the action of cold had caused a spread of the disease among human beings."

CORRESPONDENCE.

THE MEDICAL TREATMENT OF PERITYPHLITIS.

MILWAUKEE, February 5, 1894.

MR. EDITOR: Through my pupil in the "Old Hahnemann" I learn that the Clinical Society will discuss the *medical* side of the appendicitis question at its next meeting, and I rise to say that for one I am very glad of it. The truth is that nowadays the surgeons are having it pretty much their own way. What with digging out the ovaries and the fallopian tubes from all the dowagers and spinsters who will consent to it; tinkering with everybody's rectum who will submit to mutilation and faecal incontinence, and pay roundly for it; and cutting for the worm that never dies, if the surgeon can get it on his hook early enough, we poor doctors are likely to find ourselves without cash or credit, or, for that matter, without anything to do but to direct our patients to some abdominal, or abominable specialist.

These fellows forget the good old proverb which holds that: "When it rains on the minister it ought to drip on the deacons." So, I do hope that if I am not at the meeting, somebody else will have the pluck to say and to insist that we country doctors have cured typhlitis, or perityphlitis, time and again by internal and local means without resorting to the knife. We are just as sure of it, too, as we are that we have cured the croup, or pneumonia, or anything else.

O. W. CARLSON.

ERIGERON IN HÆMORRHAGES.

ROGERS PARK, February 7, 1894.

DR. LUDLAM: I have thought for some time to call attention to the use of erigeron as a hæmostatic, and a paper in one of the back numbers of the *CLINIQUE* on uterine hæmorrhage followed by a discussion in the Clinical Society has called it forcibly to my mind. What struck me as curious was that, although one of the speakers was a professor of materia medica, and a number of remedies were suggested by him, not a word was said of the drug in question, while in my own experience it is the most important and reliable of them all.

I have used this remedy for more than twenty-five years and have come to look upon it as almost a specific in all

kinds of hæmorrhage, and the only indication for its use that I can give with all my experience is simply hæmorrhage. I cannot now recall but two cases of hæmorrhage where it failed, one of which was found to be caused by a uterine polypus and the other by cancer. The following cases will illustrate its action and the form in which it was administered:

Case 1. Mrs. R., pregnant at five months, fell down the steps of the porch, which was followed in a few days by a miscarriage. When I saw her the fœtus and secundines had been delivered but a severe hæmorrhage continued, and she was becoming very weak. As it was in the country and I had no remedies suitable with me, and there was not a syringe in the house, the case would have been a desperate one had it not occurred fortunately when the erigeron was just coming into blossom. So, going into the garden I found a vigorous plant which I proceeded to make a decoction of in an uncertain strength and gave tea-spoonful doses every ten minutes until the flow was under complete control, which was after a few doses.

Case 2. Mrs. H., æt. about sixty, consulted me at the Homœopathic Dispensary in Detroit for a defect of vision in the left eye accompanied by protrusion of the ball, evidently from a tumor which proved to be cancerous. Enucleation was decided upon and the late Dr. D. J. McGuire performed the operation. After the eye was removed it was found impossible to control the hæmorrhage within the orbit notwithstanding various expedients were tried. I then suggested stuffing the cavity with absorbent cotton saturated with erigeron oil which was done and the hæmorrhage stopped in a few minutes and did not return.

Case 3. I was called about midnight to see Mrs. T., æt. fifty-eight, who had been bleeding from the nose since early the previous evening and who was becoming alarmingly pale and weak. As the hæmorrhage was passive and the blood venous, I prescribed hamamelis internally and locally but without any effect whatever. I then gave three drop doses of erigeron oil on sugar, and introduced pledgets of cotton saturated with the oil up each nostril. The bleeding stopped within a few minutes, but as a precaution I gave another dose of the oil in fifteen minutes and a few more at two hour intervals, which effectually prevented any return.

Case 4. A few months ago I was called in the night to see a typhoid patient of Dr. Bragdon's, of Evanston, at his request, as he was unable to leave another patient, and found a girl about twelve years of age unconscious and bleeding from the nose. The same treatment I followed in Case 3 was adopted and the hæmorrhage was properly checked and did not return.

Very Respectfully,
J. D. CRAIG.

A CONDITION THAT SHOULD BE A BAR TO MATRIMONY.

Mr. Editor:—That valvular disease of the heart in women should not always be a bar to matrimony was so well shown by your correspondent's quotation from Dr. Vinay in the January CLINIQUE, tempts me to say a word on a similar subject. Considering the specific origin of a large share of cases of salpingitis and ovaritis because of a latent and perhaps forgotten gonorrhœa in the husband, is there any reason why there should not be a marital quarantine for men who by entering into this peculiar and intimate relation might cause a deal of suffering and ill health? If anything is true in our professional experience it is that, in so far as the wife is concerned, the effects of a latent gonorrhœa in the husband are more to be dreaded than those of syphilis. If the man who has a stricture as the result of gonorrhœa in former years marries the chances are that his wife will either be sterile, or what is worse, will become a chronic invalid from diseased uterine appendages. So, therefore, why not protect the young and innocent women who are about to marry, not by sending the male candidate to one of those doctors who assume that such a horrible disease can be and has ever been radically cured, but by one who is competent to detect the gonococcus, and candid and honest enough to speak the truth and to sound the warning in season? Knowing what we do of these matters, if I were a woman, and a marriageable one, I should certainly not take the risk of entering into the relation of a wife with any man, old or young, who had a stricture as a sequel of specific urethritis.

Sincerely,

O. M. T.

Miscellaneous Items.

The Hahnemann Hospital has received the snug sum of \$1,260.20 as its share in the proceeds of the Grand Charity Ball.—The sociable given by the Religious Club of the College on the evening of February 1, was a thoroughly enjoyable affair.—Death has claimed our good friends Drs. C. N. Dorion, of St. Paul, Helen Heffron, of Washington Heights, and O. E. Stearns, of Freeport.—Drs. Spaulding, Culver, Hicks, and Hendy are doing excellent service in the Hospital and the Clinics.—Dr. O. G. Tremaine has located in this city at 145 Oakwood Boulevard, and Dr. Sarah B. Duncan at Auburn Park.—The marriage of Dr. Burt J. Maycock with Miss Sarah Louise Heath took place in Buffalo, N. Y., January 17, and we enclose our hearty congratulations.—Attention is called to the new advertisements in the outskirts of this issue.—The Commencement Exercises in the “Old Hahnemann” are set for April 5, at 2:30 P. M., and the banquet to the Alumni and Graduating Class for the same date at 7 P. M.—The Denver Homœopathic Club is making a fine reputation as a working body.—Prof. Arnulphy’s lecture at page 56 may be said to touch a burning question.—At the next meeting of the Clinical Society, February 24, Dr. O. L. Smith will read a paper on the Medical Treatment of Perityphlitis, and a full and interesting session is anticipated.—Prof. H. B. Fellows has gone south for a brief breathing spell.—Sharp & Smith, 73 Randolph Street, have donated, through Prof. Dunn, an air compressor and a set of Davidson’s atomizers valued at sixty dollars to our Throat and Nose Clinic.—The eighteenth annual session of the Missouri Institute will be held in St. Louis, April 17-19.—The Publisher’s page will be a valuable *post-scriptum* to our Items henceforth, and it is easily found by turning over a new leaf—of advertisements.

THE CLINIQUE.

VOL. XV.]

CHICAGO, MARCH 15, 1894.

[No. 3.]

Original Lectures.

THE SURGICAL DISEASES OF WOMEN.

EXTRACTS FROM PROF. LUDLAM'S CLINIC IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO, SESSION 1893-94.*

REPORTED BY CORNELIA S. STETTLER, M. D.

THE RADICAL OPERATION IN EPITHELIOMA OF THE CERVIX.—
Case 21,099, referred by Dr. Finnerud, of Dakota, was one of uterine cancer in a woman *æt.* 41, who two months before had undergone an amputation of the cervix by the galvano-cautery in another hospital in this city. In a month the old symptoms had returned and now she insists upon the removal of the entire uterus.

February 13 a vaginal hysterectomy was made before sub-class 12. The operation was very difficult, because the vaginal cervix having been removed, it was not only impossible to draw the organ fully into view, but very difficult to find a margin of healthy tissue; and besides, the vaginal canal was unusually narrow. However, its extirpation was effected, and safely too, for the patient subsequently made a prompt recovery.

Wednesday, February 14, Prof. L. remarked: This specimen shows the progressive extension of the cancerous lesion to the abdominal cervix and also to the mucosa of the uterine cavity (Fig. 4). Knowing the clinical history of such cases and their tendency to extend above the *os internum*, so as ultimately to involve the entire uterus and

*Continued from page 104.

the neighboring structures, the mere cutting off of the vaginal cervix by any method whatever must be regarded as an unsatisfactory expedient. But its high amputation, which is an enucleation of the uterus that may be more or less complete, as practiced by Schroeder and Byrne without the ligation of its vessels, is quite a different operation, and may sometimes be sufficient. In truth, the early and total extirpation of the diseased organ, without any compromising expedient, is the only radical and satisfactory remedy, and even with that we cannot warrant that there



FIGURE 4.

shall be no return of the disease. The primary result may be all that we could desire, but its non-recurrence sooner or later is the exception and not the rule.

Wednesday, February 28. I have had this patient brought before you in her sick-chair so that you might see how well she looks and what a prompt and satisfactory recovery she has made. Her two weeks were up yesterday, and she will leave the hospital on Saturday next. Her convalescence has resembled that of a simple, natural labor.

REMOVAL OF A PAROVARIAN CYST WEIGHING FORTY POUNDS. RECOVERY.—Wednesday, Feb. 16, *Case 21,088*, sent to the hospital by Dr. Gorton, of Portage City, Wis., was one from which a very large parovarian cyst had been removed before sub-class 7, January 20. She had had an unbroken convalescence. The wound was shown to the general class. The weight of the cyst and its contents was forty pounds, which was unusual for one of its kind.

ABDOMINAL HYSTERECTOMY TO AVERT THE MALIGNANT DEGENERATION OF FIBRO-MYOMATA.—*Case 22,002*, referred to this clinic by Prof. Shears, was a woman *æt.* 43, mother of one child now fifteen years old. Although apparently frail her general health has been good until eight months ago, when she first observed an abdominal enlargement. Since that time, while her digestion is good, and she has no other symptoms, there is a marked and progressive loss of flesh.

Operation. February 15. Before operating, Prof. L. said: I have advised an operation in this case because of its bad family history, a sister and two other near relatives of the patient having died of cancer. Here is a uterus which is the seat of numerous fibromata, and under the circumstances we naturally fear the degeneration of these growths. If not already sarcomatous they are likely to become so; and since they cannot be disposed of in any other way, we feel justified in removing them before they become malignant.

A supra-vaginal hysterectomy was decided upon because of the size of the tumor and the impossibility of bringing the uterus down to the vulvar outlet. But when the incision had been made and the tumor exposed, it was found impossible to draw it upward because of the lateral growth of two fibroids extending toward either hip. On the left side the fibroid, which was entirely within the broad ligament, was as large as the adult fist; and that on the right side was almost as large as the other. Taken together they made it absolutely impossible for these ligaments so to stretch that the growth might be delivered. Dr. L. then split the broad ligament on the left side and enucleated them both, after which the extirpation of the uterus and ovaries was safely accomplished. Beside the intra-ligamentous fibromata there were twelve others of different sizes attached to and disseminated through the uterine tissue.

Wednesday, February 28. Our patient has reached the end of the second week in good condition and is making a slow but certain recovery.

POST-OPERATIVE PERITONITIS FROM AUTO-INFECTION.—
Wednesday, February 28. Obstinate post-operative paresis and obstruction of the intestines is almost certain to result in intrinsic or auto-infection. When the bowels have been neglected before or after a peritoneal operation of any kind the arrest of the proper peristaltic movement is beset with peculiar dangers. And these dangers are none the less imminent and serious because their field of operation is removed from our sight. In these aseptic times we take the most scrupulous pains to make clean the outside of the patient, the site of the wound, the instruments, our hands and clothing, and everything that can by any possibility become a source of external or hetero-infection. And, so far as it is accessible, the genital mucous membrane is also rendered thoroughly aseptic in advance of an operation. But, although the usual practice is to free the bowels of the fæcal accumulation by a proper diet and purgatives, I am satisfied that in most cases sufficient stress is not put upon the necessity for a thorough cleansing of the digestive tube either before or directly after most gynecological operations.

I caution you, therefore, not to forget that shock, occlusion from old peritoneal bands, anchorage, strangulation, compression by old tumors and other causes of inveterate constipation, as well as of perforation, may induce an intestinal paresis that will destroy your patient's life through an internal and perhaps an unavoidable sepsis. The result of this condition is the retention and absorption of the vitiated secretions that are infested with myriads of bacteria, which soon set about their deadly work. If they do not pass beyond the peritoneum their mischievous ptomaines reach the heart and so intoxicate it as to give us the quick, feeble and irregular pulse of peritonitis. This single fact explains the disparity between the pulse and the temperature in some of the worst cases, just as it does in the ulcerative or perforating appendicitis which was discussed in your hearing at the last meeting of the Clinical Society. Indeed, so to speak, the pulse is the true thermometer to the toxic complication and the danger in most cases of post-operative peritonitis. It is because the ptomaines play hob with the heart's action, without neces-

sarily developing a hyperthermic condition, that some very clever operators have insisted that this form of peritonitis is not septic.

More than a hundred years ago a Dr. Forster of Edinburgh, in his work on midwifery, advised saline cathartics in what used to be called "puerperal fever." He had no conception of their antiseptic qualities, nor of their ability to drain away noxious material by reason of the watery stools which they caused. And yet this is the key to their beneficial action in preventing and aborting peritonitis, whether in childbed or after an ovariectomy or a hysterectomy. They eliminate and expel as no other purgatives will, the infectious material and gases with which the torpid bowel is filled, and from which the greedy absorbents convey the poison into the general circulation.

But suppose they fail to act, what then? There is a pinched expression, vomiting, tympanites, a hoarse voice, a thin, rapid pulse, cool extremities and perhaps a sub-normal temperature. By auscultation you find an entire absence of the gurgling sound over the general surface of the abdomen, and you recognize a complete intestinal paresis. Or, if you listen over the cæcum while an enema is being forced into the rectum and there is no sound, you know that there is an obstruction below that point. In acute strangulation the distention would be of limited extent, extreme, and would form rapidly; while, if it were chronic, these symptoms would develop slowly, and above the point of obstruction the peristaltic movement might be recognized. In a diagnostic way these symptoms are unmistakable; and now we know that if nature does not open this alvine outlet, and we fail to do so, the poor patient will very soon pass beyond our reach.

I have been led to these reflections through the death one of our patients, Case 22,001, upon whom we made a vaginal hysterectomy before sub-class 3, February 19, by *morcellement* for small multiple fibroids and a badly damaged uterus, and who died on the fourth day. The woman had been a chronic sufferer from repeated attacks of peritonitis, and from the most inveterate constipation. In preparing her for the ordeal it was impossible to get a thorough and satisfactory movement of the bowels. The rectum was, however, carefully cleansed. The pelvic adhesions were the worst that I have ever encountered in making that operation; but she did well until the close of the second day. There was a free and natural flow of

urine, no temperature, and the pulse was nearly normal. But then the abdomen became extremely sensitive and distended; she had great thirst and some vomiting; the pulse ran up to 135, and in another day could scarcely be counted. Her mind was clear, there was no chill, and only a slight rise of temperature. Our attempt to move the bowels resulted only in the escape of a little gas; she was nourished, and stimulated, and medicated most carefully and prudently but to no purpose. An autopsy was made by Dr. J. M. Hicks, assisted by Drs. R. Ludlam, Jr., E. M. Spaulding and Mr. Frank Teak, a member of the class. From Dr. Hicks' careful report of what was found we learn that there were peritoneal adhesions to the liver, the spleen, and the gall bladder, the latter being very much distended. The intestines were glued together by a recent fibrinous exudation; there was a small perforation of the descending colon at its junction with the sigmoid flexure, and just below this the bowel was so constricted by fibrous bands that its lumen was almost closed. The bladder and ureters were intact.

Two things are evident from this bit of clinical history: 1, that the operation of vaginal hysterectomy is not always easy or successful if the patient has been subject to extensive and relapsing peritonitis; 2, that auto-infection and sepsis is sometimes an unavoidable result of paresis and obstruction of the bowels.

OVARIAN DROPSY MISTAKEN FOR PREGNANCY IN A GIRL OF FIFTEEN.—OPERATION.—RECOVERY. *Case 22,003*, brought to the clinic from Michigan, by the Drs. Brewer, was a healthy girl whose only complaint was of an enlargement of the abdomen that began a year ago, and had continued and increased from that time. It was traced to a strain in attempting to save herself from falling, and began as "a lump" which she could not locate very definitely. The chief point of interest in her case was that before she came into Dr. B.'s care, several different physicians had pronounced her to be pregnant. An ovariectomy resulting in the removal of a fifteen pound cyst filled with a dark chocolate fluid, was made before thirty senior students February 17. The sac, which was very thick, had a patch of ulceration as large as a dollar on its outer surface.

Wednesday, February 28, the patient was brought into the general clinic; the wound was firmly closed, and she had not had a symptom, nor had she taken any medicine whatever.

CARDIAC INVOLVEMENT WITH FACIAL ERYSIPELAS FOLLOWING A HYSTERECTOMY. RECOVERY.—Wednesday, February 28, the attention of the general class was called to the further history of Case 21,087, upon whom an abdominal hysterectomy was made January 11 for two large fibroids.* The patient, Mrs. Spotted Bear, had recovered promptly from the operation, was able to sit up and to walk about the ward, but as a precaution against any mishap, was kept in the hospital longer than usual. February 21 her temperature arose from the normal to $102\frac{2}{3}^{\circ}$. She complained of headache; became very drowsy; her pulse increased from 77 to 114, and four days later her temperature had reached $105\frac{2}{3}^{\circ}$. Briefly, she had developed a very severe attack of facial erysipelas of the vesicular type, which ran its course in a week. There was no suppuration and no spread of the eruption; but meanwhile she had three attacks of dyspnœa, which were brought on by the slightest exertion, and accompanied by thoracic pains. The eruption disappeared by partial desquamation. She is now convalescent.

The dictum of Trousseau that facial erysipelas is not usually a serious affair, but will get well of itself, is undoubtedly true, and you will be careful, therefore, not to claim such a result as due in every case to the effect of your remedies. The history of this patient, in whose welfare we have all been interested, illustrates the fact which is not generally known, that facial erysipelas is sometimes complicated with cardiac affections, especially with endocarditis and pericarditis. This was a case of the kind, and I have requested Prof. Arnulphy to give you the detailed history of it farther on. It is the only case of erysipelas that there has been in the hospital during the last four years, and I am satisfied that it was no way connected with the operation itself.

March 4. The patient is sitting up again, and will leave for home in a few days, if there are no signs of a relapse.

ECTOPIC KIDNEY.†—Case 21,077 is also recalled as being of especial interest because my diagnosis was confirmed by the rapid development of a renal cyst, and the increase of all the symptoms since the patient was in our clinic, as well as by the removal of that organ by Prof. Shears in your presence on Monday last. I am glad to say that the patient is making an excellent recovery.

*See page 98 of this volume.

†See pages 35-37 of this volume.

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

FEBRUARY MEETING, 1894.

The regular monthly meeting was held in the Clinical amphitheatre of the New Hahnemann Medical College building on Saturday evening, February 24. The attendance was unusually large because of the general interest in the paper.

VI. ON MEDICAL APPENDICITIS. By ORRIN L. SMITH, M.D.—When one's morning paper parades such head-lines as, "A Perfect Epidemic of Appendicitis at Cæcumville;" when "*Life*" is stirred by such instances as the following: "Van Gilding is quite the leader of fashion, isn't he?" "Well, h—m, he has'nt had appendicitis;" and when a doughty Englishman declares the only safety for mankind is the removal of the appendix as soon after birth as practicable, one is compelled, in self-defense, to offer the notes of several cases in which the diseased condition has seemed to center in and about the cæcal appendix. And while their treatment has been medical, we would not have it seem to disparage the important service rendered by the surgeon's knife. Happily, in these liberal times, one may interest one's self in the medical phase of a disease without the fear of precipitating upon his luckless head the charge of indirectly accusing indiscriminate and non-conservative surgery. Before you say of a surgeon that "he always advises operation," remember that operators rarely see these cases, in consultation practice at least, until they have reached, and many times passed, surgical jurisdiction, thus affording them but occasional observation of cases responding to medical care. As truly may it be said of a clinician who has successfully piloted through a series of

cases that he recommends non-surgical methods exclusively. We believe conservatism constitutes the middle ground, and that it is manifestly unfair for either faction to assume that their methods only reflect true conservatism; yet, we regret to say, that in too many instances this is true, and why? Surgeons are more aggressive, and perhaps more progressive, so that medical, when compared with surgical, literature is meagre and scattered, exhibiting but slight, if any, crystallization. Thus, excursions into territories deemed medical, and the necessarily slower movement of the larger mass, has forced the advocate of medical methods to don the "great coat" of conservatism. Just as surely as there exist cases obviously surgical, so surely there are cases which are distinctly medical. It is with a few of the more salient points of the latter class that this paper deals, which, when coupled with the complemental paper of the evening, the controversial ground will have been swept, we trust, of a few types more clearly stamped than others. Then, if subsequent discussion springing from the rich field of appendicular experience abounding within the confines of the Clinical Society shall result in a more definite solution and classification of the knotty residuum, our object will have been attained. It is unfortunate that we are unable to have with us to-night, those of our professional brethren who are not within telephonic distance of a skilled surgeon, and whose treatment is necessarily medical, even though better judgment declares otherwise, and I earnestly hope we may be favored, in the near future, with some articles from the source indicated.

Case 1. Was called at 4 A. M. to see a young man who assured me he was going to have "inflammation of the bowels." He was twenty, of nervous temperament, inclined to overeat, and alternate constipation and diarrhœa. He had retired at 10 P. M., feeling some uneasiness in right side. Pulse 90, temperature 100°, right limb drawn up, had vomited once, diffuse abdominal pain, some tenderness but no dullness over the McBurney point. Hot flannels ordered and nux 3x given. A noon call found him no better. Half gallon enemas of hot water and

glycerine were ordered, the first two three hours apart, and the third following in four hours; bryonia 3x; left, asking if no better by 6 P. M. to send for me. The succeeding day found the temperature 99°, the acute pain had disappeared and the tenderness had materially lessened, although the right side "felt pretty sore yet." Had vomited immediately succeeding the second enema, but not since. Bryonia was continued, and in one week from the initial attack he was "doing half duty." Nine months to a day he had a second attack, though lighter, but pulled through all right, he obeying instructions to call a physician at once upon the reappearance of these symptoms. Hydrastis 2x was prescribed, bi-weekly flushings and some few dietary changes recommended.

Case 2. Mr. Mc——, Canadian, stone mason, æt. thirty-two. Bowels had been grumbling for a day or so, with frequent disposition to stool without satisfactory result. About 4 P. M. began to have pain over entire abdomen, which toward evening confined itself to the right side. Some nausea and vomiting. Was with much difficulty that he took a full step with right foot. When called about midnight he was in bed suffering much from the pain. Marked tenderness and slight dullness was elicited in the region of the appendix, right limb drawn up, temperature 102½°, and pulse 110. Enemata were administered, bringing away some fecal matter, dispersing the dullness, relieving the pain but slightly; hot flannels recommended, and nux vom. 3x was prescribed. The succeeding morning after the enema the temperature was 100°, the pain was considerably lessened and the vomiting and nausea had ceased. Enemata and hot flannels were continued. Bryonia 3x was substituted, and on the fourteenth day he walked almost a block to my office. There remained in this case for some time weak eyes, which symptom had never before appeared.

Case 3. Mr. G., æt. thirty. Boss carpenter. Gave an office prescription of colocynth 3x for what I thought to be colic, which doubled him up in the orthodox fashion. He grew "no better fast," and was soon summoned to find considerable tenderness to point pressure, vomiting and a temperature of 99½°. Enemata, hot cloths and colocynth made up the prescription, and the patient made an uneventful recovery in one week's time.

Case 4. Mr. C., æt. sixty. "I have always been hale, hearty and rugged. Am here for the Fair, and have given

every day attendance for a week ; but this morning I had been there but a short while until I began to have a diarrhœa attended with cramps. The diarrhœa stopped about noon, but the pain grew worse, and I finally became sick at my stomach and came home. I have tried drinking hot water and applying hot flannels, but with little relief."

Status præsans.—Eight P. M., temperature 101°, diffuse abdominal pain, occasional vomiting but nausea pretty constant, abdominal walls very thick ; appendicular tenderness to deep pressure, but no dullness on percussion. Hot starch water enemata recommended. Bryonia, 3x was prescribed, and the next morning he sent word he was so much better I need not call. His son since told me that he kept quietly within the house for several days, then went home, and has had no further trouble.

Case 5. Harry G., æt. twenty-eight, reporter, dined out Sunday, failed to have the usual morning stool the next day, and by evening had developed what I should term a beautiful case of appendicular colic, plus marked abdominal distension. Remedies, hot applications and small enemas having failed, something of a typhoid state gradually appearing, coupled with the fact that it was my first case, counsel was called. More copious enemata were advised, and as they occasioned much rectal pain, the long rectal tube was attached to the fountain syringe. This case recovered very nicely, being discharged on the ninth day, and in a few days was at work again. For a month or more there remained "weak eyes."

Case 6. S. W., æt. fourteen. Had worked late Saturday night, and eaten heartily before retiring. Was followed by cramps in stomach all day Sunday, succeeded by a restless night, not caring to arise Monday. I found what seemed to me a case of cæcal and appendicular inflammation. The usual treatment was given and on Wednesday of the following week I discharged the case, stating that he was not to attempt to walk at all within four or five days. However on Friday he left the bedside rocker and walked to the bath room and as it caused no particular discomfort, he was about the room pretty much as he chose. Tuesday I was summoned to a reattack and adopted the same measures, the fever, tenderness and pain gradually lessening, though there persisted frequent desire to urinate. On Thursday morning about four o'clock he suddenly became worse and when I reached him some hours later he

was anxious, in great pain, pulse 120, hiccoughing and vomiting. Surgical aid was at once summoned, the median incision made, a deep perityphilitic abscess and a much swollen and congested appendix disclosed. The abdomen was flushed with hot water, the dressing rapidly made, but he succumbed in less than one hour. I have taken care of but one case occurring in a woman and I shall not report it, for while there seemed marked involvement of tissue peri-appendicular, I cannot furnish post-mortem proof that the initial point of attack was not an ovary or Fallopian tube, for in three and one-half weeks she had recovered her wonted good health and a few weeks since left to spend the winter in the Carolinas.

Preferring to consider differential diagnosis piecemeal, as is naturally suggested, let us devote our attention to each of these symptoms in detail.

These were male patients and each presented an individual grouping of the symptoms; pain, tenderness, vomiting, tympanites and temperature, but without exception, exhibiting significant relation. Within our limited experience pain or uneasiness is usually the first symptom of which the patient is cognizant. Ordinarily sudden, the initial paroxysms are variously located, some declaring it "all over the abdomen," others "in the stomach," and some few referring it "over the bladder," even when by tenderness you have decided the appendix to be at home, but finally centering about the offending member.

Quite naturally you suggest that nephritic colic simulates very closely appendicular colic, so closely indeed that an eminent New York surgeon operated for the latter affection only to have the patient present him with a renal calculus the succeeding day. Perhaps we *were* deceived, only we failed to find: 1, corresponding thigh numbness; 2, vesical tenesmus, except in the reattack of case six, in which the operation confirmed the diagnosis; 3, the retracted testicle; 4, the bloody urine; 5, the renal calculus. Of course it might have been the passage of a gall-stone, although there was no jaundice, nor was there noted any gall-stones in the stool, and I am sure they were

not cases of abdominal neuralgia, for we were unable to discover the "four painful spots," and there was present fever, vomiting, etc.

Tenderness treads close upon the heels of pain, due of course to the diseased tissue, and affords, perchance the appendix should be in the McBurney neighborhood, the most important diagnostic symptom we possess, occasionally almost wanting if the inflammation be slight and the abdominal parietes of unusual thickness. That the location of the appendix does vary many of you have verified, both from operative and "posting" experience. Lenander, while posting the body of a "sixteen-year-old" found the cæcum in the left hypogastrium and the appendix grown fast to the spleen.

Dr. Fowler, of Brooklyn, reports three cases of left-sided inflammation, where the appendix was either beneath or in contact with the border of the left rectus abdominalis. Pleurisy has been occasioned by an appendicular abscess occurring high and breaking through the diaphragm. Croizet reports thirty cases of pleurisy due to propagation without appendicular perforation. Several instances are recorded where the appendix has followed down the cæcum through the inguinal canal, complicating a scrotal hernia with appendicitis. All of which is proof positive that this bit of anatomy which begins nowhere in particular and ends nobody knows where, is to be looked for anywhere. Vomiting or nausea was present with one exception and closely succeeded or developed with the pain and tenderness. Hand in hand with the satisfactory progression of the case it decreases and shortly disappears. In these mild cases we get neither the stercoraceous nor coffee-ground vomitus, indicative of profound septic infection. Although distension was observed in but one case, authors rather consider it a usual symptom, due, we have but small doubt, not infrequently to fæcal accumulation impeding gaseous circulation. Although various explanations are offered, Robinson concluding that there exists an irregular irritation of Meissner's plexus, producing disproportion-

tionate secretion which ends in the fermentation and formation of gases. Richardson says when the distention is due to profound septic infection no sounds whatever will be heard on auscultation, a significant fact and worthy of remembrance, chargeable to paresis from overwhelming pus absorption.

In these non-suppurative cases, the decadence of the temperature along with the subsidence of the symptoms would, of course, augur rather favorable than otherwise. If, on the contrary, pus is present, the thermal record is little short of valueless. The majority declare thermometry in this affection scarcely to be relied upon, less from a prognostic than a diagnostic point of view, however difficult may be the disassociation, for we believe few physicians fully realize the immense importance accorded the little instrument. Dullness, comparative only, was elicited, there being no distinct tumor present. Such a sign would not absolutely exclude it from the medical class, yet it is to be regarded with great suspicion, the more if it does not yield at once to the treatment instituted.

Abscess of the abdominal wall, if in the McBurney region, may possibly be complicated with appendicular inflammation. Thanks to the kindness of Dr. Ludlam, I saw a case involving this question a few weeks since. In commenting upon the case before operating, he said: "But for two reasons we might decide upon this being a case of purulent inflammation of the appendix. One is that the tumor is of traumatic origin, and the other is its chronicity; for appendicitis is rarely, if ever, caused by such a direct blow as this woman received. Nor is it a constantly progressive affair as this has been for many months." The result of the operation proved the correctness of this view.

Appendicitis has been mistaken for typhoid fever, rarely so if seen early. Later, differentiation is perplexing, still the prodromes, the peculiar thermometric curve, the enlarged spleen, the rash, and possibly epistaxis, may elucidate matters somewhat. Again, improbable as it

may seem, the intestine has been greatly *mortified* by the failure of the attending physician to recognize a hernia. Possibly the necessity of cutting an acquaintance would have been avoided, had he but remembered that the tender spot is always over the inguinal canal, the symptoms are more profound from the start, distention follows more rapidly, and there is always vomiting and constipation.

Excluding the relapse of Case VI., we believe these to be instances of non-suppurative, catarrhal appendicitis involving principally the mucosa, although both the entire wall and the contiguous tissues may be involved to the extent of simple or fibrous inflammation, and yet resolve without the formation of pus, just as does fibrous peritonitis; indeed, we have small doubt but that there was something of typhlitis or perityphlitis, or both, primarily or secondarily. Granting they were primarily such, we do not deem it probable to have had such symptoms without implication of the appendix.

We believe, however, that very mild cæcitis dependent upon unmistakable fæcal pressure might be diagnosed to the exclusion of appendicitis, at any rate. As such the cæcal pocket becomes overdistended by the superincumbent weight, and what is the natural result? It renders Gerlach's valve patulous, and foreign bodies and septic materials gravitate in the direction of the least resistance, the appendix is soon occupied, the fluid absorbed, sudden movements of any kind shake up this residue, and you have an accompanying inflammation. Or suppose there were perityphlitic inflammations. But how often does that affection occur when not dependent upon cæcal or appendicular inflammation? Einhorn says that 91 per cent is caused by the appendix. McBurney avers that 98 per cent of cases diagnosed as pericæcitis, are in reality appendicitis.

Hartly found that in 324 cases of so-called perityphlitis collected from various authors, 282 times the appendix was found to be the seat of the disease. Autopsies prove that 20 per cent of patients dying from other affections have recov-

ered from appendicitis without operation. Therefore, it would appear that we have some slight grounds, at least for assuming the presence of appendicular inflammation in these cases. We general practitioners are not cymini sectores, and so long as it is taught that these are distinct affections, much valuable time will be lost in endeavoring to establish a differential diagnosis. This might be obviated by including in a practical, clinical way, these phenomena under one name, the preference, by the greater frequency of its occurrence, falling upon appendicitis. Fully aware are we that the propositoin will send up in diagnostic horror hands galore, yet remember we are dealing with medical appendicitis, and the generalization is upon that basis purely. By so nominating, however, we do not deny the possibility of the uncomplicated or separate existence of these affections, or that a differential diagnosis cannot be made, but rather that in the initial stages the treatment is practically the same. Among these cases there were probably no stangulated appendices. But suppose there were, and medical treatment had been instituted. Perforation rarely occurs before the second day, occasionally as late as the fifth, and the rule observed is to abandon medical treatment if rational improvement is not apparent within twenty-four hours. The fulminating variety is confessedly medical for about twenty-four minutes only. Richelet and Terrillon insist that a certain per cent of these cases are tuberculous, and we heartily agree with them that excision is the remedy. I find that Guttman, in treating one hundred cases of appendicitis by simple medical means, lost but four patients against 4 per cent of loss reported by McBurney, in which operative measures were adopted. Dr. Talamon, of Paris, says 90 per cent of appendicitis cases get well with a certainty without an operation. Robinson is convinced that 85 per cent recover without the knife. Richelot reports:

	TOTAL.		RECOVERIES.	DEATHS.
Chronic Cases, {	15	Operation	15	0
	9	no "	8	1
Acute Cases, {	62	" "	50	12
	88	Operation	58	30

Of Case VI., we believe to have induced a relapse by flagrant disobedience and that in the reattack, while the acute symptoms partially subsided, an abscess formed with but the symptom of vesical tenesmus, suddenly lighting up peritoneal sepsis, disclosing the true state of affairs. An occasional case dying without operation is not proof that surgical intervention ought always to be practiced any more than does a post-operative death prove that medical methods should be invariably employed.

While reviewing the treatment instituted in these cases we certainly do not offer it for adoption, but rather because the patients recovered, some will say, in spite of it. Ordinarily the patient is full content to seek the bed and remain there, but if not, it is strictly enjoined. Latterly we have advised the use of the bed-pan instead of getting up, and believe it worth the insistence. Ofttimes moist heat externally allays the severer pain, counter-irritates and relaxes. The use of ice has been recommended but we have never used it. One or two glycerine and hot water enemata are given at once in half-gallon or gallon quantities through a fountain syringe, placing the patient upon his back, charging him to retain the enema as long as possible, assisting the sphincter by towel-pressure if necessary.

The water carries heat at once to the diseased tissue, relaxing it, also softening and carrying away any fæcal accumulation, thus subserving intestinal drainage and to a certain extent, antisepsis. Long ago Marion Simms suggested the use of glycerine tampons for insalivation of the uterine cervix, and mindful of the practical results observed during our internship, we were led to use it in this affection. In addition to the serous depletion, it excites intestinal as well as appendicular peristalsis. The hot water relaxes the appendicular tissue, and the glycerine depletes, each tending toward enlarging the lumen; the increased flow of mucus and the mild expulsive efforts favoring the extrusion of any foreign substance.

We have had no experience with cathartics or salines, believing them unsafe.

During the attack milk, beef tea and eggnog were allowed, afterward the convalescent typhoid diet was advised, with somewhat more rapid progression, however. Unquestionably remedies are rather the most important factor in the treatment of these cases and while the choice seems to have fallen upon a few, a more extended experience will have seen such remedies as belladonna, German phosp., hepar sulphur, lachesi and the iodide of calcarea, as frequently indicated as bryonia, colocynth, gelsemium and nux vomica. With some of these patients weakly colon flushings were recommended, some few dietary changes were made, with instructions to summon a physician instanter upon the reappearance of the symptoms of the former attack.

Conclusions.—1. There exists a class of appendicular inflammations which are amenable to medical treatment, or at least, cover without operative interference. 2. That for clinical convenience the phenomena known as corcitis and pericorcitis may be included in the term appendicitis. 3. The roving disposition of the appendix many times renders the recognition of the affection additionally difficult and caution demands a diagnosis proven by exclusion. 4. When compared with surgical researches and work, the crystallization of details medical is noticeably deficient. 5. Initial pain is of doubtful locative value. 6. The location of tenderness will depend upon the whereabouts of the appendix; the extent upon the severity of the inflammation and the thickness of the abdominal walls. 7. The permanent disappearance of tympanites after an enema is a favorable sign. 8. Intestinal peristalsis augurs well. 9. Thermometry is but little short of valueless. 10. The presence of a tumor persisting after repeated and copious enemata soon spells knife. 11. Appendicitis has been proven to have existed and entirely resolved in 20 per cent of autopsies on people who have died from other causes. 12. The majority of the cases occur among young men. 13. Direct violence is rarely an ethiological factor. 14. A relapse closely succeeding or occurring during convalescence

usually passes beyond the domain of remedies. 15. Recurring appendicitis, showing a ready response to treatment, a decreasing severity of the symptoms and an increasing interval between the attacks justifies endeavoring a cure without the knife. 16. If within twenty-hours rational improvement is not apparent, with but few exceptions, medical treatment should be abandoned. 17. Rest, absolute, constitutes no slight element in the treatment of these cases. 18. Ultimately, the enemata establish intestinal and appendicular drainage. 19. No one of these measures will prove efficacious and prompt and thorough operation is absolutely essential, while desultory methods are to be roundly condemned. 20. Careful attention to diet possesses a modicum of common sense. 21. The administration of the properly indicated remedy, once the coast is clear of mechanical conditions, is perhaps the strongest bulwark of the physician. 22. When in doubt an early consultation of surgeon and clinician is a godsend to the patient.

VII. THE NON-SURGICAL TREATMENT OF APPENDICITIS.
BY O. W. CARLSON, M.D., of Milwaukee, Wis. *Case 1.* About a year ago I was called to visit Mr. B. C., twenty-three years old. He was suffering with great pain in the right abdomen and had been for a number of days. I located the trouble in the appendix and told him so, but began the treatment by filling him up with warm soap-suds from a fountain syringe, and flooding the bowel until he cried with pain. The water passed away and he felt easier. He was then given *nux vomica* 3, and a large flaxseed poultice was applied over the abdomen. Just as I was leaving he asked if it would be necessary to have an operation? "I want to tell you the truth now," said he, "for Dr. F. has been attending me for five days, and he has now gone for Dr. S., the surgeon, to come here and operate." But I said, why did you not tell me this before? He replied "I really wanted to know if it was necessary that I should be cut." Well, I said, you will lose nothing by waiting until to-morrow, and if you wish me to continue the case in a medical way, you may send the doctor word to that effect. On the next morning I repeated the injection and he soon became quite well. Since then he has occasionally had slight and temporary pains in that region, but no severe

attack, and is now in excellent health. There was no discharge of pus from the bowel, the bladder, or from any other source.

Case 2. A conductor, aet. 38, on the M. & St. P. R. R., returning at night from a hard trip was seized with a severe pain in the centre of the abdomen, located at the right of the mesian line. He was put to bed, had a severe chill, and sent for me. I gave him fifteen drops of gelsemium tincture in water, applied a hot flaxseed poultice, and followed this with a bottle of the effervescing solution of the citrate of magnesia. The next morning the pain still continued, but less severely, and there was a lump of induration at the site of the pain. He was frightened and desired counsel so, at three P. M., Dr. L., a local surgeon, saw him with me. He diagnosed appendicitis and advised an immediate operation. The poor fellow had a great dread of the knife, and demanded that we should find some other way out of it; so I then flushed him thoroughly with the suds, continued the poultice, and administered one-fourth of a grain of morphine hypodermically.

He also took *nux vomica* 3 instead of the gelsemium. In about a week he was quite well again. The thorough flushing disposed of the swelling in the cæcal region. There was no abscess nor discharge of pus. This attack occurred about three months ago, since which he has slight pains now and then in that region for the relief of which the usual remedies are sufficient. He, however, wears a flannel belt about the abdomen for protection against taking cold.

VIII. APPENDICITIS FROM THE SURGICAL STANDPOINT.—BY DR. HOWARD R. CHISLETT.—I have listened to the paper presented by Dr. Smith with a great deal of interest and must express my commendation, not alone from the professional but likewise from the literary point of view. Appendicitis is to me one of the most interesting problems of the day; a problem still, in spite of the decided opinions of physicians on the one side and the equally positive assertions of surgeons on the other. Viewed from the standpoint of the physician, Dr. Smith's paper is one of the most fair it has been my pleasure either to have listened to or to have read. He has given us clearly and concisely the symptoms, the diagnosis and the medical treatment and has furnished us with statistics showing that from 80 to 90 per cent of the cases do not die even without the aid of surgery. To say that patients

do not die or that they recover is not by any means equivalent to saying that they are cured, for I dare say the experience of every physician here will corroborate my statement that recurrence is the *rule* and *not* the exception in these cases treated medically. It falls to my lot to-night, through the kindness of Dr. Smith, to dwell more minutely upon the pathological and surgical aspect of appendicitis, for in this as in every other surgical disease it is the knowledge of the pathological conditions alone that should guide the surgeon in the selection of the proper cases for operative interference.

Appendicitis in all its phases is a surgical disease. In stating this, my earnest belief, I mean not that every case demands an early operation, not at all, but that the physician in attendance, if not an operator himself, should ask a surgeon to watch the case with him.

I shall base my argument for surgery upon the ten cases that have come under my treatment during the past eighteen months. Of these ten cases eight occurred in men, two in women. Four patients were suffering from the first, one from the second, two from the third and two from the fourth, and one from the thirteenth attack of the disease.

In eight cases there was a positive diagnosis of appendicitis. The ninth case was one of diffused septic peritonitis probably from rupture of the appendix, and in the tenth, seen the third day after the onset, the nearest we could arrive at from the meager history, was diffuse septic peritonitis resulting in intestinal obstruction.

Of the eight cases where a positive diagnosis could be made, one was regarded suitable for medical treatment and recovered under topical applications of heat, interrupted doses of saline laxatives and glycerine and turpentine enemata.

Seven cases were operative with five recoveries and two deaths. Two of these were of the catarrhal form, five of the suppurative variety. One death was due to septecæmia from embolic infection of the venous radicals of the liver; one to secondary intestinal perforation and general peritonitis owing to his obstinate refusal to submit to operative measures until eighteen days after he was first advised to do so.

The ninth case was one of exceedingly great interest, as he had undergone the operation for appendicitis under the hands of my friend, Dr. Coon, seven weeks before, and had made an uninterrupted recovery. The day before I saw

him he had felt a sudden and intense pain upon making an effort to urinate. The pain extended all over the abdomen and in a few hours the poor fellow was a typical picture of general peritonitis. Operation twenty-three hours after onset easily demonstrated rupture of adhesions separating old abscess cavity from general peritoneum. In spite of irrigation and stimulation the patient sank rapidly and died fifteen minutes after his removal from the operating table.

In case No 10 I could not operate because the patient collapsed three different times under our efforts to induce a sufficient degree of anæsthesia to warrant me in undertaking an intestinal operation. The post mortem revealed a diffuse suppurative peritonitis due to perforation of the appendix. The obstruction was due in part to distention and in part to adhesions which glued intestinal coils together. To sum these cases up we have: Two cases treated medically with one recovery and one death; eight cases treated surgically with five recoveries and three deaths.

Now one word in regard to statistics: It is not just to the surgeon and still less just to the patient to institute comparisons between the general results obtained by physicians and those secured by surgeons. The reason of this is obvious if you will but follow me a moment longer. Of the ten cases cited above only two occurred in my own patients; one treated medically, one treated surgically. Both recovered.

Eight cases were either referred to me from the medical wards or sent to me by other physicians after medical treatment had been unsuccessfully tried for periods ranging from three days to three weeks. I am sure that seven of the eight cases would have died without operation; the quantity of pus varying from a few drops to eight ounces. The other being catarrhal would probably have suffered a few more times and then had the operation for perforation. Instead of that he is now well.

I think I can safely say then, that five lives were saved by timely operation, for while absorption after suppuration is possible it is very improbable. One more life might have been added to this list by an earlier operation.

Now let us see what there is to decide us in our choice between medicine and surgery. As I said before it must be the pathology. The generally accepted theory now of the catarrhal form is that it is an infective inflammation of the mucus membrane of the appendix which may or may

not go on to ulceration. The causative factor in localization is regarded in most instances a foreign body. I accept this for primary attacks and should recommend medical treatment for all such cases that are positively catarrhal in nature.

From the number of appendices that I have examined where there has been a history of *recurrent attacks*, I am certain that this causative factor has been overestimated. In five cases where I have secured the appendix for examination, three of them showed the typical constriction in varying parts of the tube, so nicely illustrated in the specimen I bring for your inspection. On this account I am convinced that more frequently than the irritation of a solid foreign body, the ulceration and consequent cicatricial



FIGURE 5.

stenosis of the lumen of the tube, by retaining semisolid and even fluid contents that undergo decomposition, may be held responsible for the recurrent attacks. When, then, in cases of recurrent appendicitis, you have the increased frequency and severity of the attacks, operate. Where your patient is not at all times where he can command surgical skill, operate. Where the patient lives in dread, constantly fearing a recurrence, operate, for the operation is far less dangerous than another attack of the disease. The best time to operate is between two of the attacks.

A well defined tumor forming after the clearing out of an impacted cæcum by interrupted doses of saline laxatives of glycerine and oil enemata indicates *always* involvement of the peritoneal coat and *generally* perforation

and consequent suppuration. In my judgment, those cases in which a distinct tumor forms and absorbs the peritoneal coat has *not* been perforated, the microorganisms passing that membrane in too small numbers to excite suppuration. Where perforation takes place and there is extravasation of intestinal contents, suppuration is a certainty. *There is absolutely not a single clinical symptom that will enable a positive differentiation between these two conditions in the early days of the attack.* To be sure, as a rule, the tumor forms more rapidly in cases of perforation, but this is not invariable and the *temperature* is no guide whatever.

Therefore I hold that all cases of well-defined tumor are operative cases, because: first, if there is perforation the operation is a necessity and the sooner it is done the better the chance of recovery; second, if the peritoneal covering is involved perforation may occur at any moment, and the operation is less dangerous than the waiting; third, if involvement of the peritoneum means, as I believe, destruction of both mucous and muscular coats at some point, recurrent attacks *must* follow soon or late. When such conditions obtain my belief is in the earliest possible operation. In one of the cases reported, at least, delay can be held accountable for the death, and in another it allowed the patient to sink so low that anæsthesia was impossible.

Gangrenous appendicitis means practically intestinal perforation and diffuse septic peritonitis, and demands early operation. Although you will not save more than one case in one hundred your patient should have the chance. Death is certain without it, and it seems to me cowardly to refuse to operate because the odds are so much against you.

Now one word about the diagnosis of these cases of peritonitis. Great pain, very rapid pulse, extreme restlessness and persistent vomiting, with the facial expression of anguish are the most reliable indications. The temperature is no evidence. I have had two fatal cases of suppurative peritonitis in which the thermometer registered between 99° and 100°. Tympanitis may not be present until intestinal paralysis is practically complete and should not be looked upon as a guide. A tympanitic condition may be extreme even in the catarrhal form, being a reflex symptom from irritation of Auerbach's and Meisner's plexuses.

Allow me then to present, in closing, the following conclusions: I think the operation is called for, first, in recurrent catarrhal appendicitis when each succeeding attack

shows increased severity; second, when the patient is a traveler or is living where he cannot at a moment's notice command the services of a skilled surgeon; third, when the mental condition is one of constant fear and dread of suffering from another attack; fourth, all cases where there is a pronounced tumor after cæcal impaction has been excluded; fifth, all cases of gangrenous appendicitis and diffuse peritonitis.

DISCUSSION: DR. G. F. SHEARS: I desire to express my pleasure in the reports which have been read both on account of their scholarly character and the amount of careful observation which they indicate has been given to this most important subject. I consider the question of treatment of appendicitis one of the most important now before the medical world, first because of the frequency of the disease, second because of its dangerous character, and third, because of the difficulty of laying down close rules for its treatment which have a scientific basis for their formulation, and are not simply dependent on the individual tendencies of the medical man in charge, toward conservatism or radicalism. The London *Lancet* said editorially in 1891, after discussion of this subject before the London Clinical Society, that "the question of the treatment of appendicitis would probably be the subject of controversy between the medical man and the surgical man for many years to come," and the abundant literature presented on this subject in the last two years, as well as the meeting of this society to-night, indicates that that prophecy is being fulfilled.

It can hardly be expected that I, from my standpoint, should spend much time in defending the medical treatment of appendicitis. The medical man has no cause for complaint because of a lack of opportunity either to defend or to practice his art. For almost 6,000 years, if we may accept the biblical account of creation, there has been no other form of treatment. He has had an exclusive monopoly, and like all monopolies, has made no improvement on his original plan of treatment. It is only some twelve or fifteen years ago that the possible surgical treatment of

appendicitis was considered, and when one or two bold surgeons modestly claimed that certain forms of appendicitis should be treated by operative measures, they were immediately placed upon the defensive. What a change has taken place in these few years! The very position which this subject assumes in this meeting to-night is only representative of the condition of things which is taking place all over the medical world. Our friend, the essayist, instead of claiming, as was done twenty years ago, that this condition was wholly a medical disease, is now practically admitting the surgical character of the disease, and simply asking for the right to treat it otherwise under very limited conditions and in certain very easy cases. This is not strange when we consider what surgery has done for this malady. It is through the work and investigations of the surgeon that the real pathological condition present in this trouble has been brought to light. Before his time we knew from the investigations of pathologists of certain results, but we did not know the processes to which those results were due.

The very nomenclature of the subject has been changed as a result of the work and treatment by the surgeon. While we do not indeed discard the term of typhlitis and perityphlitis we now use them to indicate secondary processes in the progress of appendicitis rather than primary processes of which appendicitis is only a part.

As a result of the work and treatment of the surgeon, the 20 per cent of cases which, according to the statistics of the medical man, were doomed to death, have now a good chance for their lives; and the still larger per cent destined to be harassed during life by a painful and dangerous inflammation, have now for them the blessed possibility of permanent cure. If so much is due to the work of the surgeon, why is it then that the question of medical treatment arises? First, because there is a certain number of limited, mild cases which are properly the subject of medical treatment; and second, because of our lack of knowledge of the varying conditions which are really present in each case, or at least of our inability to fit the

symptoms present to the pathological conditions taking place during the early history of the disease. Take for example a dozen cases starting out practically in the same way, and at the end of ten days, under the best medical treatment a certain number will have died, a certain number will have had localized abscesses which threaten their lives, and the remainder will be on the road to recovery ; and I venture the assertion, that no one however wise or skillful, will be able during the first twelve hours to accurately classify these cases. Even the same pathological conditions in different individuals take a longer or shorter time in traversing the same road. Inflammation, sloughing, and perforation in one may require three days, and in another six. For instance, a patient came into my office in terrible pain ; he became nauseated and while in the bathroom fainted ; he was removed to his home, and within twelve hours developed a most pronounced case of appendicitis, with severe pain, persistent vomiting, tumefaction in the right inguinal region, temperature 103° , and every indication of rapidly progressing disease, and yet he recovered within three or four weeks without, so far as we were able to ascertain, suppuration having taken place. Again, in another patient whom I saw in consultation, the disease had a much milder advent and yet he developed a peritoneal abscess which was only relieved by operative measures. Still a third case with no severer symptoms than those narrated in the first case, died upon the fourth day of the attack ; and these typical cases might be increased many fold without finding one which would give a real indication from the first day of attack as to its final outcome.

Is it strange, then, that with these possibilities the physician accustomed to the habit of expectancy, seeing many cases recover under careful medical attention, indeed knowing from observation and reading, that the majority of cases do recover, at least from the initial attack, holding as he often does a close relationship to his patient, should naturally incline to conservatism. On

the other hand is it strange that the surgeon, confident in his operative technique, accustomed to prompt mechanical and operative measures, knowing the impunity with which the great cavities of the body, the brain, thorax, and abdomen, may now be opened under aseptic precautions and in skillful hands, seeing as a consultant, the more serious cases, and knowing the benefits which his art has already conferred, is inclined to be radical.

The medical world is very like the many other little worlds, financial, social, and religious; it is only after the pendulum has swung to its extremes that the final adjustment comes. There is no doubt that an exclusive medical treatment is an extreme. There is no doubt that an exclusive surgical treatment is an extreme.

Treves, one of the earliest writers on this subject, and one whom no one can accuse of lack of operative courage, said recently that the epidemic of removal of appendices which has prevailed in some quarters, is deplorable. It is our duty to-night, as it is the duty of every conscientious, scientific physician, to consider this question from both its standpoints, and to formulate his decision as to the best treatment, not from his particular standpoint as a physician, but from the standpoint of the best interest of his patients. Personally, I agree with what has been already said of the advisability of operative procedures in recurrent cases of appendicitis. I should advise such patients as I would advise a patient who has hernia which he cannot retain with a truss, to have an operation for its radical cure: "You are in greater danger from strangulation than from any operative procedure." And so with a patient suffering from recurrent appendicitis: "You are in greater danger from a possible secondary attack than you are from an operation for the removal of the appendix."

But it is not in these recurrent cases of appendicitis, neither is it those cases in which an abscess has already formed that the difficulty of deciding as to the proper treatment arises. It is rather in those first cases, in which the outcome of the disease is difficult to forecast, that one's

anxiety as to the proper advice to offer, is most pronounced.

If one fails to advise operative measures, and the patient dies, and the physician is a conscientious man, how great must be his regret. It is not my intention to report a long list of operative cases or their results. You all know that these operations are made, and are made successfully. The great question is, *when* are these operations demanded? Upon what evidence shall we base our decision in these cases? Experience has shown that the pathological processes which cause death on the third, fourth, or fifth day, begin before the end of the third day, and it behooves us, if we desire to do our duty to our patient, and to give him the best opportunity for his life, to operate before this change has taken place. We must not wait for signs of threatening perforation. No one can give them. The signs come when the lesion has occurred. These should be anticipated. It is only by frequent and careful examination that we can decide when the medical treatment should end, and the surgical should begin. If one is called to a case of appendicitis, and at the end of twelve hours the nausea has increased, the tenderness has become more pronounced, tumefaction is noticeable, the face has assumed an anxious expression, it is time to operate. If, however, there has been no advance in these symptoms, or there has been a slight improvement, wait twelve hours longer, and if at the end of that time there is still improvement, continue the medical treatment, and it will probably be all that is required in the case. If there is slight increase in the symptoms, especially if there is increased tenderness the patient may be watched twelve hours longer when, if he does not improve, an operation should be advised. Keen says that by the second day, certainly by the third, operate: *a.* If there is tenderness at McBurney's point, attended with nausea and vomiting; *b.* If there is rigidity of the abdominal wall; *c.* If the temperature runs 100° to 102°. *d.* If there is tumefaction and increased resistance; *e.* If there is œdema of the abdominal wall.

He would even urge the operation if the nausea and vomiting be absent. Consider carefully, then, the condition of the patient, remembering that upon prompt decision depends the lives of the 20 per cent whom exclusive medical treatment doomed to death, and upon the greater number whom the same treatment doomed to frequent, long and dangerous illnesses.

Dr. O. G. TREMAINE: I wish to emphasize the statement made by Dr. Chislett that "these cases of appendicitis are surgical ones and should be attended by surgeons." It is well for those of us who operate to remember that it is far easier for us to advise operative procedure than it is for the patient and friends to consent. In fact if any one of us was suffering with appendicitis and not critically ill, if an operation was advised, he would feel like postponing it a little, hoping to get well without it, and we should be willing in cases not very severe or critical, to allow our patients the same privilege we should crave.

I believe in making an earnest effort to cure these cases medicinally, for it is my experience that such effort is often successful. Waiting to see if medicinal means will cure the patient is fraught with danger, as the gravest conditions frequently develop very rapidly, except it be that the attending physician is as skilled in diagnosis from a surgical standpoint as is the surgeon, it is emphatically necessary that he have a surgeon to attend the case with him. For when an operation becomes necessary it should always be made *at once*. It is often the too great delay that causes the fatality after surgical interference.

Dr. N. C. KEMP: I recall a case which came under my care which had had three attacks in the space of two years. Man *æt.* 37, during first and second attack suffered from the usual pain and tenderness in the right inguinal region. He was put to bed, the usual and indicated remedies employed locally and internally. He was quite sick for five days, at the end of two weeks was about. I supposed he had had appendicitis. The third attack began in similar manner to the first and second, only symptoms rather more

severe; after ten days an abscess had formed over the region of the cæcum. A half pint of very foul smelling pus was evacuated through the abdominal wall and the patient very rapidly recovered. Perityphlitic abscess resulted, but probably the two first attacks were perityphlitis only.

My nearest neighbor, professionally, an O. S. brother was called to see a young man æt. 20, across the street from my office, a week ago. I don't know what he found, he said appendicitis, counsel was called and the case operated upon. He died next day.

The same week I was called to see a man æt. 50 whom I had often previously attended; found him very much alarmed, said he had had a chill and was now suffering from pain over the abdomen, particularly in right side. Temperature 102°, no vomiting. He was sure he had the dread disease that he had heard so much about and wanted an operation.

I said all right, if he was no better or was worse by the following day. He was slightly better next day, was sick ten days and made a good recovery.

I think the plan outlined by Dr. Shears a good one. I think the conscientious, close observing physician may generally know when his patient passes from the medical to the surgical field in this disease. I do not believe all cases of appendicitis can be cured by medicines alone. I do not believe all cases require surgical interference.

Dr. ARNULPHY: After the exhaustive papers presented by Dr. Smith and Dr. Chislett, and the full discussion that has followed, there is but very little for me to say. The best points have been made; the juicy pulp of the evening is gone, leaving only the pits and stones for the belated speakers. *Farde venientibus ossa.*

Being no surgeon, I can only speak as a physician, and let me tell you, ladies and gentlemen, that when a physician approaches this subject of appendicitis, it behooves him to do so with a penitent heart and a modest spirit. I admire the youthful energy with which the medical aspect of the knotty question has been brought before us, sup-

ported as it appears to be by such encouraging statistics, but I do not feel that my diffidence toward that most treacherous affection is perceptibly allayed. Somehow it seems to me, as the French say, that "*la mariée est trop belle.*" the bride is too beautiful. The pitfall is near the bait. Let us beware.

The proper thing for a physician to do when confronted by a case of appendicitis, is to call in a surgeon; and while I would be inclined to temperize and follow a conservative course, still I would never stand in the surgeon's way, if he thought the time had come for intervention. The least the physician can do in such cases is to give the surgeon a chance, thus paying in a small way a great debt of gratitude. For what the physician knew about the true nature of the disease, and what his resources were in serious cases before the surgeon took hold of the question, amounts to practically nothing.

These remarks while applying to all cases of appendicitis, apply with still greater force to the recurrent cases. Here it becomes the bounden duty of the physician, when he has been successful enough to tide the patient over the attack, to strongly urge upon him the necessity for an early operation, so as to remove once for all the abiding danger of another abrupt attack under more unfavorable circumstances.

I will briefly cite a case in point. Last fall I had to attend a case of appendicitis in a boy of fourteen. It was the second attack, as I could make out that eight months before the boy had suffered with an acute seizure of abdominal pain, which the attending physician, in Boston, had called rheumatic peritonitis. The second attack, as is almost always the case, was more severe than the first. I called in Prof. Shears, who according to his wise, conservative method, advised to wait, and it was thought best to do so especially as the patient was with his grandparents, who did not wish to take the responsibility of having it done at once. The boy slowly recovered, the disease following a tedious course, enlivened, however, by two un-

usual episodes, viz: one attack of nephritic colic with hematuria, from calculi of calcic oxalate, followed about one week afterward by a seizure of hepatic colic. I hardly need say after this that the boy comes from a profoundly arthritic family.

When I sent the boy back to his parents, in Boston, it was with written instructions, setting forth the necessity for surgical intervention at an early date, in the interval, before a third and more dangerous attack should occur.

The parents have been wise enough to act accordingly, and I have here a letter from Dr. N. W. Emerson, of Boston, relating the operation with full details. The appendix was found seriously and extensively diseased, in a state of sub-acute inflammation, imbedded in a mass of adhesions; moreover, the appendix presented a point of incipient necrosis, promising perforation at an early date. Commenting on the subject, Dr. Emerson writes as follows: "Your judgment that an operation would be better undertaken at a time when the acute symptoms were in subordination, was a most wise one, and I am sure the operation would have been much more difficult at another time. I have never undertaken a serious operation of election where the pathological results were more satisfactory and the indications more imperative than they were in this case.

"On this occasion I want to thank you personally for the clearness and emphasis of your opinion as to the need of an operation. What you wrote was so direct that it fortified my own opinion in my own mind, and I congratulate you that the result is so in accordance with your advice."

The operation was very successful and the boy is now perfectly well.

This case seems to me to illustrate the role of the physician toward the patient and the surgeon. Watch and wait. Tide the patient over the attack when possible. Advise the operation at an early date, when all the circumstances are favorable.

I wonder what the practice of some of our high potency

friends is in that respect? Considering their sublime indifference toward diagnosis, we might reasonably infer that their statistics are eminently favorable, and that they never lose a case.

If all the good people now rotting under the sod, and who have died of appendicitis for want of recognition and timely treatment, when they had no business to die at all, were allowed to tell their tale of woe, every cemetery in the land would become a forum where posthumous eloquence might be profitably cultivated.

DR. R. LUDLAM reminded the Society that this was its seventeenth annual meeting, and said that the practical character of Dr. Smith's paper, as well as of the discussion that had followed, attested the fact that the original design and purpose of the organization had not been abandoned. For with Dr. Chislett's essay also, and with all that had followed the reading of all three reports, the aim had been to properly balance the claims of these two kinds of resource in the treatment of appendicitis. It is true that for hundreds of years physicians stumbled over these cases, failing to learn what they were, and how to cure many of them; and that in our day some of the very worst of them are amenable to surgical measures. Dr. Shears is quite right when he claims that what we now know of their morbid anatomy and of their dreadful trend in many cases toward ulceration and perforation has come of surgical exploits and experience. But who taught the surgeons that with a careful aseptic technique this form of peritoneal surgery, or any other, is possible and expedient? The surgical craft is as old as the medical, but until the gynæcologist had literally opened the way for this kind of work, and surrounded it with the modern safeguards, the surgeons were quite as helpless as the doctors whenever they had to do with a bad case of appendicitis.

A parallel might be drawn between appendicitis and salpingitis. In both there is tubal colic, and in both the inflammation may be catarrhal or purulent with a resulting abscess and secondary peritonitis. Both are accompanied

by exudates; both are relapsing in character; and both bring up this everlasting question of the possibility of cure by medicine without surgery, or by surgery without medicine. Both are of frequent occurrence; but while one is comparatively rare with women, the other is confined to them exclusively. Doubtless in many cases both these affections have been overlooked and have recovered spontaneously, while others have died because they were not properly and radically treated; but in the case of salpingitis there are added sources of mischief that do not exist with a majority of those who have had, or who may have appendicitis. The generative intestine in women is not only liable to such specific inflammation as never reaches the vermiform appendix in man, but it is almost certain to be the seat of menstrual and puerperal congestion and inflammation with such tedious consequences and sequelæ as are never met with in appendicitis.

Naturally enough these clinical considerations should have their weight in treating such cases. The tentative measures that have been advised are always best, if too much time has not been lost already, and if the case was not desperate from the first. This applies to appendicitis as well as to salpingitis. But when it comes to surgery the odds are greatly in favor of operating in appendicitis because the organ being visible is much more easily found and removed, or, if it cannot be taken, excision may be substituted by drainage with almost equally good results. It is a minor operation compared with taking adherent and suppurating uterine appendages from below the superior strait, when it must be done in the dark, and when artificial drainage without removal of the diseased organ or organs is even worse than no operation.

VOLUNTEER PAPERS. IX.—TUBERCULIN AND TUBERCULOSIS. By Dr. B. S. ARNULPHY.—In May, 1892, I read before the Illinois Homœopathic Medical Association, a paper on "The Proper use of Tuberculin in the Treatment of Phthisis Pulmōnalis," which subsequently appeared in the October issue (1892) of the *Medical Era*.

My plea was that Koch's lymph, or tuberculin, exhibited wonderful remedial action in the treatment of some forms of acute tuberculosis, and in support thereof I cited three striking cases in which recovery had been effected by tuberculin alone.

One of those cases I saw in consultation, and one was treated at the Hahnemann Hospital (No. 19,563), and was seen and examined by scores of students during the winter of 1891-92. The third case was in my private practice.

Since then I have observed two cases, one of which ended fatally, the other one recovering. The first case was a typical instance of acute disseminated pneumonic phthisis, in a girl eighteen years old. It was one of those cases in which the appearance of the patient is very deceptive, owing to the animated expression of the face, the brightness of the eye, and the alacrity of the mind. When I was called in, numerous centres of crepitation, softening and excavation existed in both lungs, and nothing could be done, save a temporary abatement in the intensity of the fever, cough and dyspnœa. The attack ran a rapid course, and two weeks later, the girl succumbed.

The second case began with slight hemoptysis. The subject was a young woman, twenty-two years old, tall and thin, whose health had always been delicate. She had been delivered of a child four months prior to my first call, and had tried to suckle the little one, but it lived only a few weeks. I learned that the patient's mother had died of a suspicious lung affection about one year before.

Examination showed slight dullness at the left apex, with a few sibilant râles on forced expiration; a faint to and fro crumpling sound was also perceptible over that summit, both in front and behind, evidently due to localized specific pleurisy. Over the remainder of the left lung the breathing was indistinct, reticent so to speak, jerky and wavy. The right lung revealed nothing abnormal. With the exception of a slight cough, the patient was feeling about as usual, the hemoptysis having promptly disappeared.

Two weeks later, December 3, 1893, I was called in again and found the scene considerably altered for the worse. The fever was high (104°), the dyspnœa intense, the cough dry and frequent, the face pale and anxious. On examination the left lung exhibited a few patches of small

bubbling râles disseminated over the posterior aspect, and the axillary region; the vesicular murmur more indistinct than ever; the percussion sound hardly modified, except at the apex, where the dullness is more pronounced than a fortnight ago. Over the right lung, marked puerile breathing, but no adventitious sounds.

Now, while the stethoscopic signs, at that particular moment, tallied pretty accurately with those of acute congestion of the lung, still from the height of the fever, the tubercular lesion of the summit, and the general physiognomy of the case, I felt authorized to conclude that I had to deal with an acute tubercular outbreak. The patient was put upon tuberculin 8 x one grain every hour.

In the course of the three following days the temperature, cough and dyspnoea slowly but steadily abated; during the night there had been profuse perspiration, and then diarrhoea set in, which lasted for a few days. Little change upon auscultation, save that near the angle of the scapula I could perceive some well limited but distant bronchial breathing, mainly expiratory. The moist bubbling had almost entirely disappeared, and at some places was replaced by dry sibilant râles.

On December 10 the general condition of the patient was very much improved; (temperature, $100\frac{2}{3}^{\circ}$ at 2 P. M., pulse 92, dicrotic, but not particularly weak; respiration 24).

December 11. Chill in the morning; temperature 102° , falling to $99\frac{1}{3}^{\circ}$ in the afternoon; December 12, chill again in the early morning, temperature 102° ; at 9 A. M., after a prolonged fit of coughing, the patient raises a large mouthful of purulent sputum, streaked with blood, then feels easier. At 4 P. M., temperature $100\frac{2}{3}^{\circ}$, night good, no perspiration. Microscopic examination of the purulent sputum reveals the presence of numerous bacilli.

December 13. Muco-purulent expectoration, patient feels better, appetite returns. Diet: milk, bovine, phospho-albumen. Temperature 99° ; respiration 22, pulse 87. Auscultation reveals a better type of respiratory murmur over the left lung. There never had been any particular change about the stethoscopic sounds over the affected apex. I made a critical examination of that region, expecting to find some signs indicating the presence of a cavity, which would explain the sudden appearance of that purulent sputum, as certainly some part of the lung parenchyma must have broken down; but no trace of

a cavity could I find at the apex, not the slightest aphonic pectoriloquy.

The inference must be that a limited focus of tubercular pneumonia had formed in some deep-seated portion of the lung, very likely on the level of the angle of the scapula, where the distant bronchial breathing was heard. I fail to see how we could otherwise explain the abrupt advent of the threatening symptoms, the rapid evolution of the whole process, and the chills which preceded the purulent expectoration.

We know how serious is the prognosis of pneumonia when it fastens on tissue already tainted with tubercle, especially when the acute onslaught is heralded by such a flourish of trumpets as we had in the present case, which in clinical language meant rapid generalization of the infection from the secondary pneumonic focus, spreading to the neighboring lung tissue, probably to the whole lung.

It is, therefore, of considerable interest to know that this patient recovered entirely and rapidly from the effects of the seizure above described. From December 13 she steadily improved. She has now resumed her former occupation, and auscultation only reveals some slight prolonged expiration at the left apex, the general health being better than before the attack.

Only one remedy was given throughout, and that was tuberculin. The mode of administration was as follows: as long as the acute symptoms were present, tuberculin 8x one grain tablet every hour; when amelioration set in, one grain tablet of tuberculin 6x every two hours. Later on, the same dose, three times a day, until quite recently.

Physicians who have had to contend with similar cases, and are aware of their exceptional gravity, will surely appreciate the nature of the service rendered in the present instance by the above remedy. So far as my experience goes, and cases like the one here cited are not of frequent occurrence, it must be remembered, I have nothing to retract from the statements I made in the paper referred to at the beginning of this communication. Once more I assert "that the proper field for the activity of tuberculin is acute tuberculosis, precisely those cases which Koch and his followers persistently, and from their standpoint, consistently refused to treat with the lymph, on account of the reaction that they dreaded."

It is something to know that in dealing with a class of cases generally considered quite hopeless, we have within

easy reach one agent which promises to yield an encouraging measure of success. This is not all, however. Within the last six months I have repeatedly tried tuberculin in cases of incipient phthisis, and I am glad to say with more success than I expected to meet with. I have quite a number of cases under treatment, both in my hospital and private practice, who are doing remarkably well under that treatment. The more interesting among them will be fully reported later on. One of those cases I saw in consultation with Dr. Snow, and is particularly gratifying, as it was assuming a threatening aspect.

The final test in medicine must always be the clinical test. So that the true value of this agent can only be determined by further and more extensive experiment. Only let the experiments be conscientious and the cases carefully selected and diagnosticated. From a doctrinal point of view there can be no objection to the use of tuberculin by homœopathic practitioners. Some might be inclined to consider this particular application as a bit of isopathic practice. I would refer them, as well as those who have any scruples in the matter, or who delight in knotty points of theoretical contention, to the inaugural address read before the World's Congress of Homœopathy, held in this city in May last, by Dr. Chas. Gatchell, chairman of the bureau of clinical medicine.* I can only thank the author of that remarkable paper for so warmly commending my position, and for his forcible demonstration of the true homœopathic relation of tuberculin to tuberculosis.

Having received a large number of letters enquiring as to the nature of the tuberculin that I used, and where it was to be found, I would say that it is simply Koch's lymph, and there is no mystery about it. I got a small quantity of the preparation direct from Koch's laboratory and handed it to Halsey Bros., instructing them to run it up in trituration to the 6, 8 and 12 decimal. I superintended the operation myself and I can vouch for the preparation offered by this well-known firm. I prefer the tablet form because I know from experience that it keeps better than the trituration.

In order to differentiate that particular preparation from Burnett's tuberculinum and kindred articles, Halsey Bros. have labeled it "Arnulphy's Tuberculin."

*"Recent discoveries in the treatment of disease by the use of disease products and their relation to homœopathy." In the *Medical Century*, July, 1893.

I make it a point, as a rule, to give tuberculin alone, but other remedies may be given inter currently, as the indication will arise. My favorite potency is the 8x, but it may be found necessary to resort to the 12x, when a slight aggravation is observed. It very seldom happens that the cough is aggravated; in fact it will be found that it is the first symptom to show the signs of improvement; but the temperature is liable to be slightly increased at times, after taking the 8x, in which case the 12x is preferable. •

Hospital Notes.

THE EYE AND EAR CLINIC.

SERVICE OF PROF. WATRY.

INTERSTITIAL KERATITIS FOLLOWING INJURY.—December 12, 1893. *Case 15,481.* A boy three and one-half years old, while playing with a garter two days ago, accidentally snapped the end of the rubber into the right eye. Although the boy did not complain of pain, the eye watered some ever since, and the mother thinks that the eye has been growing weaker. The only complaint the boy makes is that the light hurts the eyes.

Present State: Photophobia, little lachrymation, circumscribed corneal congestion, haziness of the center of the cornea, a spot about twice the size of the pupil.

Remarks: From the history of the case we would naturally suspect a corneal ulcer or a mild form of suppurative keratitis. On close inspection you will observe, however, that there is no abrasion or breaking down of the superficial layers of the cornea. The cornea has a peculiar misty appearance, which is very difficult to describe. It looks very much like a piece of glass which has been breathed upon, in addition the epithelial surface of the cornea looks as though it had been pricked all over with a pin. This peculiar aspect of the eye, with the other symptoms, places the disease under the head of interstitial keratitis. Making a further examination of the boy, we find that there is an inherited syphilitic cachexia.

The large head, the peculiar shaped forehead, the unusual curve of the lips, and last but not least the somewhat dwarfed teeth, with wide interspaces and the edges a little notched, are sufficient indications of a syphilitic dyscrasia, without asking the mother any questions. The prognosis is favorable. From all present indications the disease will run under the non-inflammatory type. The reason for this statement is that the opacity started in the center of the cornea and no blood vessels have as yet formed in the corneal substance. As this disease usually runs a course of two to six months under the best of care, it is best to inform the mother about it, or else she will soon seek

treatment somewhere else, thinking that the boy is not doing as well as he ought to. It is also well to tell the mother that the same disease is liable to affect the other eye. As the light is quite annoying, it is very necessary to have the boy wear colored glasses. He is to take merc. jod. 3x four times a day, and to have a one-half per cent solution of sulphate of atropia dropped into the eye three times a day.

December 28. Congestion less; photophobia not as marked; pupils dilated. Same treatment, merc. jod. three times a day.

January 16, 1894. The eye is doing nicely; the cornea less hazy. Atropia sul. once a day; merc. jod. twice a day.

January 30. The mother noticed that the last few days the left eye began to look weak and somewhat red. Under strong illumination the cornea shows a very faint haziness. The eye looks as though the same disease was coming on. We prescribe the same treatment for both eyes and wait for further developments.

February 6. The right eye looks stronger; can bear the light without weeping. The left eye now is quite hazy and the cornea shows a finely molecular appearance along the centre of the lower, inner quadrant. Atropia once a day in the right eye, three times a day in the left. Merc. jod. three times.

February 15. The eyes are gradually improving. Continued the same treatment.

CONJUNCTIVITIS, COLOBOMA OF THE IRIS. — February 8, 1894. *Case 15,565.* A young man of light complexion, twenty-three years old, began to have a great deal of trouble with the eyes over a year ago. At times the eyes smart and burn very much. The light is quite annoying, and sometimes the eyes feel sandy. A little secretion in the corner of the eye after waking.

Present state: The test indicates normal eyesight. There is no noticeable congestion of the eyeball, but the eyes have a weak look about them, as though they might be surrounded by too much moisture. The pupil, instead of being round, is of a keyhole shape.

Remarks: The peculiar formation of the pupil is due to a congenital defect of a portion of the iris which, in a general way, resembles an artificial pupil made by an iridectomy. The defect is usually found, as in this patient, to be unilateral, and the fissure runs downward and inward.

When it extends to the corneal scleral margin as we see it here, it is called a complete coloboma. Nothing can be done for the deformity, and if not too large a fissure exists, the patient experiences no inconvenience from it. We will, therefore, turn our attention to the above mentioned symptoms, which are brought about through an inflamed condition of the palpebral conjunctiva. The inflammation brings on the smarting and burning. The swelling and secretion of the conjunctiva make the eyes feel sandy.

Treatment: One-half per cent solution of argentum nit. Two drops of this in each eye at night, and one drop in each eye in the morning.

February 15. Eyes feel stronger to the light, less smarting and burning. Same treatment.

February 22. No secretion mornings. Light does not annoy unless it is very bright. Conjunctiva looks almost normal. Drops once a day.

March 1. Eyes feel all right.

Treatment: Zinc sulphate grains, two, to one ounce of water, two drops every other night, and report once more in two weeks.

CHRONIC CONJUNCTIVITIS AND PHLYCTENULAR KERATITIS.
—July 19, 1892. *Case 14,730.* A girl eight years old began to have sore eyes at the age of five. The mother never took the child to an oculist because the trouble never was very severe; child takes cold easy; eyes grow weak every time she takes a cold. A week ago the girl took a very severe cold and the eyes became inflamed as usual. Instead of clearing and growing stronger as they used to the eyes have grown weaker and look different to the mother than they ever have. The lids are agglutinated every morning, and eyes water very profusely when exposed to the light. The mother thinks there is something growing on the eyes.

Present state: Ocular and palpebral conjunctiva very much inflamed. On the cornea of both eyes, near the scleral margin, are several minute infiltrations with a number of blood vessels running toward them in a triangular manner, the apex of the triangle touching the infiltration.

Remarks: This little patient is afflicted with a complication of diseases. There is hardly any doubt that if the girl had received treatment several years ago, for the repeated attacks of weakness of which the mother spoke, that the conjunctivitis would never have been complicated

with the phlyctenular inflammation of the cornea. Scrofulous signs such as you observe in this case are usually present; swollen lymphatic glands under the jaw, small neck, a pale and nervous look. The skin is often coarse and flabby, with the sabaceous follicles of the face much developed. In some cases the disease is coincident with conjunctivitis, and in others with deafness. It seldom attacks infants at the breast; from the time of weaning till about ten to twelve years of age is the period of life during which it is most prevalent. The disease is most always attended by intolerance of light, by spasm of the orbicularis, pain and profuse lachrymation. It is characterized by vesicles on the cornea. Lashes of blood vessels generally shoot from the conjunctiva toward the vesicles. As soon as these burst, from the overlying epithelium becoming detached, they pass into open ulcers, as you see them in this case, which may either heal or may penetrate deeply into the substance of the cornea. The fact that the patient has had conjunctivitis for three years with acute exacerbations, is most probably one of the chief causes of the child's irritability and nervous condition, does not call for immediate treatment. The astringents which are indicated in conjunctivitis might be the ruination of the eyes; for when the cornea is diseased they hasten the breaking down of its tissue. Our patient under such treatment would gradually grow worse and the treatment might be the cause of permanently injuring the vision or cause even entire loss of sight. The best way to proceed in this case is first of all to look to the cornea and let the conjunctivitis take care of itself. Our object must be to reduce as soon as possible the corneal inflammation, which is best done by local treatment. At the same time we must bear in mind that it is the manifestation of a scrofulous constitution.

For the local treatment we prescribe atropia sul. to be dropped into both eyes three times a day. Bichloride of mercury one part to 5,000 locally three times a day.

Internally, calc. carb. 3x three times a day.

July 26. All the improvement the mother noticed is that the lids are not stuck together so much mornings; pupils largely dilated; photophobia some less; atropine once a day, the other treatment the same.

August 4. Eyes are a great deal stronger; appetite improving; patient looks healthier; epithelial surface of the cornea healed; minute cloudy opacities at the seat of the infiltrations; blood vessels on the cornea are disap-

pearing; discontinued atropine and bichloride; prescribed yellow oxide of mercury ointment; locally, calc. carb. 3x once a day.

August 25. Opacities disappearing; eyeballs are looking quite clear; same treatment.

October 13. Discharged the patient with the advice to keep on using the ointment occasionally for some time and to report as soon as the eyes should begin to show symptoms of weakness.

The patient did not return until February 15, 1894. The eyes have been quite well until a few weeks ago, they began to smart and burn, and there has been secretion mornings; prescribed a mild solution of sulphate of zinc to be applied twice a day. Under the treatment the eyes improved and at present are almost cured.

SECONDARY GLAUCOMA, CAUSED BY SEROUS IRITIS.—February 15, 1894. *Case 15,573.* The girl patient only two and a half years old. Five weeks ago she began to have whooping cough; two weeks ago last Monday the girl had a spasm. About the same time the mother noticed that the right eye began to look red. The inflammation grew worse. About nine days ago the entire pupil was covered with a white scum. Mother had used an eyesalve and eyewater given her for one of the children, who had a cold in the eyes.

Present state: The eye is annoyed by the light, but does not water much. The iris looks different in color than that of the other eye. Anterior chamber shallow. The pupil is contracted and the pupillary space looks yellowish white. Tension of the eye somewhat increased.

Remarks: It is impossible to make a complete diagnosis of the eye to-day. It is easy enough to see that there has been a severe form of serous iritis from the amount of exudation that covered the pupil and the discoloration of the iris. The difficulty is to state if the opacity in the pupillary space is all exudation or if we have a cataractous lens. From the peculiar yellowish white appearance we assume that it is due to exudation which settled over the capsule of the lens. We will put the patient under the treatment for iritis and possibly the next time we see the patient, we will be able to settle the point. Prescribed atropine, bandage, merc. sol.

February 20. Opacity in the pupillary space has nearly disappeared. The atropia has had no effect upon the pupil. Anterior chamber is very shallow, the iris is resting almost against the cornea. Tension + 2.

From the fact that the opacity has almost entirely disappeared, we are convinced that the supposition of last week is correct. That the exudation settled on the lens, and is now absorbing. The question now arises, why did the pupil not enlarge under the use of atropia as it ought to, and how is it that the eyeball is hard. The answer is easy when we consider the pathological changes that have taken place as a direct result from iritis. That the inflammation of the iris was very severe is embodied in the mother's statement when she said, "the eye looked as though a white scum had grown over it."

The white scum was exudation which filled almost the entire chamber of the eye. This crowded the inflamed iris against the lens, and the margin of the iris adhered to its capsule, so that now we have exclusion of the pupil from complete posterior synechia. This caused an obliteration between the anterior and the posterior chamber, and a disturbed condition of the intraocular circulation and tension, so that now we have a confirmed state of glaucoma. Such an eye is a dangerous one. It usually grows harder and larger until it bulges out between the lids. Oftentimes there is danger, through sympathy, to the fellow eye. We should never lose time in similar cases by treating the patient locally and internally; but we should at once attempt to reestablish the communication between the anterior and posterior chamber by performing iridectomy. Such an operation will reduce the eye tension, remove all danger to the other eye, and make the eye a harmless one. If the mother brings the child the day after to-morrow, we will perform the operation. Pres. Eserine sulphate to be dropped in the eye three times a day.

February 22. Patient did not return.

PARALYSIS OF THE RECTUS EXTERNUS OCULI SINISTRI.—
May 23, 1893. *Case 15,203.* A woman thirty-five years old, began to have severe headache, mostly on the left side, over three months ago. About the same time she began to see double. The eyes looked red and watered; lids on the left side were swollen for several days. Feels very dizzy when both eyes are open. She attributes the whole trouble to a cold she took.

Present state: Some photophobia, lachrymation when exposed to strong light. Ocular and palpebral conjunctiva somewhat inflamed. Vision of either eye normal.

Asking the patient to fix an object, the axis of the right eye corresponds with the object, while the axis of the other eye is off toward the nasal side, giving the woman the appearance as though she had convergent strabismus.

Remarks: The only question that can arise in regard to the position of the eye in this case is: whether it is strabismus or paralysis. The differentiation is easily made. When we cover the right eye and ask the patient to let her left eye follow an object moved from side to side, if it is strabismus the eye follows in all the different directions; if paralysis the movement is defective toward the side on which we have paralysis. You will notice no matter how much the patient tries she cannot move the eye outward.

You will also observe that if a pencil is held at a distance of five feet, and ask the patient to look at it with both eyes, that she sees two instead of one. When the pencil is moved toward her left, the two images separate in proportion as it is moved to the extreme left. When it is moved to the extreme right, the double images disappear. This is the usual sequence of the disturbance of the normal physiological coördination. The dizziness is caused by the confusion of images; to prevent this the patient keeps the left eye closed.

In giving the prognosis and in treating the patient, the most important point is to determine whether the cause is cerebral; perhaps arterial or venous congestion; sanguineous or serous effusion, or some tumor found within the cranium, and pressing on the nerve which supplies the muscle affected, or whether it is peripheral and arising merely from a cold. In the incipient stage of the trouble it is often impossible to tell, but when the trouble has been going on for over three months as in this case, we can usually tell with certainty from the general symptoms in the case. The fact that the symptoms are no worse than a month ago, and that the sight is perfect on both sides, and that the paralysis is confined to the rectus externus only, assures us that the trouble is only a temporary one, and possibly brought on from being in a draught. Inquiring into the general symptoms of the case we find that bryonia is indicated, hence we give 3x every two hours, and have the patient wear colored glasses, the left lens covered so as to use only the right eye.

June 1. Patient reports that the last few days the double images are not so far apart; the headache is very severe, but almost entirely in the back part of the head. Gels. 3x.

June 6. Right eye feels all right ; there is a great deal of burning in the left eye ; there seems to be some hyperæmia of the iris ; atropine locally. Bell. 3x internally.

June 13. Left eye slightly congested ; pupil dilated ; iris looks normal ; agglutination of the lids in the morning. Replaced atropine, with zinc sulphate once a day.

June 27. The eye feels much better ; no headache for the last few days. Tannic acid locally. Bell. 3x twice a day.

July 11. No headache ; no double sight, but everything appears still blurred, especially when she looks toward the left. The eye moves almost the entire distance toward the temple. Tannic acid once a day. Gels. 3x once a day.

July 20. Eyes feel all right ; can see as clear as ever.

February 15, 1894. Patient reports that the eyes have been feeling perfectly easy until three weeks ago ; they began to smart and burn, feel sandy, and has a great deal of headache. Mobility of the eyes is normal. Swelling of the caruncle and the semi-lunar fold. Prescribed a mild solution of sulphate of zinc to be used twice a day, and advised her to wear colored glasses.

March 1. Eyes feel a great deal stronger ; has very little headache. Continued the astringent once a day.

CHRONIC SUPPURATIVE INFLAMMATION OF BOTH MIDDLE EARS. FURUNCLE IN THE LEFT.—February 8, 1894. *Case 15,549.* Man thirty-two years old has been having a discharge from both ears for over nine years. Eleven years ago, during a runaway he was thrown from the wagon and landed on his head. The fall was so severe that it rendered him unconscious for several days. He thinks that the ear trouble must be due to the accident because, shortly after noises came on in both ears. He has had difficulty of breathing through the nose as long as he can remember. Of late years he has become almost an entire mouth breather. Takes cold very easily.

Present state: Thick, yellowish white discharge from both ears ; almost total destruction of both drumheads ; can hear the watch on the right side only when it is placed in contact with the ear ; on the left side at one-half an inch.

Remarks : No doubt you have observed that one very prominent symptom which is most always present when a suppurative discharge from the ear takes place, is denied

by the patient, and that is *pain*. Although the patient claims that the hearing was not impaired before the injury, we are not to attach too much importance to his statement, because the hearing may be impaired in one ear and not be noticed by a careless observer. It does not seem plausible that the injury had anything to do with the condition the ears are in. The man told us distinctly that before the discharge came on there was a feeling of fullness in both ears for several days, but no pain. That statement means a great deal when we connect it with the condition of the nose, which is filled with adenoid vegetations, and thickened turbinated bones. It seems almost probable that the catarrhal condition of the posterior nares and the throat extended gradually to the middle ear. This chronic catarrhal condition caused the drumheads to soften. A subsequent acute inflammation brought on closure of the eustachian tube and secretion in the tympanic cavities. The drumheads, not having enough resisting power, gave way very easily to the pressure of the fluid, and the patient was spared the pain which usually accompanies a perforation of the drum membrane. The prognosis is rather unfavorable, because the changes which have taken place in the tympanic cavities are such that the parts can never be restored to the normal. What we can do is to stop the discharge, improve the hearing some and restore the breathing through the nose. We have to cleanse the ears thoroughly by syringing and insufflate boric acid powder. The patient is to keep his ears as clean as possible by syringing and by using peroxide of hydrogen several times a day. We give him merc. sol. three times a day.

February 15. Discharge about the same, the last few days there has been a great deal of throbbing and a burning pain in the right ear. The ear has been feeling full and the noises are very marked. Inspection shows a circumscribed inflammation along the lower wall of the external auditory canal, which points and looks as though it was ready to break. He has had a number of boils about the neck. Incised the furuncle, cleansed the ear. Prescribed yellow oxide of mercury ointment to be applied on cotton to the canal. Same treatment as before.

February 27. No pain; ear feels very comfortable. No discharge from the left ear; right ear is still discharging. Thinks he is beginning to hear better.

March 1. Very little discharge from the right ear; thinks the hearing is quite a little better. Testing the

hearing with the watch, he can hear it at ten inches with the right ear, and six inches with the left. Same treatment as when he first came.

CHRONIC CATARRHAL NON-SUPPURATIVE INFLAMMATION OF BOTH MIDDLE EARS.—February 20, 1894. *Case 15,583.* Patient is a woman thirty-two years old. Four years ago she noticed that whenever she took a cold the ears would feel uncomfortable for a few days. Three months ago, after taking a cold, she began to have noises in both ears. The hearing has been quite impaired since. Occasionally there is a shooting pain through the ears. Pain is usually worse outdoors. Ears are quite sensitive to the cold air.

Present state: Drumheads somewhat opaque, but not perforated. The tuning fork is heard a great deal clearer through the bone than through the air. Placing the tuning fork on the median line of the head, it is heard best on the left side. Patient can hear the watch at twenty inches with the right ear, and at ten with the left. Using Politzer's method of inflation the air rushes to the tympanic cavity without any trouble. There is an improvement of ten inches on each side after inflation.

Remarks: The fact that the disease has not been existing very long and that the hearing has improved very decidedly after improvement, is sufficient assurance that the disease is not going to be very obstinate. If the patient can keep from taking cold, the hearing can, no doubt, be brought back to almost normal. Treatment, inflation, hepar sul. 30x.

February 22. Hearing has been a great deal better. Has had no pain to speak of. Same treatment.

February 27. Took a very severe cold a few days ago, in consequence she has had considerable pain, and the hearing is a great deal worse, but no worse than when she first came. Treatment, inflation, bell. 3x.

March 1. Cold a great deal better. Hearing is also some better.

After inflation the watch could be heard at thirty-six inches on the right side and at thirty on the left. Hep. sul. 30x.

Clinical Reviews.

AN AMERICAN TEXT-BOOK OF GYNÆCOLOGY, MEDICAL AND SURGICAL, for practitioners and students. By Henry T. Byford, M. D.; J. M. Baldy, M. D.; Edwin B. Cragin, M. D.; J. H. Etheridge, M. D.; William Goodell, M. D.; Howard Kelley, M. D.; Florian Krug, M. D.; E. E. Montgomery, M. D.; William R. Pryor, M. D.; George M. Tuttle, M. D. Edited by J. M. Baldy, M. D., with 360 illustrations in text, and thirty-seven colored and half tone plates. Philadelphia: W. B. Saunders, 925 Walnut Street; 1894; pp. 713.

When the farmer is about to winnow his grain the first step is to get it into a heap upon the floor. The gynæcic grains, as our learned neighbor of the *Homœopathic Journal of Obstetrics*, etc., calls them, have hitherto been scattered and mixed with an immense amount of chaff. The plan of this work is to gather and sift them so that the reader, whether a specialist or not, may not have to go afield for what he wants and needs in the line of gynæcology, medical or surgical. And the idea is a good one, especially when the work can be done as it has been in this case, by responsible parties who are not writing and publishing for the sake of getting into notice, but because, on the basis of experience, they know "vich is vich", as Sam Weller had it, and cannot afford to endorse what is sensational and spurious.

The fact, too, that even with such a good editorial backing, the text is impersonal, gives it an added value in these times when the tendency among authors might be said to be too voluminous. If for certain subjects and resources that are considered and advised there would sometimes be an added emphasis were the author's name attached, we can forgive the lack of it in the compensation that comes of cutting off the personal bias which might otherwise have led us astray, or disappointed us altogether.

A prominent politician has recently spoken of the difference between theory and practice in party matters, and it is possible that his definition may also apply to matters medical and surgical. "Theory," said he, in a famous speech, "is all that I can think of, while practice is all that

you can do." What the reader is to do under given circumstances and conditions which are clearly stated is set forth in no equivocal terms. It would be too much to expect that the personal equation should be perfect, or should always please or satisfy, but in most cases it certainly approximates it very closely.

The faults inherent and unavoidable in former works have in this new candidate for professional favor been largely overcome, and we believe that this work will be correspondingly useful to physicians in both schools of practice. The plates, excepting the colored insets, are many of them new and most of them very appropriate and satisfactory. Especially is this true of the half-tones which illustrate many subjects that until now have not been seen outside the operating room.

OPERATIVE SURGERY. By T. H. KOCHER, M. D., Professor at the University and Director of the Surgical Clinic at the Berne University, N. Y. Wm. Wood & Co., 1894.

The work opens with an excellent article on the treatment of wounds, the preparation of dressings, and the selection of the direction of incisions. Indeed this latter subject is the real basis of the work, and it is in the elaboration of this that the chief interest of the work lies. The author says: "Langer's investigations into the directions into which the skin splits show that the tension of the skin varies greatly in two different directions. Two incisions vertical to each other, exhibit a varying retraction of the wound margins; while one gaps widely, the edges of the other remain in contact even without artificial means. For years we have noted our incisions which were not united by sutures in a schematic diagram, according as to whether they appeared open or closed when the dressings were changed. For this purpose we made use of the drainage openings, made close to the sutured cutaneous wounds. If the drainage tubes are removed after twenty-four hours, and the sutures of the main wound in forty-eight hours, we are enabled to become posted as to the condition of cutaneous wounds not closed by sutures. This having been ascertained, we gradually came to prefer the direction of the cleavage line, also for the longer incisions, and have convinced ourselves that the difference in cicatrization after incisions with or against the cleavage lines is so important that it behooves us to indicate normal incisions for

every region of the body. These show for that particular region the cleavage lines of the skin, and at the same time are so placed as to avoid the course of the superficial nerves and vessels. We have convinced ourselves in the course of our frequent operations for struma that the cicatrices after such normal incisions become so faint in the course of time that they are hard to recognize, while cicatrices after incisions in different directions, especially on the neck, may often cause great deformity by contractions and folds. Diagrams are given showing what may be called normal incisions. The succeeding chapters take up the skull, the face, the triangles of the neck, the thorax, the spinal column, the lumbar region, abdomen, perineum, sacral regions and extremities, giving the anatomy and the normal incisions, and classifying operations around about the incisions rather than taking set morbid conditions and describing operations for each. The book is in this respect unique, and while it cannot fill the same place as is filled by Jacobson, Treves, Smith and others, it will prove of service to the surgeon desiring to post himself rapidly as regards the best line of incision and the anatomical difficulties to be met in certain regions.

G. F. S.

A PRACTICAL TREATISE ON MATERIA MEDICA AND THERAPEUTICS, WITH ESPECIAL REFERENCE TO CLINICAL APPLICATION OF DRUGS. By JOHN V. SHOEMAKER, A. M. M. D., etc., etc., etc. Second Edition. Thoroughly revised. In two volumes. Volume II., Philadelphia and London; The F. A. Davis Co., Publishers, 1893; 8vo. pp. 1046.

Between the inordinate habit of resorting to proprietary medicines and the growing propensity to dabble with and to depend exclusively upon surgery, or some form of manual treatment, the study of materia medica and special therapeutics has fallen into comparative disrepute. That this unfortunate neglect will sooner or later be remedied by a sensible and natural reaction we cannot doubt, for it is not in the nature of things that it should continue indefinitely. Moreover, it is extremely doubtful if in the whole range of the studies that are collateral to medicine there is any other which is so intrinsically interesting and important as this. Nor should it discourage those who would pursue it with the proper spirit and enthusiasm that so many active workers have been enticed into other fields where they have become more or less famous as teachers, authors and practitioners.

In the light of this fad, for it is a fad to limit one's range of resources to any single variety of treatment, we should welcome such publications as this, the purpose of which is briefly to put forth the best old school indications for the use of remedies at the bedside. Those indications do not always, or often perhaps, square with such as we are accustomed to rely upon, but they suggest many things in an empirical way that may be of advantage to ourselves and to our patients. In this book, for example, under the head of Physiological Action, is a great deal that was unknown in Hahnemann's time; that had no place in the first physiological notes on *materia medica* by Trousseau and Pidoux; and indeed, that are not otherwise available to those who would study all the individual peculiarities of remedies even from our own point of view. So that we are free to recommend both volumes of this work as suitable for reference and study to all who would be thoroughly equipped in therapeutical means and methods, and who would maintain the proper judicial balance between medicine and surgery.

TRAITEMENT DE L' ÉCLAMPSIE PUERPERALE EN PARTICULIER
PAR LES INJECTIONS SOUS-CUTANÉES D'EAU SALEE. PAR
LE DR. BERNHEIM.

Treatment of puerperal eclampsia by sub-cutaneous injections of salt water, etc.

We have already called the readers' attention to the report upon this subject recently presented to the Obstetrical Society of France, by Dr. Porak.* This thesis by his pupil, Bernheim, is an elaboration and extension of that very interesting paper, in which the author, after giving the clinical history of this form of eclampsia, and of the various modes of treatment that have been practiced for its relief, sets forth the new method, its mode of application and its results in a most interesting and suggestive manner.

After having discussed the use of saline injections in Asiatic cholera, in puerperal hæmorrhage, and in certain post-operative conditions, poisoning, the gastro-enteric and tabetic affections of children, chronic dyspepsia, etc., the author makes a powerful argument for its use in the elimination of the toxic principle, or principles, that infect the blood in most cases of puerperal convulsions. He insists that the hypodermic method of its introduction is decided-

* The CLINIQUE, Vol. XIV., 1898, page 378.

ly preferable to venous transfusion; and that its results are infinitely more prompt and satisfactory than the taking of large quantities of milk into the stomach, as advised by Tarnier.

Physiologically, two points are gained by this saline and sub-cutaneous invasion: (1) the toxic element in the blood is diluted and rendered less harmful; and, (2) the enunciations, especially the kidneys, are stimulated to greatly increased activity whereby the stagnation is overcome and the poisonous elements are turned out of the body. The chloride of sodium, which is the salt that is employed, not only preserves the integrity of the red globules in the blood current, and relieves the albuminuria which almost always attends upon these cases, but it seems to act the part of a stimulating diuretic. The artificial serum employed in this way consists of a quart of water that has been sterilized by thorough boiling and the addition of from 100 to 110 grains of common salt. The temperature of the solution should be faithfully kept at 112° during its administration. It can be given by any kind of apparatus like a fountain syringe or a pitcher, providing it is thoroughly aseptic, the needle being at the end of a tube, the same as in using the aspirator. The needle should be fine and thoroughly clean, and passed into the cellular tissue of the thickest part of the thigh with the same precautions as with the ordinary hypodermic syringe. The patient should lie upon the side and the field of operation should be thoroughly scrubbed and cleansed. The needle having passed as deeply as possible the penetration of the liquid causes the skin to appear white or mottled, which a light massage will remedy. About twenty minutes will thus be required to inject a quart of the liquid, but there is no occasion to hurry it up with a larger needle. It is well to inject the whole quantity at first, but if the tissues are too much distended turn the patient over and put a portion of it in the opposite thigh. The puncture may be dressed aseptically. The tumefaction is usually but not always gone half an hour after the operation. In case of puerperal infection, however, there may be signs of sphacelus.

The advantages of this method are its simplicity and availability under all circumstances; and the fact that it does not interfere with the use of other safe and proper means as anæsthesia, internal remedies, the milk diet or even with the induction of premature labor when that risky expedient may be deemed necessary. If any of our readers see fit to test its efficacy we should be very glad to hear from them.

Miscellaneous Items.

The XXXIVth Annual Commencement of the Hahnemann Medical College and Hospital of Chicago will be held in the Grand Opera House, April 5, at 2:30 P. M. The Alumni Meeting occurs on the previous evening at 8 P. M., at the new college building, the Address to be given by Dr. O. G. Tremaine, of this city. The Alumni banquet to the Graduating Class is set for April 5, at 7 P. M. at the Auditorium Hotel.—Dr. C. T. Canfield has donated thirty volumes and a lot of unbound medical journals to the College library.—Prof. H. B. Fellows and Bailey are at home again and hard at work.—The Clinical Society enters upon its eighteenth year with a good record and a better prospect; everybody says that its last meeting was one of the very best.—The Wisconsin Hom. Med. Society meets in Milwaukee, May 29–31.—The death of Dr. J. M. Scudder, of Cincinnati, the famous Eclectic, the author of *Specific Medication* and various other works, is announced.—For a notice of the Spring Term in the “Old Hahnemann” see our advertising pages.—Prof. Shears will report on Hernial Surgery at the next meeting of the Clinical Society.—The appendicitis question has given our readers another overflow issue of the *CLINIQUE* at which they surely will not complain.—Several letters from correspondents, including those from Prof. Gilman and Dr. Holman, must lie over for another month: ditto the lecture by Prof. Evans.—The final examinations begin March 22.—The *Pulse* is becoming deservedly popular with our Alumni. Its current issue furnishes a good portrait of Prof. Leavitt.—Don't fail to be here at the “grand doings” April 4 and 5.—This year we celebrate the 50th anniversary of the introduction of Homeopathy into the city of Chicago by Dr. D. S. Smith, late President of the Old Hahnemann Medical College and Hospital.

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VOL. XV.]

CHICAGO, APRIL 15, 1894.

[No. 4.

Original Lectures.

ISOPATHY.

A LECTURE DELIVERED IN THE HAHNEMANN MEDICAL COLLEGE
AND HOSPITAL OF CHICAGO, MARCH, 1894, BY PROF. CHAS.
H. EVANS, M. D.

During the session now rapidly drawing to a close, the teaching from the department of materia medica has been one of unswerving fidelity to the law of similia. It has been represented in all the majesty of an eternal force, co-existent with other natural forces and energies, that united, maintain and govern the whole universe from the smallest atom of matter to blazing suns far beyond our solar system, from the mutations of the inorganic world to the subtle phenomena known as life. The harmonious working of natural force and energy in the plan, development and maintenance of living structures has also been passed in review, as well as the regularity with which mis-directed effort, called disease, proceeds. The method of applying the law *similia similibus curantur* and the means by which it is accomplished have been explained to you step by step and illustrated by example and object lessons. You are now in possession of the edifice reared by a master hand, one who shares a place in the temple of natural truth in company with Copernicus, Kepler, Lyell, and Farraday—the immortal Hahnemann. But our task is not

yet complete. You have been instructed in the truths and doctrines of homœopathy. It now remains to be shown that these bear no relationship whatever to the newly resuscitated dogma known as isopathy. The pretensions of this oft buried doctrine to share the honors of homœopathy will constitute the subject of to-day's lecture. No protest, up to the present time, has been voiced on this subject in any of our seats of medical learning; it is therefore proper and fitting that such heresy should be denounced in this college, the first to bear the honored name of Hahnemann, and within its walls to defend his name and fame.

The word isopathy is derived from two Greek words signifying equal suffering, and the theory directs the employment of morbid products of a disease for the cure of a person suffering from the *same* disease.

It may be formulated in the sentence *equalia equalibus curantur*, meaning that the same will cure the same.

It also includes not only the administration of morbid products, but the use of healthy organs from the lower animals as remedial agents for the cure of diseases occupying the same organs of a sick person.

You will readily perceive how entirely at variance such tenets are with the operations of the natural law of *similia*, by means of which similarly acting forces contained in natural objects are employed to efface the results of the natural forces that have instituted disease. Furthermore, homœopathy insists upon a knowledge of drug effect, to be ascertained by experiments made upon healthy human beings, the sum total of these being known as provings, which then constitute definite knowledge as opposed to theory. By this method similar effects to those caused by disease can be produced at will on the sick person in precisely the same structures and along the same lines traversed by other natural forces concerned in the production of disease. In this manner the artificial drug disease is made to approximate the phenomena of natural disease, and in accordance with an inflexible law of nature,

two similarly acting forces cannot exist in the same structure at one and the same time. Both of these, then, having ceased to act in the cells and tissues of the body, the organism returns to its normal state, being subject only to those forces which preside over its healthful growth and maintenance of function. It is, therefore, readily apparent that homœopathy and isopathy are not interconvertible terms, and cannot occupy the same ground or march together under the same banner.

The peculiar theory of medication known as isopathy is one of great antiquity, dating back to the medical beliefs of the most primitive people. Xenocrates, who lived four centuries before Christ, enunciated this doctrine in his writings. Galen recommended the lungs of a fox for the cure of persons suffering from asthma, and this prescription was repeated by many of his contemporaries and successors. The maxim that "the hair of a dog is good for its bite" extends back to the first century of the Christian era, when Dioscorides vouched for the efficacy of the roasted liver of a dog to counteract the results of its bite, *i. e.*, the development of hydrophobia. Ancient pharmacy prepared quite a number of concoctions in which the flesh of vipers was included, which were lauded as antidotes for the bites of poisonous serpents; and powdered earthworms was another pharmaceutical agent highly esteemed in the treatment of intestinal verminous parasites. Numberless instances abound down through many ages where the organs of animals were professionally and popularly administered for the purpose of relieving diseases situated in the same organs in the human subject, but the recapitulation of all such, or in part only, would occupy too much time at the present; enough has been related, however, to show the prevalence and practice of isopathy at a period more than two thousand years ago, and its descent through the ages in apostolic succession. The writings of Van Helmont, an orthodox physician, in the early part of the seventeenth century, recommended the use of pathological substances for the cure of those diseases of which they were a

product, and his directions and opinions on this subject are so fully stated that scarcely anything has been added to the doctrine since his time.

The treatment of syphilis by means of its own virus, the so-called syphilization, was first broached by Anzias Turenne, in 1844. It was adopted by M. Robert, of Marseilles, at a later date, and experiments in this line of medical treatment were also conducted by Sperino, in Italy. About the same time Boeck, in Norway, under governmental auspices, carried out this method of treatment on a large scale, extending through quite a number of years. He published the results of 250 cases, and at a later period reported 1,200 instances in all. This mode of practice was introduced shortly afterward in the London Lock Hospital and also the London Charity Hospital, though it was conducted in these institutions on a much smaller scale. It was also practiced in a desultory way in different parts of Germany at various periods. Briefly, the process consisted in the use of matter taken from a venereal sore which was inoculated upon the subject for treatment. In a few days when the pustule resulting from such inoculation had made its appearance, matter was taken from it likewise and a new point of inoculation made, until the virus would no longer act, when a fresh supply was obtained from another syphilitic inoculation again and carried out in the same manner. This was inoculation and auto-inoculation.

The daily drinking of fresh blood by tuberculous patients from the bodies of animals at slaughter houses, notably in Paris and Boston less than a score of years ago; the ingestion of bone-ash for osseous disease, and the transfusion of living blood from the veins of a healthy into those of an anæmic person were all applications of this ancient belief in isopathy, while the transplantation of the living structures of animals upon human organs, such as the cornea of rabbits and other organs, as well as the process of skin-grafting from man to man or from animal to man is but the extension of the same isopathic doctrine into the domain of surgery.

In more recent times Pasteur has apparently cultivated this same isopathic belief extant centuries before the Christian era, and seemingly practices the administration of hydrophobic virus for the cure of rabies in man. But he has made a considerable departure from the original idea in that he weakens and changes the virulence of the infectious material by first passing it through the organism of rabbits, and instead of introducing it in man through the mouth, injects it subcutaneously.

The studies and practice of Koch, in the isolation of tuberculous matter for the treatment of tuberculosis—the so-called tuberculin, are upon similar lines to those of Pasteur, the premise being that in some form the disease product is necessary for the treatment and cure of the self-same disease.

Contemporaneously, Brown-Sequard, eminent as he is in the domain of neuro-physiology, has also given the sanction of his illustrious name to this cult, and as a result of the quasi-endorsement given by these three distinguished men, the mummied doctrine once more disinterred and unwrapped from its cerements, is exhibited as a novelty to a wondering public. The practice of Brown-Sequard consists in bruising the freshly obtained testicles of guinea pigs and dogs (though some of his followers use those from sheep), then straining the resulting fluid, which is principally seminal, and administering this liquor to human beings by means of the hypodermic syringe. He recommends this so-called elixir for the purpose of restoring lost vigor to individuals long past their prime. Experiments were made upon old men, as well as upon debilitated patients of both sexes within the wards of numerous hospitals and in private practice throughout Europe and the United States, and many clinical contributions to medical periodicals certified to the "great improvement" that took place in the subjects of this treatment. However, it was soon observed that after an apparent improvement lasting during periods varying from a few days to three weeks, the objects of experimentation went down to death all the more rapidly.

Nevertheless the demand for this so-called elixir still continues, and an establishment for its manufacture is located within a mile of this lecture room. Hydrochlorate, and the phosphate of spermine are also formulæ for the application of this substance for the relief of debility in worn-out subjects.

It is not the first time in medicine that this physiological secretion has been recommended ; for we find the London Dispensary of 1684 advising the use of the testes of boars, dogs, horses and deer for the same purpose, while Asiatic peoples have practiced it popularly during many centuries.

In our own day the well known Dr. Loomis, in the New York *Medical Record* of August, 1889, affirms his belief in this isopathic treatment of disease. In the same year another to give his adherence to this antique and grotesque conception was Ex-Surgeon General Hammond, who also contributed a lengthy article upon this subject to the New York *Medical Journal* a little more than a year ago in which he maintains the position he previously adopted.

To give an idea of the extent to which this method of treatment is now being carried by the dominant school of medicine, the fact is well known that two of the largest manufacturing pharmaceutical laboratories in the United States, one in New York and another in Michigan, are pouring into the market such commodities as cerebrine cardine, thyroidine, musculine, medulline, etc., made from the anatomical structures that their names denote. These facts and others that might be adduced bring the practice of isopathy in all its ramifications down to our own day and almost to our own doors.

It would seem almost impossible that any homœopathic medical practitioner, one having knowledge of a natural law under whose guidance an intelligent and successful prescription can be made, would voluntarily retrace his steps and become involved in the fog and mist of isopathic tradition. Yet such unfortunately has been the case. Dr. Constantine Hering, a man of great learning and attainments in

many scientific fields, and who was among the earliest practitioners of homœopathy in the United States, is the one who is responsible above all others for introducing this ancient fallacy into our school of medicine.

In the year 1830, Dr. Hering wrote an article in the *Archiv für Homœopatische* in which he advocated the use of the saliva of a hydrophobic dog for the cure of hydrophobia in man.

The suggestion was not, however, original with him, for Xenocrates had made the same recommendation four hundred years before Christ. To make it appear, however, as if homœopathy endorsed this doctrine, or at least, that it was not incompatible with it, Dr. Hering directed that the hydrophobic saliva be highly potentized, and thus *hydrophobin* was offered to the materia medica for empirical use.

In quick succession, and in accordance with the creed of isopathy, Dr. Hering advised the use of potentized smallpox matter for treatment of the smallpox, and thus *variolin* was born. The employment of the so-called *vaccinin*, said to have been potentized from the fluid of the vaccine pustule, for protection against smallpox, followed as a matter of course. Not content with this heterodoxy he advocated the use of the highly potentized discharges of cholera, and yellow fever, as well as those of other infectious diseases. It was considered wholly unnecessary that the dynamic effects of these disease products should be ascertained by means of carefully instituted provings upon healthy persons, such as homœopathy unvaryingly demands and requires, they were simply to be used in accordance with their isopathic relation to special diseases. This, it is scarcely necessary to say, is the rankest kind of empiricism. Nevertheless, Dr. Hering afterward wrote a labored essay in which he insisted that this practice was in every way identical with that of homœopathy.

In 1833, he contributed an article to the *Archiv*. in which he announced the birth of another nosode, as these products have been named, viz., psorine. He also published a detailed account of this in the second volume

of the *North American Journal of Homœopathy*, as to the method by which he had obtained it, from which journal the following description is taken *verbatim* :

“In the autumn of 1830, I collected the pus from the itchy pustule of a young and otherwise healthy negro. He had been handling some stuff from Germany and had thus been affected, *but whether by means of acari or not I cannot say* (italics ours.) The pustules were full, large, and yellow, particularly between the fingers, on the hands, and forearms. I opened all the mature unscratched pustules for several days in succession and collected the pus in a vial with alcohol. After shaking it well and allowing it to stand I commenced my provings with it on the healthy. I called this preparation psorinum.” He adds “When this alcohol is placed in a watch-glass and allowed to evaporate, small needle-shaped and transparent crystals of a cooling, pungent taste will be left behind, and I have always been of the opinion that this salt contained in the morbid product was the cause of its peculiar effects.”

The fact however that there could have been nothing specific in the mere presence of these unanalyzed crystals, will be appreciated by the members of this class whose instruction from the chair of physiology, and personal experience in the laboratories of this college, has taught them that each and every animal fluid, both normal and abnormal, yields crystals upon evaporation.

It was not to be expected that this innovation upon homœopathic principles and practice would lack imitators. Immediately there arose a host of claimants disputing with each other for the doubtful honor of spreading this departure from the truths entertained by homœopathy. Each vied with the others in proclaiming the superior merits of this antiquated dogma and in the presentation of the most singular and disgusting substances for medical use, all of which being duly potentiated, but unproven, were thus made to appear as if they were akin to homœopathy. In Germany, Gross and Lux were perhaps the foremost in advancing this form of isopathy in print, where they indulged

in the wildest vagaries ever permitted to man. Lux, who was a veterinary surgeon, fairly wallowed in the vileness of his so-called medical agents, and published a volume in 1833 entitled, "The Isopathy of Contagions," in which this doctrine is allowed to run mad, and where in addition to his opinions he described a long list of dynamized secretions and excretions from the human body and other sources. The reader of this book rises from its perusal with all the sensations of a horrible nightmare!

Among other extravagances suggested at that period by the followers of isopathy was one that demanded the potentization and readministration of the discharges of the person himself, an auto-infection resulting from the disease products of the patient's own body. This you perceive is somewhat analogous to the practice of syphilization under the auspices of the orthodox school. In the year 1848, a surgeon by the name of Hermann published a work entitled "True Isopathy, or the employment of the organs of healthy animals as remedies in diseases of the same organs." This volume, as its title implies, suggested the manufacture and administration of tinctures prepared from the various organs of different animals for the cure of diseases of the same organs in man. Thus, a tincture made from the kidneys of some animal and called reinine, was recommended to cure all diseases of the urinary organs. In the same way a tincture of the lungs called pulmonine, was warranted to cure all diseases of the respiratory apparatus in mankind, of whatever nature or character. Tincture of the liver derived from the same sources, and designated hepatine, was considered serviceable in relieving diseases attacking that viscus in the human subject. It would be only a repetition of the same process to extend this list to other anatomical regions, and time will not permit. Under this arrangement not only were the diseased organs to be treated with their appropriate tinctures, but general diseases were arbitrarily assigned to certain organs in human beings and the tincture made from the same organs in animals was therefore adapted to their cure.

Quite recently the late Dr. Samuel Swan contributed a considerable number of unsavory pathological products for use in disease, all of which have been potentiated to such an extent that Roman numerals are required to express their degree of dilution. In common with other enthusiasts of this class he spared neither tongue nor pen in advocating this method of prescribing.

Against this rising tide of isopathic speculation and practice which threatened at one time to seriously compromise homœopathy, Hahnemann raised himself, and denounced it in the most unqualified language. You will find his views on this subject set forth in the *Organon*, to the teachings and denunciations of which this chair appeals. Your attention is directed to what is said in section 56 of that authoritative work, and also to section 34 of the Introduction to the *Organon*, in both of which Hahnemann wholly repudiates the claims of isopathy and denounces the isopathic writings of Gross and Lux by name. In his work upon chronic diseases, Hahnemann says: "The medicines treated of in the following volumes contain among them no so-called isopathic medicines," and he glories in the fact of their omission. These references to the *Organon* and *Chronic Diseases* in refutation of the pretenses of isopathy, are of too great length to be reproduced at this time, but you can read them for yourselves and reflect how utterly Hahnemann refused to admit that isopathy was in any sense a part of homœopathy, or that it bore the slightest relationship to it. In view of this record of Hahnemann's positive and unqualified rejection of isopathy, it is quite surprising to observe that the believers in this hoary fad should arrogate to themselves the name of Hahnemannian homœopathist, thus making the master of homœopathy, by implication, an advocate of the very doctrine that he stoutly disowned.

In the light of this brief review it will be seen that isopathy has been exploited for ages to its fullest measure, both in theory and practice under the auspices of the other school of medicine, revived at varying periods only to be

laid aside again and again as an inefficient and discredited method in the treatment of disease. At the same time, the attempted introduction of this alien into the homœopathic school under the guise of potentiation was and is in utter defiance of the law of *similia*, and contempt for the teachings of Hahnemann. The requirements of isopathy insist that a general diagnosis shall be made the foundation for specific medication. This general diagnosis having been determined, the so-called nosode, a dilution of the products of disease to which it is said to be related is then administered to the person supposed to be suffering from the same disease. This is prescribing solely upon a pathological basis, and one which in this general form is largely a matter of conjecture.

Diagnosis, and by this I mean specific diagnosis, is important in deciding upon the kind of ailment from which a patient is suffering, together with a knowledge of the morbid processes present, and their probable course and termination; yet in the vast majority of instances it has failed to designate the appropriate medicine, or at the very best has been but an imperfect guide for cure, during the past 2,000 years. It was this lack of precision, this generalizing upon the supposed indications furnished by pathology and diagnosis alone, that led Hahnemann to search for something more definite and reliable, something more enduring than theory in the treatment of disease, and he found it in an unvarying law of nature, upon a due observance of which the greatest success in therapeutics has been attained during all recorded time. The garb of potentiation does not conceal the cloven foot of isopathy. In what respect does the prescriber of syphilinum *c. m.* differ from the "regular," who resorts to syphilization, except that the substance differs in the degree of attenuation; or in what particular does the prescriber of potentized pyrogenium for fever vary in practice from his allopathic confrère who employs thyroidine in the treatment of myxœdema? Parallel instances of this kind might be multiplied indefinitely.

The attenuation of medicinal agents is only a means by which these may be safely administered to sick persons, but in the absence of drug provings, by which process only accurate drug knowledge can be obtained, does not constitute homœopathy any more than it does allopathy.

Stripped then of all its pretensions to homœopathy, and the assumed mantle of potentiation having been torn from around it, isopathy stands revealed in all its nakedness as a time worn and oft discarded theory of traditional medicine during twenty-five centuries, whose revivification reflects credit upon no one, least of all upon the handful of those professed followers of Hahnemann who adopt it into their practice at the present day. As before mentioned, Hahnemann viewed the attempted introduction of this kind of practice into homœopathy with extreme disapprobation, and expressed himself as uncompromisingly opposed to it, and we in our day and generation owe it to homœopathy and to ourselves to discountenance its practice among us.

THE SURGICAL DISEASES OF WOMEN.

EXTRACTS FROM PROF. LUDLAM'S CLINIC IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO, SESSION 1893-94*.

REPORTED BY CORNELIA S. STETTLER, M. D.

THE DIAGNOSIS OF PREGNANCY FROM ABDOMINAL TUMORS. Wednesday, March 7. *Case 22,008*, æt. 21 and unmarried, was carefully examined before the class for a supposed abdominal tumor. The physical signs noted and discussed were those of pregnancy. In closing his remarks Prof. L. said: Three weeks ago we had a patient in this clinic, a young girl of 15, whom several physicians had declared pregnant; but, you remember, we found the symptoms of ovarian dropsy instead and in the presence of thirty of your number I removed a plump cyst weighing fifteen pounds. That girl has gotten well and gone home. To-

*Continued from page 115.

day the case is reversed, and here we have a patient who has been supposed to have a tumor but we find that she is pregnant. The lesson for you is not to confound the two conditions, and above all things not to fall into the easy going, common habit of supposing that because you have happened to be right in the diagnosis of one doubtful case, therefore the next one will be just like it. The doctor who has one case of diphtheria or of scarlatina, may easily and perhaps rightly, conclude that his next patient with a sore throat has the same disease. For those affections are often and usually epidemic, but it is not so with pregnancy and ovarian tumors.

A TRAUMATIC SUPPURATING CYST OF THE OVARY WEIGHING FORTY POUNDS. REMOVAL. RECOVERY.—Wednesday, March 7. *Case 22,009*, brought to this clinic by Dr. J. P. Wayland, of Sycamore, was aged forty-eight, mother of three children, the youngest being nineteen years old. The menstrual history is one of profuse flowing until three years ago when, although the periods recurred every three weeks, the discharge gradually lessened. Eight years ago, and three months after falling from the second to the first floor of her house, she first noticed an abdominal enlargement. She was badly bruised all over the body and was lame for a long time afterward. For a month or more she had a severe cystitis and urethritis. The growth seemed to increase and then to decrease, but has never disappeared.

Before the accident she had had a prolonged attack of metritis. Five years ago Dr. Ludlam examined her and pronounced the tumor to be a uterine fibroid, advising not to be in haste about an operation. Her present symptoms are pain in both iliac regions and the back, bearing down, constipation and frequent urination with strangury. The abdomen is very large.

Operation.—March 8, at 8:30 A. M., an ovariectomy was made in the clinical amphitheatre before a class of forty senior students and a multilocular ovarian cyst weighing forty pounds was removed.

Two or three points in this case are worthy of your immediate notice: (1) the traumatic origin of this tumor; (2) its early location low down in the right side of the pelvis, which because it was accompanied by menorrhagia, led me to

conclude five years ago that it was a fibroid; (3) the purulent character of the contents of the original cyst, which was drawn from below the pelvic brim and delivered without rupture and the escape of its infectious contents.

Wednesday, March 21. Here you have the best of evidence that our patient is at the fourteenth day and doing extremely well. She has had no symptoms, sits up in the bed, and the wound has closed perfectly with the dry dressings.

THE REMOTE EFFECTS OF TUBO-OVARIOTOMY.—Wednesday, March 21. Particular interest was manifested in the examination and history of three cases that were grouped in this clinic.

Case 22,011 was that of an unmarried woman, æt. twenty-seven, and sent to the hospital by Dr. R. L. Snow. Puberty was established at fourteen, with irregularity, severe dysmenorrhœa and ovarian pains that were atrocious and finally constant. Eleven years ago both ovaries were removed by Dr. Battey, of Rome, Ga. For a year she was worse off than before, but she afterward improved somewhat. A year ago she began to have symptoms of prolapsus of the uterus with frequent urination, which sometimes occurs as often as once in five minutes. The menses have not returned since the operation. She is highly neurotic, but eats and sleeps well. On local examination, under anæsthesia, the womb was found in its proper position, but the upper part of the vagina was the seat of a violent inflammation. No other lesion could be found.

Case 20,079, æt. twenty-seven, mother of one child, had the vaginal cervix removed three years ago for a supposed cancerous growth. As her symptoms did not improve and the ovarian pains increased, both ovaries and tubes were taken a year later. Both operations were made by a gynecological surgeon of Cleveland, O. She enjoyed fairly good health for a short time, when she was taken with insomnia, intra-pelvic pressure and attacks of painful bloating of the abdomen which, with pains and extreme tenderness in both iliac regions, continue to make her life a very wretched one. She does not menstruate but has a nasty, exhausting vaginal discharge most of the time. The temporary use of galvanism increased this flow and induced a bloody diarrhœa.

Case 21,069. Mrs. —, æt. thirty-one, underwent an operation for the removal of a traumatic cyst of the right ovary in this clinic December 11, 1893.* The growth was as large as an ostrich egg, very adherent, and a diseased tube was removed with it. She has been in perfect health since the operation.

These three cases are brought before you as a clinical illustration of the sequelæ of tubo-ovariotomy. A proper estimate of the value of this operation depends upon circumstances. It cannot be determined in all cases within a few weeks, or months, perhaps. Some of these patients recover almost directly, while others take a long time, and become very much discouraged with having to wait for a good result. Not a few of them would get well more speedily and surely if we could control the conditions to which they return when they leave the hospital. The resumption of household duties, of the married relation, or of the wear and worry of social life, are almost certain to interfere with, and perhaps to arrest the progress of recovery. Under these circumstances we are likely to be blamed, and wrongfully too, by those who do not approve of surgical treatment, as well as by those who, because they do not know the whole history of cases upon which we have operated, are inclined to think that we have not chosen the proper expedient, or have not done our work in the proper way.

The fact that the first of these three women ceased to menstruate at eighteen, nine years ago, directly after Dr. Battey's operation, proves that he removed both tubes as well as both ovaries; and the fact that the uterus is not enlarged, diseased, or permanently displaced, shows that there is no need of our making a complementary hysterectomy in her case.

The next patient seems to have been one in which, as it followed childbirth, there was probably an ascending salpingitis and ovaritis, the trouble having begun in the uterus and extended upward. With our present knowledge it

*The CLINIQUE, vol. xiv., 1893, page 564.

would seem that the best course to have pursued, especially when the cervix was the seat of a suspicious growth, would have been to have practiced a vaginal hysterectomy at the outset. You know the argument for uterine instead of ovarian castration in such cases; and you also know why in cases that are bound to become cancerous the excision of the cervix is almost always an unsatisfactory operation. This poor woman is left with the body of the uterus to vex and worry her while ever it remains, and it is very doubtful if she recovers until it also is removed.

The third case got well very promptly and satisfactorily, not so much because the operation was made here, and with your assistance, as because of her robust constitution; of her never having been pregnant; and because she took unusually good care of herself after leaving the hospital.

PORRO'S OPERATION AT THE FOURTH MONTH IN AN EXTREME CASE OF MYO-FIBROMATA.—Wednesday, March 28, the specimen from a very interesting case (See Fig. 6) was shown in this clinic.

Case.—The patient *æt.* twenty-seven, was married seven months ago; had her last period almost four months ago, after which she was under the care of a physician in the East, whose diagnosis was retroversion and who after treating her locally every day for a fortnight pronounced her well. She arrived in Keokuk, Iowa, February 25 and two days later sent for Dr. G. E. Ehinger who, soon becoming aware that he had an unusual case to deal with called Dr. A. A. Whipple, of Quincy, Ill., in consultation. Having located a foetal tumor, a probable ectopic gestation, in the left iliac region, with a serious pelvic complication of some sort, and fearing a rupture because of the terrible local suffering and threatened collapse, Dr. W. advised an immediate operation. Dr. Ludlam was accordingly sent for and on March 16, with the assistance of Drs. Whipple and Stettler, in the presence of Drs. Ehinger, W. Bancroft and G. N. Seidlitz of Keokuk, a laparotomy was made with the result of removing the uterus with the contained foetus of about four months and one very large fibroid that almost entirely filled the lower pelvis, with another that was located at the left, immediately above the



FIGURE 6.

brim and which was sessile and attached to the whole left side of the uterus. The mass weighed eighteen pounds.

The points of clinical interest in this case were the excellent general health of the patient to within a very brief period; the growth of a fibroid that was more than big enough to fill the pelvis without the knowledge or suspicion of the patient, or of the physician who had treated her for a retro-deviation of the womb, and without any history of menorrhagia; and the forcing of the gravid uterus into the left iliac region where it felt like an extra-uterine tumor, gave rise to the most atrocious pain with syncope and to a bursting sensation that was insufferable. An accurate diagnosis before the operation was impossible, and when the condition was made manifest by the section it did not take long to decide that, while she could not possibly go on to term, there was no alternative but to remove the uterus and its appendages with the tumors attached, and this was accordingly done. The patient reacted well and ten hours after was comfortable with a temperature of 99°, pulse 80. For some unaccountable reason which for lack of information I cannot at present explain, she died on the fourth day. Had it been possible I would have been glad once more to have closed the incision, gotten the patient along to term, and then made another successful Cæsarean section.*

A COMPLEMENTARY HYSTERECTOMY UNDER PECULIAR CIRCUMSTANCES.—*Case 22,024*, æt. twenty-seven, referred to this clinic by Dr. Sarah E. Bacon, had a history of chronic retroversion and diseased ovaries and tubes, the latter of which were removed six years ago in another of our city hospitals. At the same time the uterus was stitched forward, but she says the sutures did not hold very well, and soon "gave away." She recovered from the operation in due time and felt somewhat improved, but as soon as she resumed her duties, which required her to be upon her feet most of the time, the old symptoms all returned, and

*EXPLANATION OF FIG. 6.—1, placenta; 2 and 4, margin of the uterine cavity; 3, sessile fibroid from the left upper pelvis; 5, the larger fibroid that filled the lower pelvis.

of late they have become so unbearable that she is determined to have the uterus itself removed. She has not menstruated during the six intervening years.

Operation.—March 29 a vaginal hysterectomy was made before sub-class 11. The points of especial interest were the atrophied condition of the uterus, as after the menopause; the existence of retro-uterine adhesions and the attachment of the fundus uteri by a strong fibrous band to the lower angle of the old abdominal incision.

Wednesday, April 4. At my clinic a fortnight ago I showed you three cases illustrating some of the possible sequelæ of tubo-ovariotomy. In this patient's case we have also a remote result that is very rare, but which should properly be ascribed to the stitching forward of the uterus (hysterorrhaphy) rather than to the removal of the appendages. At the time of the former operation the woman had a serious retro-deviation of the uterus that was doubtless complicated with posterior adhesions. While the abdomen was open those adhesions were either overlooked or disregarded, and after the ovaries and tubes had been taken an attempt was made to fasten the fundus uteri forward. The attachment that was formed between its anterior surface and the abdominal peritoneum developed into a firm and mischievous adhesion that was stretched into a band by the old disposition of the womb to fall backward, and to yield to the dragging of the antagonistic posterior adhesions. These actual lesions that were demonstrated to class eleven, and which are illustrated by the specimen, furnished a ready and satisfactory explanation of the patient's suffering whenever she was upon her feet. They also suggest the necessity for care in making a hysterorrhaphy lest an old anchorage of the womb might interfere with its being cured by that operation. Small as this womb is in consequence of the artificial menopause that was induced six years ago, it has been the source of great suffering and disability because those two sets of adhesions had been pulling at it like so many horses attached to each end of a wagon.

REPORT OF THE CLINIC ON GYNÆCOLOGICAL SURGERY IN THE HAHNEMANN HOSPITAL, CHICAGO, SESSION 1893-94.— Wednesday, April 4. As usual at the close of this clinic for the winter session, Prof. Ludlam reported upon the advantages that he had given the class within the last six months: During the term this department, devoted exclusively to the surgical diseases of women, has furnished you *seventy-three* clinics, thirty of which have been given to the whole class in this amphitheatre, and forty-three were sub-clinics with operations before the sub-classes. Besides this a short course of six lectures on minor gynæcological surgery was given to the entire college class. An excess of *twenty-one* clinics over what the lecture-card called for, especially when you consider the number and great variety of cases that have been brought before you, will hardly be ground for complaint.

In my sub-clinics during the winter we have had *seven* ovariectomies; *eight* tubo-ovariectomies; *eight* vaginal hysterectomies; *five* abdominal do.; and one explorative laparotomy; besides a lot of trachelorrhaphies, perineorrhaphies, amputations of the cervix uteri, colporrhaphies, curettings, etc., etc.

Of the women upon whom the major operations were made a much larger share than usual were extremely complicated and in a very bad condition either from the age of the patient, or of the tumor, or both, or from previous neglect or maltreatment. While the predominance of very serious cases has rendered this clinic all the more interesting and instructive for you it has had the effect to increase our mortality; and yet with the aseptic safeguards and precautions that we have taken, and the excellent care that our patients have had, the record is not what it otherwise must have been. One of our ovariectomies, (21,057) in every way promising, died on the fourth day from a sudden attack of grippal pneumonia; one vaginal hysterectomy, (22,000), in a feeble old woman proved fatal from shock; and another (22,001), from a relapsing peritonitis with intestinal sepsis and perforation of the colon; one after an abdominal hysterectomy, (21,074), for a calcareous and badly degenerated myo-fibroma; one (21,047), after an ovariectomy for an enormous cysto-cancerous tumor of the ovary, a forlorn hope from the first, as was also another case, (21,043), of hysterectomy in a poor old woman who had postponed the operation too long. If therefore, despite our best efforts, we have lost six of our patients

we have had the compensation and the satisfaction of saving the lives of many more who could not have gotten well without the knife, nor without such care in the after-treatment as was given them by Dr. Spaulding, our excellent house physician.

Of late years, since my work here has been limited to clinical teaching and to the giving of object lessons, with the living patient in the presence of the class for study and observation, I find no time for preaching, nor for the discussion of themes that are foreign to the interests of the sick and suffering women who appeal to us for help and for relief. And I am happy to say that the extraordinary interest which our large class of pupils has taken in my clinics this winter, as well as the success of the seniors in their final examination upon this branch, is extremely gratifying and encouraging. It only remains to thank all those who during the session have so kindly and faithfully assisted me in this good work. I am under especial and individual obligation to Drs. Stettler, Spaulding and Hendy, who with the several nurses have been so vigilant, loyal, prompt and untiring in carrying out my instructions and in caring for the welfare of my patients. As the prime requisite of a good officer is to have been a good soldier, so their excellent service like your own sympathetic interest in this specialty, betokens a most promising future for all concerned.

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

MARCH MEETING, 1894.

The regular monthly meeting was held as usual in the clinical amphitheatre of the new Hahnemann Medical College building on Saturday evening, March 24. In the absence of the President, Dr. Otto Poppe was called to the chair, and the society heard and discussed the following report :

ON IRREDUCIBLE HERNIÆ.

BY DR. GEORGE F. SHEARS.

At the last meeting of the Clinical Society, and during the discussion of the treatment of appendicitis, I made this statement, that I would advise operation in recurrent cases of appendicitis in the interval, just as I would advise operation in cases of hernia in which there was difficulty of retaining the gut in position, believing that the patient suffers more from the danger of strangulation than he would from the operation made in proper hands and under proper precautions. When called upon by our President to make a report this evening, this statement recurred to me, and I could not but reflect upon the resemblance in some respects of the position of the irreducible hernia and the inflamed appendix. It seemed to me, therefore, that it might not be inappropriate to follow the subject of appendicitis by that of the treatment of irreducible hernia.

By this term I do not intend, however, to limit our paper or discussion to those cases in which the protruded bowel cannot be returned into the abdominal cavity, and this without any symptoms of obstruction or strangulation, as the word is commonly used, but rather all forms of hernia which cannot be reduced, including simple ob-

structions, incarceration and strangulations. All of these cases present, as I said before, several points in common with appendicitis; there is constriction, or threatened constriction of the intestine; delay after reasonable non-operative treatment may result in peritonitis, gangrene, death; the symptoms are often obscure, the destruction going on is not always evinced by the severity of the symptoms; early operative measures are accompanied by little danger.

Cases of irreducible hernia may be divided into three classes: first, those in which the hernia has been previously reducible, and those in which it occurs for the first time, but in which no symptoms of strangulation are present; second, those which have been irreducible or incarcerated, and in which some acute symptoms have supervened; and third, those cases in which the symptoms are manifestly those of strangulation.

In the first of these cases, reduction by taxis is undoubtedly the treatment to advise, and it may often be carried out, under proper precautions, without danger to the patient. My own practice in these cases is to make careful efforts at reduction for from five to ten minutes. If this does not succeed, I then refrain from further manipulation, and advise the following treatment: make all preparations for a herniotomy, give the patient an anæsthetic, make a second trial under anæsthesia, and if this does not succeed proceed at once without further delay to operate. If called upon, after a careful physician has made an attempt at reduction, and especially if the attempt has been at all prolonged, I advised the anæsthetic at once, the necessary preparation for an operation having been made. By this means the patient is saved the second administration of an anæsthetic, the strength is conserved, there is no useless waiting, and the parts are in the best possible condition. Often the operation is not demanded and some unnecessary work is undergone, but if in only one of a dozen cases the operation is needed, the outlay is warranted. The following cases illustrate this line of practice:

Case 1. Mrs. B, aged sixty years, had had a left

femoral hernia for many years. Twelve hours previously the hernia became irriducible. Ineffectual efforts were made at reduction. When called to see her by Prof. Cobb, she had little pain, but considerable nausea and vomiting. Under anæsthesia careful manipulation resulted in speedy return.

Case 2. Willie B., aged five years. Right inguinal hernia, often slipped out and refused to return, but had always been put back by the doctor after gentle manipulation. It has now been out six hours, and could not be returned. The usual preparations for an operation were now made, and an anæsthetic given. Gentle taxis maintained for some ten minutes, resulted in a successful return.

Case 3. Mr. D., aged sixty years. Large scrotal hernia. Patient fell on the sidewalk. The hernia could not be returned. I was called by Dr. McCracken. The tumor was tense and hard, and the prospects of its return seemed poor. The patient was told of the probable necessity for an operation, but under anæsthesia reduction was accomplished.

I hesitate to give directions for so simple a procedure as the manipulation of a hernia, and yet I am convinced from some of the complications which I shall further relate, that much unnecessary injury is often done the parts in the attempt at reduction. Gently handle the tumor until the neck is found, then supporting it with the left hand, grasp the body and fundus in the right, and make pressure in the direction of the opening. Let this pressure be gentle but firm, regular, but without undue force, using the pulp of the fingers and not the ends. By observing these precautions the sac is not pushed up against the sharp edge of the stricture, cutting or lacerating it. The tumor is not bruised by the sharp tips of the fingers, and the intestines are not ruptured by undue force.

An incarcerated hernia is not only irreducible, but obstructed as well. Most of these cases have hernias which have been irreducible for some time, and which have been neglected because they did not cause inconvenience. The patients of the happy-go-lucky sort are unmindful of danger. Finally the sac, the intestine, and the surround-

ing tissue become united, and the hernia cannot be returned. Still it may cause little trouble. Eventually the neck of the sac grows smaller, or the intestine deprived of its active function, for if adherent normal peristalsis cannot be maintained the intestine loses its muscular power to propel its contents, an accumulation of fæcal matter results, and obstruction takes place. The surgeon is now called in. Shall this case be operated upon? If possible, yes, for no course of treatment can prevent a repetition of the attack, and final strangulation. But one may not be allowed to operate, or may not be prepared to operate, and under these circumstances manipulation may often remove the obstruction, even if it does not return the hernia.

Case 4. Mrs C., aged seventy-six years, had had an irreducible hernia for several years. Twenty-four hours previously symptoms of obstruction appeared. The patient was old and feeble with asthma and heart disease. Upon careful examination I was convinced that the history of an irreducible hernia was correct, and that we now had an incarcerated hernia. Under careful manipulation the fecal matter was pushed forward, and probably some of the dislocated bowel reduced. The acute symptoms subsided, and the patient remained comfortable for several months, when she died from other troubles.

Cases of this kind are, in my judgment the most difficult ones we have to treat. If the obstruction is simply removed, the evil day is only postponed. If an operation is made the intestines may be found to be adherent and the peristaltic function found to be impaired. If this is the case it cannot be returned to the abdomen without some danger of similar obstruction taking place within the abdomen that occurred in the hernial sac. Shall the non-strangulated but apparently paralyzed gut be excised, or shall the risk of possible secondary obstruction be taken? Such a case only emphasizes the fact that no portion of the bowel should be allowed to remain outside of the abdomen, even if no inconvenience is experienced by the patient, for sooner or later danger will result.

The third variety, the strangulated hernia is the one, more than all others, in which care in manipulation and promptness in action are demanded if the life of the patient is to be preserved. I am firmly convinced if there were operative measures instituted at once in all cases of strangulated hernia, of course in competent hands, and using all the improvements in modern surgery, that the mortality would be almost nothing. We are told that one out of every 600 deaths results from strangulated hernia. Why this great fatality? To what is it due? Ignorance on the part of the patient and either that or negligence on the part of the physician. Let me relate to you some cases:

Case 5. Mr. B., aet. thirty-five years. Was seized with severe pains in the region of the umbilicus. His wife thinking these symptoms due to disordered stomach gave him some Garfield tea. This he could not retain. Twelve hours later she gave him an enema. After thorough evacuation of the stomach and rectum the patient seemed somewhat better. Upon attempting to eat the vomiting recurred and the matter ejected became very offensive. Their physician was then called. Nothing was said of hernia, but upon examination a left oblique inguinal hernia was discovered. The patient then said he had noticed this little lump, but he did not think that it had anything to do with the stomach. Upon my advice an immediate operation was made. The intestine was black but fortunately not gangrenous. The patient made a good recovery. It is quite possible that had there been added to this case the bruising of manipulation sphacelus might have been present.

Case 6. Mrs. C., aet. sixty years. Had had hernia for thirty years. Sixty hours previously she noticed the tumor was painful and could not be returned. A physician was called who manipulated it with some force, and claimed that he had returned it, although a swelling remained. Another was then called and a second attempt at reduction made, but without success. Upon examination I found a left femoral hernia. The tumor was the size of a large apple and very tense. No attempt was made at reduction but herniotomy proceeded to at once. The intestine was found to be gangrenous, was fixed to the enlarged hernial aperture, and an artificial anus formed. The patient never recovered from the shock.

Case 7. Mrs. D., æt. forty-five years. Five days previously was seized with severe pains near the umbilicus, accompanied by vomiting. Morphine was given to relieve the pain, and the diagnosis of gallstones was made by her physician. The next day the vomiting and pain returned. This continued intermittently under morphine until the evening of the fifth day when I was called in consultation. I thought I discovered in the right femoral region a tenseness not found on the opposite side. The patient was very fleshy, and I was not positive of the presence of a tumor, but as the case was so extreme, and I could account in no other way for the accompanying symptoms, I advised an exploratory incision at this point. It was made with the result of discovering a small portion of intestine strangulated and black. It was not gangrenous, and was, therefore, returned. The patient died in twenty-four hours, apparently from shock.

Case 8. Mrs. B., æt. seventy-two years. Right inguinal direct hernia. Irreducible for some six hours. In consultation with her family physician, Dr. Cobb, it was determined to prepare for an operation, give an anæsthetic, and although nearly midnight, to operate at once if reduction could not be effected. Gentle taxis failing, the operation was made, the gut was found tightly bound, congested but apparently healthy. The Bank's operation for radical cure was made. The patient made a good recovery.

Case 9. Aged woman, patient of Dr. Kemp. A large tumor, irreducible for several days. Taxis, hot water, ether, poultices, and various other means had been tried. The tumor was hard and the tissues around about it were inflamed. I advised immediate operation. The patient desired the presence of her son, then in Omaha, for consultation. I insisted on an immediate operation and was discharged. Dr. Andrews was then called, and other measures tried for two days. At the end of that time an operation was made with a fatal result.

Case 10. Man, æt. thirty-five years. Right oblique inguinal hernia. Irreducible for six hours. No pain or vomiting. Inasmuch as the patient, who was intelligent, and quite an adept at the reduction of the hernia, which he had managed successfully on other occasions, could not return the protrusion, I determined to make no attempt at reduction, until anæsthesia had been accomplished. The usual preparations for an operation were made. Careful taxis failed, and herniotomy was made.

The intestine was congested but healthy; it was returned, and McEwen's operation for radical cure was carried out.

Case 11. Pole, æt. forty-five years. Immense scrotal hernia. Frequent vomiting. Had been irreducible for eighteen hours. The intestine had been out several times before, but his physician had always been able to return it. Herniotomy was made after a prolonged effort at reduction, The bowel was blue but viable. It was returned, the patient was at once relieved and continued so until the third day, when he arose to help himself against the remonstrances of his friends. He could not be made to believe that he was not all right. The cat gut sutures gave away and the hernia returned. He did not at once report it, being ashamed of what he had done, but made strenuous efforts to return the mass. At last the pain and the return of the vomiting led his friends to be apprehensive and assistance was called. There was increased tenderness, bloating of the abdomen, and other symptoms indicating peritonitis. The wound was reopened, the bowel returned, the abdomen flushed, but the patient died three days later from peritonitis.

Case 12. Man, æt. thirty-eight years. Was taken suddenly ill after taking a lunch of pie and doughnuts. He believed that he had an attack of indigestion. The next day he sent to his physician, Dr. Parsons, for medicine for indigestion. On the third day Dr. Parsons was called to see him, and discovered a hernia, which from the history of the case, he believed had been irreducible for some time previous to this attack of pain. The patient insisted that he had had the hernia for some time, and so far as he could see, it was no larger now than it was before. He felt sure that it was the pie and doughnuts. Attempts were made at reduction, under ether, but were unsuccessful. On the 5th day I was called and advised an operation, believing the symptoms due to strangulation. Upon making the usual incision, a large strangulated omentum, adherent to the external ring, and also at the fundus of the sac was discovered. It was evident from this fact that the hernia had not been reducible for some time. A strangulated omental hernia did not however, account for the symptoms present, and the inguinal canal was therefore carefully opened for further investigation. At the upper ring was found a small knuckle of strangulated bowel, black and almost lifeless. The constriction was relieved, and the bowel pulled down and allowed to remain outside, while attention was

given to the omentum. This was ligated and excised. Upon examination the bowel seemed to have lost some of its dark color, and was therefore returned into the abdomen. Under Dr. Parson's care the patient made an uneventful recovery.

Case 13. Frank D., æt. twenty-seven years. While lifting a heavy plank was taken with a severe pain in the left side extending up to the umbilicus, followed shortly after by vomiting. The vomiting continued during the night and the next day, with but little intermission. Upon examination no tumor could be discovered. Although the symptoms seemed like those of intestinal obstruction, no absolute diagnosis was made, but an exploratory incision advised. On account of the doubtful diagnosis this was made in the median line. Upon introducing the fingers into the abdomen the small intestines were found attached, and apparently entering the left internal inguinal ring. As the stricture seemed firm, fearing that any force might injure the intestine, an incision was made over the internal ring, and the operation finished in the usual manner. The intestine was dark but not gangrenous. The patient made a good recovery.

Case 14. Mrs. C., æt. fifty-four years. Had a right inguinal hernia for years. Had never worn a truss. On several occasions the hernia had come down, and caused her some pain. Rest for a few hours, the application of cold and gentle manipulation, had always returned it. It had now been down for ten hours and would not return. The tumor was painful, and the patient nauseated. She thought it would go back, but if I felt sure that if I operated upon her that it would not only relieve her, but cure her of it, she would have the operation. I gave her reasonable assurance and the operation was made. Recovery was prompt, and there has since been no return of the difficulty.

Case 15. Man only nineteen years old. Had left inguinal hernia for four years. Had usually worn a truss. Six months ago the truss was broken and he neglected to obtain a new one. He has often had colicky pains after a strain, but lying down for a few minutes has always relieved them. Yesterday after running these pains came on, and have grown steadily worse. He now vomits even upon taking water. The usual effort at reduction having been made without success, herniotomy was performed, and completed in a manner suggested by Bennett. Recovery was uneventful.

I have related these cases in a brief way, without intending to give any special emphasis to the diagnostic symptoms, the operative technique, or to the consideration of the many possibilities, or complications that may accompany or follow these unfortunate conditions, but simply to call attention to the results of the operations, and thus to more plainly mark a few conclusions I desire to draw.

First, that the manipulation of an unreduced hernia is not without danger; second, that taxis should not be prolonged after a reasonable period; third, that provision should be made for operative interference when an anæsthetic is given for reduction; fourth, that an operation should be made early, before strangulation has existed for any length of time, before peritonitis has supervened, and before paralysis of the intestine has become pronounced, as experience shows that this latter condition often remains after the strangulated part has been returned to the abdominal cavity, and that, without the bowel being gangrenous.

It may be noticed in a review of these cases that the five deaths were in cases in which there was much bruising, or in which several days had elapsed from the date at which reduction was impossible before the operation was made, and that except in one instance, No. 8, the favorable results were in cases in which the duration of restriction was numbered by hours rather than by days. This, it seems to me, is an unanswerable argument in favor of early operative interference.

My record in the treatment of non-strangulated cases, shows that there is little danger in the operation, but there is much danger from peritonitis, gangrene, and the shock which a long persistence of strangulation almost invariably causes.

I want to give to the agitation of appendicitis credit for the success of Case 12, for it is quite probable that if this operation had not demonstrated the safety of operations in this region, the surgeon might not have insisted as strenuously, or the patient consented as willingly, to what proved to be his salvation.

DISCUSSION: DR. HOWARD R. CHISLETT: If Prof. Shears had written nothing but the histories of the very interesting group of cases reported, he must have impressed upon one and all of us the three essential factors in the successful treatment of strangulated hernia, viz: First, the necessity of early diagnosis. Second, the fallacy of prolonged efforts at taxis. Third, the advisability of early operative interference.

What I shall have to say to-night, therefore, will be rather in the nature of corroborating what has already been said, than any effort at additional points. It cannot be too strongly urged that prolonged efforts to reduce an incarcerated, an inflamed, or a strangulated hernia are productive only of harm. I do not believe such reduction should ever be attempted without general anæsthesia, and even then with the most gentle and steady pressure properly directed, should never be persevered in for a period longer than from five to ten minutes. The hot applications so often advised will only serve to increase the difficulty by causing a still further dilation of the blood vessels, and an expansion of the volume of gaseous contents. Cold is better, but can only be of service before obstruction to the circulation is complete, then reducing the swelling very considerably by the opposite effect. My favorite method of applying cold is by means of the ether spray, or by pouring ether over the tumor and hastening its evaporation by fanning. In the absence of this, the ice-pack. It must not be forgotten that cold applications of any kind are extremely dangerous in strangulated hernia of several hours duration, serving to further devitalize the tissues, and thus hasten a threatened gangrene.

We cannot afford to disregard the directions given regarding taxis. Nothing shows inexperience more certainly than the rough manipulation or kneading of a hernia. The dangers of manipulation are not confined to herniæ which are strangulated, though of course, these are most liable to perforation or pressure gangrene; too much force may convert a simple obstructed hernia into an inflamed one, or an incarcerated into a strangulated hernia.

I am sorry Dr. Shears did not have time to consider the operative technique more fully, especially for the benefit of those under-graduates who are present to-night. The text-book descriptions are notoriously faulty. The so-termed hernia knife is a dangerous instrument second only to a groove director. These are probably the first you will be asked to buy. They are surely the first ones you should throw away as being indicative of surgical incapacity. The best rule one can have in this operation, as in most others, is "see what you are cutting." In other words cut from without in, making large enough incisions to show what you are doing. The time when one could cut a constriction and reduce a hernia without opening the sac and still lay claim to doing good surgical work has passed. It is just as much one's duty to open the sac and examine the contents as it is to cut the constriction. Having done so then comes the important question, what shall we do with the intestine? Shall it be returned into the abdomen, shall we make an artificial anus, or shall we resect the loop involved and establish continuity either by end-to-end or by lateral approximation? Obviously these questions must be decided by the conditions you meet. No hard and fast rules can be laid down about this. When upon opening the sac a whitish or yellowish serum escapes and the gut simply looks deeply congested, or when the fluid is even bloody or brownish but not offensive, and the gut dark purple but still glistening, it is as a rule safe to return it into the abdomen. I should rely more upon the presence or absence of the normal *glisten* than upon the color, but in all questions of doubt the constriction should be relieved and the suspicious coils wrapped in hot cloths and the result awaited. When, however, there is gas in the sac, indicative either of perforation or putrefaction and the gut looks both dark and *dull*, recourse must be had either to resection or to a false opening. The choice between these two measures must depend upon the condition of the patient. If he is strong and not in a collapsed condition, perform resection by all means, but we must

not forget that in by far the greater proportion of these cases the delay has been so long and the patient is in such extremes that prolonged operative measures are unwarranted, and the artificial anus is the best and safest plan to adopt. There is only one thing more which I wish to say, and that is to urge that it takes only a few minutes longer to do a complete operation than a partial one; in other words, do one of the recognized operations for the radical cure while you are about it. My preference is either for the operation of Halstead or Bassini.

DR. OTTO POPPE: I would like to ask Dr. Shears a question. I have a patient, a young child, who has a hernia. I advised a truss, and the physician to whom I sent him to be fitted advised that the child be first operated upon for phimosis, claiming that this was the cause of the hernia, and must be overcome before the hernia could be treated. Do you believe this theory?

DR. SHEARS: It is a noticeable fact, according to my observation, that phimosis is usually an accompaniment of congenital hernia. The phimosis in such cases is not the cause of the hernia, but is the result of the same cause that produced the hernia; both are conditions of arrested development. In one case the closure of the inguinal canal is not completed, in the other the unfolding of the preputial orifice has been interrupted. I do not claim in any instance that hernia is the result of phimosis, but I do advise in cases of hernia, that if phimosis be present circumcision be made at once, believing that the straining that is so often present under these circumstances will retard the closure of the inguinal canal.

DR. MCCracken: In regard to the second case reported by Dr. Shears, which he saw in consultation with me, I would say, that the case seemed a very unpromising one. The tumor was large, hard and very painful. The patient was just recovering from an attack of cerebral hæmorrhage. Indeed it was the paralysis accompanying this condition which caused his unsteadiness of gait, and resulted in his fall. He expected and we all did, that an

operation would have to be made. Under Dr. Shears' careful manipulation of the intestine it gradually returned. I am glad to say that the truss fitted to him by Dr. Shears has proven a success, and that the intestine has never been out since.

Dr. F. H. HONBERGER: I did not arrive early enough to hear the entire paper read. I have not had a great deal of experience with strangulated hernia, but firmly believe in early surgical aid when the hernia cannot be readily reduced; and I should never wait more than a few hours without calling such aid. My experience has been that the general practitioner frequently delays the calling of a surgeon until the case has become almost a hopeless one.

Dr. O. G. TREMAINE: I heartily endorse what Dr. Shears has said, but I would remind those just going out into practice in country towns that they will find themselves, when they meet their cases of strangulated hernia, in quite a different position than is Prof. Shears. As senior professor of surgery in a great institution, his advice to have an immediate operation carries great weight and will almost always be accepted.

Your statement that an operation should be made at once, will often be questioned, and when you insist that you can do nothing else, may lead to your being dismissed from the case. Other physicians called in, realizing the gravity of such cases, and wishing to keep upon the popular side, are likely to advise other measures, and to wait and see what can be accomplished. So that you will, in a large proportion of your cases, either not be allowed to operate, or if you are, it will be so late in the case that your percentage of mortality after operation will be high. Serious difficulties surround some of these cases. A few are what Dr. Hall called "masked cases." You cannot be certain when you meet them that an operation is imperative. Others you will not see until advanced and much aggravated by futile, but persistent efforts at taxis by the persons themselves. Late in these cases you cannot reassure interested parties that if an operation is made all

will be well, and early operation will very often be refused. People will be afraid to trust to your skill as an operator. Nobody questions the skill of Dr. Shears.

Again, you have enjoyed the study of surgery in some respects more than medicine, because everything seemed more exact. In these cases of hernia the classical symptoms are not always present. Unless you are careful you will be disappointed in not finding the practice of surgery as exact as the study.

I wish to emphasize the danger of manipulations. Always use anæsthetics. Do not continue efforts long at a time. If unsuccessful, operate *at once*. Early operations are attended with but little danger. *Taxis often kills*. It must be borne in mind that the shock resulting from many cases of strangulated hernia is overwhelming. It is out of proportion to apparent causes. As has been said the incision must be free enough to permit the surgeon to see what he is doing. Much manipulation with the fingers is wrong. The sac must be freely opened and its contents carefully examined.

Since herniotomy is an operation of so little danger, I wish such emphatic teaching could go out from this and other institutions that both people and physicians could be made to understand the subject. I would not only operate at the onset of cases of hernia, after reasonable effort at taxis under an anæsthetic, but I earnestly advise the radical operation for the cure of cases that have been strangulated, or that cannot be kept reduced by truss. By thus operating much more of glory would attach to these surgical procedures than now.

Dr. SHEARS: The remarks of my friend Dr. Tremaine, are only too true. There is great difficulty in obtaining the consent of patients to early operations, and this is especially true in country places where the patient is unaccustomed to prompt decision, and where the physician often lacks the support of colleagues equally well informed with himself. It is for this very reason that I have presented my paper as I have to-night. I have said little of

diagnosis, little of technique, to each of which a separate paper might be devoted with advantage, intending to emphasize the one point of early operations, believing that if the physician is thoroughly convinced of its necessity, if he believes it to be the best thing for his patient, if he presents it to his patient with confidence, and without hesitation, his conviction appearing in his words and manner, one-half of the difficulty of obtaining the consent of his patient is removed. No one can influence another if he half doubts himself, and hedges his opinion about with saving clauses. He must be confident if he would inspire his patient with confidence.

If this paper has any influence with those present in making firmer the belief that early operations are attended by little danger, and that the best interests of the patient are conserved by such measures, its object has been attained.

In regard to the question raised by Dr. Chislett, as to the treatment of the strangulated gut, I may say that it is my practice after having relieved the constriction, if the condition of the gut is doubtful, to let it remain outside of the abdominal cavity, protected by warm cloths, while attending to the sac, and other portions of the wound that may need my attention. If its color or feeling improves, it is immediately returned. If it is gangrenous its treatment depends somewhat upon the condition of the patient. There is as yet no generally accepted plan of treatment. Primary resection and suture of the intestine, and the forming of an artificial anus, have each their adherents. Both have their special advantages and their disadvantages. The former is attended by the danger of shock from so serious and prolonged an operation, as well as the danger of infection from an imperfect suture or the gangrenous gut, while the latter has the inconvenience of a foul fistula, the disturbances of nutrition which are often present when the part of the intestine involved is high up in the intestinal canal, and a certain amount of danger which accompanies the treatment for closure by means of the clamp. According to Schmidt, death after herniotomy

with resection of the gangrenous gut occurs in seventy-one per cent of cases, whereas after attempting to form an artificial anus, it occurs in eighty-five per cent of cases. It must be remembered in considering these statistics that it is in the more severe cases that the artificial anus is usually made. Personally, I believe that if the general condition of the patient is favorable, primary resection and suture are indicated. On the other hand, if the general condition of the patient is unfavorable, if it is difficult to determine the exact amount of intestine involved, the formation of an artificial anus offers the best chance to the patient.

In determining the question of the viability of the constricted intestine, Nothnagel's experiment should not be forgotten. He applies a few crystals of common salt on the gut near the constriction. If peristalsis is set up in the intestine, and extends over the constricted portion it may be considered viable, and may be safely returned to the abdominal cavity. In the *Deutsche Med. Wochenschrift*, No. 44, Dr. Lauenstein reports an interesting case in which this experiment led him to return to the abdomen a strangulated gut which he would otherwise have excised. The patient made a perfect recovery.

Hospital Notes.

THE CHILDREN'S CLINIC.

SERVICE OF PROF. JOS. P. COBB, M. D.

REPORTED BY MISS KATHERINE JAMES, CLERK OF THE CLINIC.

ECZEMA.—*Case 682.* January 31. This baby, \ae t. four weeks, was brought to the clinic because of a dry, scaly eruption, located mainly on the flexor sides of the limbs. While the eruption is of a scaly, dry appearance, when the scales are removed the surface of the skin is moist and sticky and denuded of epithelium.

The child has been jaundiced since birth, and has shown a tendency to constipation for which *nux vomica* had been given without benefit. It sleeps well, and does not have any distress after eating. The family history is good. *Graphites 6x* was prescribed four times daily.

February 14. The child reported again at the clinic. The skin is now perfectly smooth; the improvement being manifest three days after receiving the *graphites*. The jaundiced hue of the skin has faded a good deal; the condition of the bowels has improved; the color and consistency of the stool is normal, but there is a great deal of straining with the stool. *Alumina 30* was given four times daily. No further report has been presented.

INHERITED TUBERCULAR DIATHESIS. *Case 667.* Charles Mc., \ae t. ten years. November 25 this boy came to the clinic complaining that for a long time he had had a headache in the occipital region, worse at 4 P. M., and lasting until evening. He had no appetite for breakfast nor dinner. Slept well, and was rested in the morning, though he ground his teeth during sleep and awakened in the morning with a foul taste in his mouth. The boy was small for his age, thin and pale, with circles under the eyes, and inclined to be stoop shouldered. We learned that his father died of phthisis at the age of thirty-four. From the general appearance of the child and the class of symptoms presented we prescribed *sulphur 6x*, besides giving him a military drill to follow out at home; this drill consisted in instruction of how to square his shoulders, walk erect and breathe correctly.

A week later he reported but little, if any, improvement from the remedy.

The drill, however, had been a success, as he was quite erect. After we inquired more carefully in the case we found that he was sensitive to the cold; took cold easily, but was better when out of doors; that he did not sleep well at night, and was tired in the morning; that his feet and limbs perspired during the night, though there was a feeling of general coldness. He was given *silicia* 30x. Since this time he has reported improvement every week until January 30, when he was discharged.

CHRONIC CONSTIPATION. *Case 663.* Carrie B., æt. twelve years. This young girl had been under allopathic treatment for some time, without any improvement, when she came to the clinic November 8, 1893, complaining of pain in the abdomen, ineffectual urging to stool, with pain. Stool hard, dry and black; pain when urinating, passing only a little at a time, which is cloudy, depositing a white sediment; headache through the forehead and occiput; variable appetite; slept better toward morning, being awakened by bad dreams, which frightened her. Said she felt "tired and sick." There was present a greenish color of the skin; she appeared listless and apathetic; was nervous and irritable. *Nux vomica* was given in the sixth potency four times a day. She gradually improved until November 22. She was given *saccharum* for two weeks, when there was a return of the old symptoms, though not in so marked a degree. *Nux vomica* in the same potency was given and the symptoms disappeared. Was discharged January 4.

ACUTE DYSPEPTIC DIARRHŒA AND AN INHERITED TUBERCULAR DIATHESIS.—*Case 661.* Julia J., æt. three years. This child was brought to the clinic November 4, '93, suffering with an attack of acute dyspeptic diarrhœa. We learned that she had always been a delicate child, that her mother died of consumption when she was three months old, that two brothers and sisters had died in infancy, and only by homœopathic medication and the best of care had she been reared. She was very small, with pale, waxy complexion. The symptoms presented at the time were that she was having from six to eight movements a day; the stool was dark green mucus, sometimes watery, and frequently containing undigested particles. The first stool in the morning was brown, growing lighter toward evening.

There was prolapsus ani if she remained long at stool. The abdomen was bloated and the liver enlarged. She had been given calcarea, cham. and one or two other remedies by her father, who is a member of the class, without any appreciable benefit. We gave her merc. sol. 6 four times a day, which remedy was continued until November 25, when the stool was normal and she showed marked general improvement.

Attention was directed to the marked similarity between the conditions presented by these children and the symptoms of the calcarea salts. The inherited weakened vitality, malnutrition, enlarged liver, imperfect circulation, sensitiveness to the cold, and a nervous system easily thrown out of balance are all conditions met by calcarea carb.

It is our custom with such patients to use their constitutional remedy at intervals when they are in their best health to help them to outgrow and throw off their morbid inheritances. She was given calc. carb. 200 x, one powder each night for a week, then omitting a week to resume the remedy during the third week. This was continued until January 27, when it was reported that for two weeks there had been marked improvement, but now there was a return of the trouble. The stool was variable in color, sometimes yellow and watery, sometimes dark, but always containing undigested particles. She was having at this time five to six movements a day, but unaccompanied with straining. The father had been giving her mercurius, but there had been no improvement under its use. We decided that the symptoms indicated phos. acid, and it was prescribed in the sixth potency. She reported, February 10, improvement, stool being normal in color and but two movements a day, since which time she has not been in the clinic, but we have had occasional reports from the father that she is doing well.

THE SURGICAL CLINIC.

ABSTRACT OF REMARKS MADE BY PROF. SHEARS AT HIS CLINIC, HELD PRIOR TO THE CLOSE OF THE WINTER SESSION, 1893-04.

To-day closes our clinical work for the college year, and in review of the work that has been done in the general operative clinics, let me call your attention first to the fact that every hour has been occupied, even the day of the great snow storm, when all wise citizens remained at home,

two important operations were made before the remnant of a class that succeeded in wading through the great drifts. I am glad to say that I have been able to conduct these clinics personally, with but one exception, and although detained on that day by a case of strangulated hernia, did make my appearance, although somewhat tardily. During these twenty-six weeks of college life I have conducted twenty-six general operative surgical clinics, at which from one to three important operations have been made before the entire class. These include those upon

The Head.—Trephining for epilepsy, 3 cases; trephining for depressed fracture, 1 case; excision of meningeocele, 1 case; removal of cysts, 5 cases.

The Face.—Hare-lip, 2 cases; epithelioma of the lower lip, 2 cases; epithelioma of the nose, 1 case; nævi, 3 cases.

The Jaws.—Excision of upper jaw for sarcoma, 1 case; necrotomy (lower jaw), 1 case.

The Neck.—Extirpation of tubercular and sarcomatous glands, 3 cases.

The Shoulder.—Excision of head of the humerus, 1 case; sarcoma of shoulder, 1 case; axillary glands, removal, 3 cases.

The Trunk.—Breast, amputation of, 3 cases; hernia, radical cure, 4 cases; hydrocele, 2 cases; castration, 3 cases.

The Extremities.—Humerus, necrotomy, 2 cases; femur, necrotomy, 2 cases; tibia, necrotomy, 3 cases; feet, talipes, 4 cases, beside fractures and minor operations in different portions of the body.

During these twenty-six weeks I have also conducted twenty-six rectal and genito-urinary clinics, at which operations were made upon the penis for phymosis and epispadias; upon the urethra, for stricture by internal urethrotomy, by external urethrotomy, both with and without guide, by dilatation, gradual and forced; upon the scrotum, for hydrocele and varicocele by excision; for tubercular and sarcomatous testes, by castration; upon the bladder by incision, for the relief of stone, hypertrophied prostate, and fistulæ; on the inguinal canal, for undescended testicle; upon the kidney, for suppuration and hydronephrosis; upon the rectum, for hæmorrhoids, fissures, fistulæ, ulcers, irritable sphincter, and malignant disease. Beside these, other cases have been presented for diagnosis, prognosis and treatment.

These cases have not only been operated upon before

you, but every case has been reported upon, so that in every instance you have known of its progress, and have witnessed the result of the surgical procedure. It may interest you to know, and of this I am proud, that not a single case of sepsis, septicæmia, pyæmia, or erysipelas has occurred in any of the cases operated upon. There has not been a rise of temperature above 100° after the third day. Primary union has been the rule. Of all the cases operated upon in both clinics, but three have died; one, a little child operated upon for epilepsy in which an angiomatic condition of the meninges of the brain was found, died within twenty-four hours of shock. Another, a case of meningocele which threatened the life of the patient, died at the end of the third week from convulsions, which the operation at first relieved. The third was a little child born with a large sarcoma. This little one was only two weeks old, and was taken by the parents immediately after the operation, and against my expressed wish, to their home some five miles distant. The child reacted nicely from the operation, and I know of no good reason for its death except a lack of care.

Much of the credit for the good results obtained, especially in regard to the lack of sepsis, is due to the painstaking care, conscientious and skillful efforts of my assistant, Dr. Culver. The preparation of the patient before the operation, and the dressings after, have been made by him. I have nothing but praise for him. I could ask for no better work.

 CORRESPONDENCE.

 A FINAL ARGUMENT ON THE PROTECTIVE POWER OF
 VACCINATION.

We gladly give place to the following letter addressed to an esteemed colleague.—ED.

E. LAS VEGAS, N. M., March 3, 1894.

PROF. J. E. GILMAN, M. D.,

Dear Doctor:—I was very much interested in the paper of Prof. A. K. Crawford, contained in the February CANIQUE, on the pros and cons of vaccination, and in your remarks in the discussion before the Clinical Society. I went through an epidemic of smallpox in this territory in 1877. At that time Las Vegas had a population of about 3,000, of which number about 400 were Americans,

the balance Mexicans. An old school physician and myself treated about 500 cases. With one exception they were all Mexicans who had not been vaccinated. We visited these patients every day for about ten weeks. We would find from three to a half dozen in small, poorly ventilated rooms, in all stages of the disease. Neither of us contracted the disease, although constantly exposed; our only protection being vaccination, which we performed on each other every few days. I had a well-defined scar on my arm which was the result of vaccination twenty-four years before. None of the vaccinations "took" with me during this epidemic, save to produce a slight itching. We vaccinated all of the Americans in the town, and associated with them constantly; and the only American who had the disease was a filthy fellow who had not been and would not be vaccinated.

The natives were on the streets constantly, in all stages of desquamation. The large majority of the afflicted ones died from lack of proper care. Sometimes during the height of the fever they would jump into cold water and thus hasten the inevitable result. The uncoffined dead bodies were carried through the streets all hours of the day. Not the slightest care was taken by the Americans to prevent contagion save as mentioned. Of course, we doctors did not see or hear of nearly all of the cases, but I think that eight out of ten of the unvaccinated Mexicans who had not previously had the disease had attacks more or less severe during this epidemic. Quite a number of the better class of them were vaccinated previous to or during the epidemic.

With the experience in this epidemic of almost all of the non-vaccinated coming down with the disease, and none of the vaccinated, who were equally exposed, I have but very little patience with a doctor of any experience, *much less a medical teacher who denies the efficacy of vaccination*. I firmly believe that vaccination throughout the world in early childhood, renewed from time to time, would make this disease for our successors in the practice of medicine simply a disease of the text-books; and any physician of the least experience in this disease who will deny vaccination would, in my opinion, like Peter of old, deny Christ before the cock had a chance to crow. I am a graduate of the "old Hahnemann" class of 1870. I met you some two or three weeks ago while visiting the college.

Very truly,

J. M. CUNNINGHAM.

Commencement Exercises

OF THE HAHNEMANN MEDICAL COLLEGE
AND HOSPITAL—SESSION 1893-'94.

The Thirty-fourth Annual Commencement Exercises of the "Old Hahnemann" were held in the Grand Opera House, Chicago, at 2 P. M., on Thursday, April 5, 1894. A large and thoroughly appreciative audience was present and the occasion was enlivened by the most delightful music. The programme was in charge of Prof. Dunn, who varied the scenes with his accustomed vigor and despatch.

THE ANNUAL REPORT OF THE REGISTRAR.

By PROF. JOSEPH P. COBB, M. D.

Mr. President and Gentlemen of the Honorable Board of Trustees: The thirty-fourth annual course of lectures in Hahnemann Medical College and Hospital has been completed in all its details. It is my pleasant duty to present you the report of the year's work and to recommend to your favorable consideration the applicants for the degree of doctor of medicine.

The class here presented to you, numbering fifty-four, has each and every one completed the full legal requirements of the State of Illinois. They have pursued the study of medicine for four years; they have attended three full courses of lectures of six months each; they have had two years hospital instruction; they have been thoroughly drilled in the elements of the sciences which constitute the foundation for the professional career that they have elected. During each week of their college courses they attended seventeen didactic lectures and twenty-three clinics and sub-clinics. Three times they have submitted to a searching annual examination with credit to themselves.

The college year just closed is the first in the history of the new college building, and it is fitting at this time to make some mention of the increased facilities thus afforded the institution. The three large comfortable lecture rooms have

been in daily use for the three different courses of lectures; the dispensary and its four sub-clinic rooms have furnished clinical instruction, with over 1,000 different patients each month as object lessons; the laboratories have been found admirably arranged and the extensive equipment with which they have been furnished has been intelligently and instructively employed. The increased facilities have necessitated many additions to the teaching staff, thus broadening out the scope of the instruction given. With this broadening there has been a coincident elevation in the standard to be attained. The standard demanded by this institution, not exceeded by any medical college in America, has been attained by the members of this class with credit to themselves.

The Hahnemann Hospital, supported by this institution, has been crowded to its fullest extent during the entire year. The bedside teaching thus afforded has, as heretofore in this college, been a valuable part of the instruction given this class. With the new and spacious hospital now completed, which you propose to place at our disposal, the advantages afforded for clinical instruction will be unequaled by any of those of our sister colleges. The erection of this magnificent monument to homœopathy at an expense of nearly \$100,000, during a period of financial distress that has paralyzed the business of the world, is an evidence, gentlemen of the board of trustees, of your zeal and coöperation, and a substantial endorsement by the friends of our faith.

There have been in attendance on this course of lectures 250 students, men and women, registering from nearly every State in this fair land, from Massachusetts in the East, to California in the West. The prospects for the next year's class were never more flattering in the history of the institution.

I have the pleasure of requesting the following named students to take the place assigned them on this platform, that they may receive from your hands, Mr. President, their coveted and merited degree of Doctor of Medicine and Surgery:

LIST OF GRADUATES.

SESSION OF 1893-94.

ALMOND, ELIZABETH A.,	.	.	.	Iowa.
ANDERSON, PHEBE	.	.	.	Kansas.

BOVEE, RICHARD WILBER	Nebraska.
BOYER, WM. R.,	Nebraska.
CARTER, ROBERT LINDSEY,	Massachusetts.
CARPENTER, FRANK S.,	New York.
CLAPP, KATHERINE B.,	Illinois.
CLARK, J. MARTIN,	Kansas.
COBURN, JOHN,	Washington.
COLE, H. TRAVERS,	Michigan.
CORPE, SEYMOUR L.	Oregon.
COTTON, WILLIAM DODGE,	New York.
DAKE, ALFRED JUSTIN,	Wisconsin.
DEWING, WILLIAM H.,	Illinois.
EMMONS, C. ARTHUR,	Illinois.
FOSTER, MARTIN D., <i>ad eundem</i> ,	Illinois.
HENRY, ROBINA NICHOLSON,	Canada.
HENDERSON, BURTON W.,	Pennsylvania.
HERRMANN, CHRISTIAN ANDREW,	Illinois.
HIGBEE, FRANK OSCAR,	Minnesota.
HILL, EMILY L.,	New York.
HOBART, AUSTIN WALTER,	Maine.
HOPKINS, MINNIE M.,	Illinois.
HOUSTON, GRANT,	Illinois.
HOYT, MARY OSBORN,	Iowa.
JACKSON, HARRIET M.,	Kansas.
KAHLKE, CHARLES E.,	Illinois.
KENYON, FRANCES A.,	Rhode Island.
LAMKE, MARION E.,	Illinois.
LOCKWOOD, WILLIAM FRANKLIN,	Indiana.
LUFF, EMILY MERRITT,	Illinois.
MAAS, ELIZABETH C.,	Wisconsin.
MACCRACKEN, S. GORDON,	Illinois.
MINER, JAMES B.,	Illinois.
MONTGOMERY, ROBERT CLINTON	Wisconsin.
MORGAN, ADA B.,	Iowa.
OWEN, M. G.,	Nebraska.
PALMBERG, ROSA W.,	Illinois.
PEAKE, FRANCIS,	New York.
RIDDLE, MARY ADELINE,	Washington.

ROWLEY, GRACE ALFARETTA,	Indiana.
RYAN, MATTHEW MAURICE,	New York.
SAGER, LOUISA AUGUSTA,	Ohio.
SATTERLEE, LOUIS W.,	Illinois.
SHEPHERD, LUCY M.,	Maine.
SCHMITZ, ELSIE R.,	Wisconsin.
SMITH, MARIE W.,	Illinois.
SMITH, SAMUEL GILBERT,	Wisconsin.
WALCUTT, SHERMAN,	Ohio.
WILSON, ANNA LOUISA,	Indiana.
WISE, WILLIAM C.,	Illinois.
WOODS, HERBERT, CARLTON,	Iowa.
WORTHEN, CHARLES WESLEY, <i>ad eundem</i> ,	Vermont.
WRIGHT, MARY JANE,	Connecticut.

THE CONFERRING OF THE DEGREE.

BY PROF. R. LUDLAM, M. D., PRESIDENT.

The members of the Graduating Class having been called upon the platform by the Registrar, amid the applause of their friends and fellow students and of the delighted audience, the President, in a few fitly chosen words, conferred the degree of Doctor of Medicine and Surgery upon each and all of them. This impressive ceremony was followed by the

ADDRESS TO THE GRADUATING CLASS—SOME UNCONFERRED CREDENTIALS.

BY REV. REESE B. KESTER, OF CHICAGO.

Among the ancient Rabbins when students were admitted to interpret the law, it was the custom to impose upon them the keys as the symbol of power and authority. Something like this venerable custom is to be observed to-day. A large class of men and women having completed the prescribed course of medical study, the faculty of your alma mater propose to commit to you the keys of power and authority by conferring the degree, Doctor of Medicine and Surgery.

This conferred credential bespeaks a most honorable significance. It is not bestowed *causa honoris*, but for work done. It signifies not only certain attainments in

liberal arts, but also research in various sciences. While it signifies no cult, it does represent, at least, the reputation of high character.

This conferred degree is also an introduction into a profession which in its membership probably comprehends more men of broad learning and true scientific merit than the professions of either theology or law. Cabanis, the physician of Condorcet and Mirabeau cannot be far from the truth when he asserted that medicine is the first of the arts, and the profession of physic one of the first of professions.

And again, the degree Doctor of Medicine is an introduction to all our homes and invests the bearer with privilege to practice his art upon any patient, no matter how serious his malady. Certainly, the recipient of such power and authority is worthy of high honor and deserves congratulation.

But the degree Doctor of Medicine is, after all, largely a legal requirement. It may be only a symbol and no more.

It is a variable quantity. It may be nothing more than a passport. Once having obtained the degree from an authorized faculty, the person whom it adorns may forsake his study, pervert his good morals and even be ostracized from the medical fraternity but he still possesses his degree.

There are, however, some credentials that cannot be conferred by universities. They are the qualities that exist by the nature of things and are wrought out by the man himself. One of these unconferrred credentials is that the doctor of medicine is a doctor of mercy. When I speak of the doctor of medicine as a doctor of mercy, I mean something more than that the physician is born to alleviate pain and heal disease.

The doctor of mercy is a minister of one of the sovereign attributes in physical government. Our mortal race is common with all creatures is born under the domain of law. That law, though unwritten, is solemn, exact, earnest and impartial. For obedience it yields unspeakable rewards and for infraction enforces the most deplorable consequences. There is in physical economy a department of justice quite as rigorous as in both civil and moral government. When we behold disease, there is surprise that it should be permitted to exist. When we learn, however, that "ignorance of the law is no excuse" surprise heightens to a feeling of injustice. But when we see disease actually

transmitted from generation to generation, we feel something akin to rebellion.

If it were possible for our commonwealth to vote that an intemperate man should not suffer delirium, would we not at once vote away his possible woe? But the Sovereign Power has written in the very nature of nerve and tissue that babbling and sorrow and redness of eyes shall be to the drunkard. In this unwritten code there is nothing so sentimental as we might conjure.

Could this commonwealth vote that inebriety should not entail upon the drunkard's child unto the third and fourth generation, would we not immediately disfranchise the terrible heritage? But the Sovereign Power is not so unwise in legal enactments as we would be; or as (Joseph Cook, "Heredity,") one of our own philosophers has said, "The supreme powers have enacted such laws and executed them every time, and have not made an apology for six thousand years."

The evil consequences following the infraction of natural law may seem too stern and often quite out of proportion to the offense committed. But when it obtains that the fear of suffering and disease which the law begets produces reverence for physical commandments, then these so-called evils become solemn vigils for the protection of health, and compels us to admit that the law is good and justice one of its glories. Offense against this law transforms this world into a lazer house, such as Milton saw when

"Diseases dire, a monstrous crew"

* * * * in a place

"A lazer house it seemed wherein were laid
Numbers of all diseased, all maledict
Of ghastly spasm, or racking torture, qualms
Of heartsick agony; all feverous kinds
Convulsions, epilepsies, fierce catarrhs,
Intestine stone, and ulcer, colic pangs,
Demoniac frenzy, moping melancholy
And moonstruck madness, pining atrophy
Marasmus and wide wasting pestilence,
Dropsies and asthmas, and joint racking rheums,
Dire was the tossing, deep the groans; despair
Tended the sick, busiest from couch to couch,
And over them triumphant Death his dart
Shook, but delayed to strike, though oft invoked
With vows, as their chief good and final hope."

Surely such dire sorrow can but stir the most hardened. Were there no relief from such conditions, or the possibility of such conditions we might all curse our natal day.

But there is relief. A kind Providence has mercy as

well as justice. In the body itself is the strength of nature to heal itself, and in addition to this comes the skillful physician as a minister of mercy not to defeat justice but to avert its actual and possible consequences. I say possible consequences, for the doctor of mercy heals not only the malady of the present day, but he furnishes also compensation for the law that transmits disease from generation to generation.

“Oliver W. Holmes remarks that ‘most people think that any difficulty of a physical sort can be cured if a physician is called early enough.’ ‘Yes,’ he replies, ‘but early enough commonly means two hundred years in advance.’”

When the Son of Man was upon earth He was such a Doctor of mercy that he healed physical infirmities, frequently by use of natural means. He proposed that men should have restored bodies as well as restored health, and thereby appears to have foreshadowed that large mercy which shall prevail when medicine shall celebrate its highest triumphs. It is morning in medicine yet, but who can tell but that your art may help to usher in the day when once more even our mortal bodies shall rejoice in their complete perfection.

2. Another unconferrred credential is that the doctor of medicine is a doctor of morals. In introducing the moral element of medicine, let me assure you that I do not deem this the time nor place to deliver moral advice. Neither shall I proclaim that the doctor of medicine shall assume the functions of a priest or minister. Time has been when these offices met in one person but that does not prevail among us. By the moral element in medicine I mean that which more than all else dignifies and ennobles the medical profession. This moral element arises from the very nature of the profession itself.

It is said in common parlance that “man has a soul,” but that is a pernicious misstatement. A better statement is “man is a soul and has a body.” Now, it is the body with soul in it that affords field for the practice of medicine.

But the nobility of the physician depends in a large measure upon his conception of this compact of flesh and bone and soul. To some of us many physicians seem to see only the body. But the body is more than refined clay, more than a magnificent but delicate temple. The physician who cares for its nerves is vastly more than an artisan caring for wires and batteries. The eye and ear

specialist has a nobler craft than a mere glazier or a tuner of strings or reeds. Veins are something better than sewers and arteries are diviner than aqueducts.

It was a doctor ecclesiæ (Chrysostom) who in a moment of high thought kissed the breast of a little child and said "Thou art a temple of the Holy Spirit." It is the body with spirit in it that elevates your profession to its exalted eminence.

While a veterinary doctor has a most humane and therefore noble profession yet it is scarcely worthy to be compared with profession of medicine. Yet both professions deal with nerve and delicate tissue.

Wherein lies the difference of these two professions? Is it because that nerves of men are more sensitive than of lower animals? Is not the hearing of the fox more acute than the hunter's? Is it because man has greater intelligence? By the same reasoning, the physician of Cuvier, the scientist, was worthy of greater honor than the physician of Cuvier the babe in the cradle. The chief distinguishing feature of man is that he is a moral being, therefore you are to practice your art upon the very highest order of created beings. And it is because the subject of your skill is a moral being that I introduce the moral element. It arises out of the nature of the moral being with whom the physician comes in contact. Such a conception of the exalted dignity of the very body must be a determining factor in the building up of the greatest physician. The fact that his patient is such a being must often settle how many hours of sleep he will lose, how many miles he will travel, how many dangers of storm, flood, battle or pestilence he shall face. This must help him to settle who shall receive his attentions, whether he shall respond to calls from the mansion or hovel with equal affection, whether he is a physician for revenue only or to relieve the suffering and distressed.

Thus far I have spoken of the moral element of medicine as the chief characteristic that exalts the medical profession, but that is only one phase of it. The other phase pertains to the physician himself. It would be akin to affectation for me to give these graduates ethical maxims, for very soon they will have the greatest teacher in morals that has ever spoken, save One, viz., the *moral condition* which you shall discover in actual practice. There will be patients whose vile bodies will portray their moral depravity. They will be no more "express and admirable," but as

Ruskin sees them, with "a terrible stamp of various degradation, features seamed with sickness, dimmed by sensuality, convulsed by passion, pinched by poverty, shadowed by sorrow, branded with remorse, bodies consumed by sloth, * * * tortured by disease, dishonored in foul uses, intellects without power, hearts without hope, minds earthly and devilish and bones full of the sin of youth."

Such is the physical wreck that depraved morals consummate. In such presence you will feel, if pure yourself, that you are in the "hateful cage of unclean birds." But there is another sick chamber. There the physician shall find disease waging heroic war. The patient burns in the fire of his fever, or his body bends and almost breaks in his wild anguish, and yet upon his features there abides a halo of calm peace, his face is bathed in victor light, and the pale hands signal conquest, and while you behold the thought is irresistible, "surely this is the pure in heart."

Between these extremes is the physician's theatre for observation in morals. In effect, it is like another revelation of law.

With all reverence for inspiration, let me assert that such moral instruction as you shall behold, becomes for the physician quite as authoritative as commands from smoking Sinai. When the physician beholds the evil base morals work, and the triumph of the pure heart over physical infirmity, there is only one thing for any wise man to do, and that is to settle what manner of man he himself shall be.

There can be no better place for high character than in the doctor of medicine, for the physician becomes to his patients and their families, a friend, adviser and brother. When by the very conditions of disease, education or prejudice the priest or minister is barred out, then the physician, who is also a practitioner of morals, has golden opportunity for moral conquest. Certainly, in view of the nature of his profession, and his position in society, high morals become an obligations to him who would be the greatest physician. Lastly, the doctor of medicine is a doctor of mental progression. When Asklepios lay a helpless babe in the arms of Koronis, Apollo said, "He is born to do great things; bid Cheiron train the boy in all wisdom." It is joyful that Apollo speaks to-day to the sons of Asklepios with more earnestness and authority than he did to Asklepios himself. It is with infinite pleasure that

the laity behold the rapid strides that are being made in the medical profession.

Medicine has advanced a great distance even since Colonial days. While the Pilgrims were landing at Plymouth Rock, the doctors of our Saxon ancestors were practicing leechdom, star-craft and wort cunning and it was a boon to be the seventh son of the seventh son. The profession is not done yet with superstition and fanaticism, the quack and charlatan, but the new heavens and new earth of medicine seem rapidly to be appearing among men.

As the requirements take firmer root, physicians will the more depend upon the gray matter of the cerebrum than the gray or perhaps yellow matter of their parchments.

That these young physicians may become doctors of mental progression they may be congratulated that some at least will not be cursed at first by a large practice. A young physician ought to thank Providence if at first he is not buried in actual practice. Astley Cooper said, "all physicians are liable to make mistakes, but he is the best who makes fewest," and we may add that that physician makes fewest mistakes who takes sufficient years to develop the medical logical mind, for it is the logical mind in medicine which compels men to say even of very young physicians, what Bellario did of Portia: "I never knew so old a head on so young a body." As the medical profession shall advance in mental progression, medical intolerance shall disappear. Men who differ will not so quickly cry "heresy," and "delusion." They will not so readily excommunicate those who cannot pronounce their special medical shibboleths. We are learning that revelation in medicine as well as in religion is progressive, so that it doth not yet appear what medicine shall be, but the wise physician works on patiently and humbly, seeking the truth, as Dr. Fautus says, "For truth's own sake."

When Michael Angelo completed his "Moses" in marble, the statue seemed so complete in its perfections that the master smote the image upon the thigh and said, "Speak, thou canst." And now that this class have completed their tasks, they are about to receive their commission not alone to speak but to act. Their visible marks will be the parchment, bearing their degree, Doctor of Medicine and Surgery. In one respect the whole class are equals in that they all receive the same conferred credential. A

credential is a thing that produces confidence. But that parchment will be of little value, save in obtaining the State license. Unless the degree is a part of the man himself, the great world will soon recognize the sham.

The real thing, doctor of medicine, cannot be put on parchment. It is the possession of the soul. That is why members of the same class sometimes separate by magnificent distances. Not the shadow, but the substance will produce confidence. As the members of the class go forth bearing in yourselves those invisible but inwrought credentials, the real doctor of medicine, who is more than master of scalpel and materia medica, and who presents also those nobler credentials of mercy, morals and mental progression, then shall the sick, the lame, and the blind exclaim with one voice, "Thou art worthy."

THE PRESENTATION OF THE PRIZES.

BY PROF. H. B. FELLOWS, DEAN OF THE FACULTY.

After a very felicitous little speech Prof. Fellows announced the following prizes: The first, or Trustee's prize, for the best general examination in all the branches taught in the College and Hospital, \$50 in gold, was awarded to Emily L. Hill, of New York; the second, or Faculty prize, of \$25 in gold, for the second best general examination fell to Charles E. Kahlke, of Illinois. Honorable mention was also made of the very excellent examinations of Robert C. Montgomery, of Wisconsin, Mary O. Hoyt, of Iowa, M. G. Owen, of Nebraska, Phebe Anderson, of Kansas, Harriet M. Jackson, of Kansas, and R. W. Palmberg, of Illinois.

Prof. Shears' prize for the best report of the operative surgical clinic held each Monday, was given to Katherine B. Clapp, of Illinois; and his prize for the best report of his Wednesday clinic with operations in genito-urinary and rectal surgery was awarded to Mary Osborn Hoyt, of Iowa. The inability of the committee to whom these reports were submitted to reach a unanimous conclusion led Prof. Shears to also award a prize to Frank O. Higbie, of Minnesota, for his excellent report of the Wednesday surgical clinic.

The McIntosh prize of an office switch-board fell to Katherine B. Clapp, of Illinois.

Hospital Physicians and Surgeons. The appointments of internes for the Hahnemann Hospital for the ensuing year were then announced as follows: To go on duty April 6, as House Physician, Dr. J. M. Clark, of Kansas; House Surgeon, Dr. M. G. Owen, of Nebraska. To go on duty October 1, 1894, as House Physician, Dr. Elizabeth C. Maas, of Wisconsin; House Surgeon, Dr. Francis Peake, of New York.

THE RECEPTION AND BANQUET.

The reception and banquet given by the faculty and the alumni was held in the beautiful parlors and the famous banqueting hall of the Auditorium Hotel, where the guests to the number of two hundred spent a most delightful evening. The scene and the occasion were quite in keeping with the best traditions of the "Old Hahnemann" when its boys and girls are out for a holiday. The music was charming, and the flow of wit and eloquence elicited by Prof. Bruce as toast-master bubbled and sparkled like that which came forth when another famous old chemist smote Mount Horeb. Following is a list of those who did themselves and the college credit, each in his own particular way, the general sentiment being:

OUR COLLEGE AND OUR HOSPITAL.

OUR TRUSTEES. - - - In response to which
an eloquent letter was read from *Hon. E. M. Phelps.*

OUR ALUMNI. - - - *Prof. H. V. Halbert, M. D.*

OUR FRIENDS. - - -
*Dr. C. G. Higbee, of St. Paul, Dr. G. W.
Carlson, of Milwaukee, Dr. J. E. Sawyer, of St. Paul.*

OUR GIRLS OF '94. - *Mrs. Katherine B. Clapp, M. D.*

OUR HOSPITAL. - - *Prof. Geo. F. Shears, M. D.*

OUR COLLEGE. - - - *Prof. J. P. Cobb, M. D.*

OUR BOYS OF '94. - - - *H. F. Cole, M. D.*

OUR FACULTY. - - - *Prof. C. H. Vilas, M. D.*

OUR ORGAN. - - - *The Editor of the CLINIQUE.*

Miscellaneous Items.

The report of the Eleventh Annual Meeting of the Alumni Association of the "Old Hahnemann," which was by far its biggest and best, is unfortunately crowded out of this issue; but it will appear next month.—A medical college in the East is certified to have "A historical laboratory, supplied with excellent microscopes."—The *Pulse* for March furnishes an excellent portrait of Prof. Gilman.—The "eyes have it," for Prof. Watry is to be married, April 18, after which he will make another visit to Europe.—Our jolly good friend, Dr. Geo. A. Ordway, '93, is City Physician at Hingham, Mass.—The N. I. and S. M. Homœopathic Medical Association meets at Elkhart, Ind., May 3, and the Kentucky Homœopathic Medical Society at Lexington, May 15-17.—The twin cause of Sanitary Science and Medical Education has received a serious check in the death of our old friend and co-worker, Dr. John H. Rauch.—The Ward's Island Homœopathic Hospital, of New York, has been removed to Blackwell's Island, with much larger quarters, and will henceforth be known as the Metropolitan Hospital.—The Clinics are as full and interesting as ever since the Winter Session closed, and our visiting friends will do well to look in upon them.—Among the new books upon our table awaiting review are: A Complete Repertory of the Tissue Remedies of Schüssler, by Dr. S. F. Shannon, of Denver, Colo.; A Text-book of the Diseases of Women, by Dr. H. J. Garrigues, and a Text-book of Gynæcology, by Dr. Jas. C. Wood; Kelsey's Diseases of the Rectum and Anus, and Bouchard's Lectures on Auto-intoxication in Disease.—Everybody is going to Denver in June to celebrate the semi-centennial of the American Institute of Homeopathy.—Prof. Dunn will report on Diseases of the Nose and

Throat at the next meeting of the Clinical Society, April 28. —Prof. Cobb furnishes an additional report of Alumni subscriptions to the Hahnemann Medical College and Hospital to April 1, as follows: Amount already reported, \$3,816.60; Dr. W. H. Woodbury, '66, (add. subs.) Chicago, \$25; Dr. C. F. Perlewitz, '78, Ahnape, Wis., \$5; Dr. G. W. A. Collard, '80, (add. subs.) Bridgeport, Conn., \$10; Dr. C. A. Emmons, '94, Chicago, \$60; Dr. W. S. Harvey, '83, Chicago, \$100; Dr. Emily S. Hill, '94, Gloversville, N. Y., \$5; Dr. Louetta Wendover, '94, Ithaca, N. Y., \$200; Dr. W. D. Cotton, '94, Clifton Springs, N. Y., \$50; Dr. F. S. Carpenter, '94, Berwyn, Ill., \$5; Dr. Francis Peake, '94, Walton, N. Y., \$10; Dr. R. L. Carter, '94, W. Bedford, Mass., \$100; Dr. B. W. Henderson, '94, Henderson, Pa., \$10; Total subscribed to date, \$4,366.60. —*Apropos* of this item we are happy to state that a much larger number of non-resident alumni were present on the Commencement occasion than ever before: that they and all hands enjoyed it greatly goes without saying. —An appreciative and esteemed subscriber in the Jubilee City (Denver) writes: "I want to say that the CLINIQUE is the most welcome journal that comes to my office, and is read with the greatest interest and profit." —Prof. Shears' clinic continues to be very full and practical. April 7, he operated before the class on a rare case of appendicitis, which is getting well.

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CHICAGO, MAY 15, 1894.

[No. 5.

Original Lectures.

DISEASES OF THE LIDS.

A CLINICAL LECTURE BY C. H. VILAS, A. M., M. D., SENIOR PROFESSOR OF DISEASES OF THE EYE AND THE EAR IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

Before demonstrating the diseases of the lids, a glance at the anatomy will refresh our knowledge of this important matter. A thin skin overlies the subcutaneous areolar connective tissue, in which is imbedded the orbicularis palpebrarum, the sphincter muscle of the lid. Continuing from without inward, underneath the sphincter lies the tarsus, which stiffens the lid and maintains its shape. The tarsus is a dense plate of connective tissue about one inch in length, that of the upper lid about one-half of an inch in width, and the lower only about one-quarter of an inch, and is fastened to the margin of the orbit by the palpebral ligament, a thin, strong aponeurosis adherent to the border, which is curved so as to form the segment of a sphere. Attached to the upper edge of the upper tarsal cartilage is a strong muscle, the levator palpebræ superioris, which by a broadly expanded tendon secures an even and firm hold. Firmly attached to the inner sides of the tarsal cartilages is the conjunctiva; imbedded in them are from twenty to forty glands known as the Meibomian, the upper carti-

lage having about one-third more in number than the lower. These glands have openings by numerous ducts on the inner side of the margin of the lids, by which they discharge an oleaginous, sticky fluid.

From the outer margin of the lids the cilia, or eye-lashes, project in a curved manner; those of the upper lid longer than the lower, the former about three-eighths to one-half an inch in length, and more numerous than those of the lower, which are only about one-half the length of the upper, though variable as to this and the number of rows.

The duct of a small sebaceous gland opens into each hair follicle, the latter penetrating deeply into the lid, and back of which lie the openings of the glands of Moll, minute affairs.

The orbicularis palpebrarum arises from the inner tarsal ligament, runs outward in a curved direction, some fibres passing beneath and over the lachrymal sac, and becomes inserted in part in the external tarsal ligament.

Branches from the ophthalmic division of the internal carotid supply the larger part of the blood for the lids, the naso-frontal and lachrymal running outward into the substance of the lid at the internal and external canthi, forming the inferior and superior arteries of the margins of the lids; but the facial from the external carotid furnishes a portion to the deeper parts as well as to the skin.

The facial nerve sends motor branches to the orbicularis palpebrarum; the third cranial, or motor oculi, supplies the levator palpebrarum superioris.

It will thus be seen that the lids are richly supplied with blood, a fact that should be borne in mind, or you will be surprised when you come to operate upon them. Even operations apparently trivial will try your skill and nerve unless you are fully prepared to meet the strong and persistent flow of blood when incisions are made.

Time being precious I must before considering the distinctive diseases and at the outset make a very comprehensive statement ever to be borne in mind. This is that the lids are subject to the same deformities, injuries and

diseases as other parts of the general system similarly composed. By these I mean wounds, burns, eczema, œdema, emphysema, paralysis, phlegmonous and erysipelalous inflammations, malignant growths, syphilitic ulcerations, etc. Into their treatment I cannot now enter, nor should it be essential to more than remark that the same treatment deemed effectual for these troubles when they are found elsewhere, modified by good judgment and the limited area presented, will prove efficacious.

The edges of the lids are especially liable to inflammation, usually associated with more or less conjunctivitis, a condition called marginal blepharitis. The edges of the lids are first hyperæmic, then swell and become smooth and glossy. Fine scabs form in the reddened margins, or else scabs conceal ulcerations; the lashes become matted together, fall out, and if replaced, are apt to be stunted and ill-formed. The glands may also become involved, forming blepharadenitis; the edges become hardened, a condition named tylosis, or the lashes being shed create an unsightly baldness called madarosis.

When blepharitis is due to ametropia the refraction should first be corrected; when due to disease, cleanliness is an excellent remedy, and to that end the matted lashes should be separated, and the scabs carefully soaked and sopped away with a solution of soda (five grains to the ounce of distilled water) and cold cream or simple cerate applied. Should the disease be persistent, graphites ointment (three or four grains to the ounce of vaseline) may be used. The other troubles yield to the cure of this disease. Belladonna, silicea, calcarea carbonica and graphites will be found very valuable internal remedies, but care should always be taken to ascertain that no local irritation such as pediculi, fungi, etc., is the origin of the disease before trusting to local or internal remedies.

Styes, technically hordeola, are a painful, localized swelling, which appear on the margin of the lid, and eventually form pustules. They may appear singly or in groups, and are generally due to some derangement of the general

health, though the effect of eye-strain should always be borne in mind.

The earliest symptom is a deep pain at the lid margin, proceeding from a swelling of a deep red color, the pain increasing with the swelling, and being accompanied by lachrymation, often some photophobia, and an inclination to disuse of the eyes. Pus forms in three or four days, the sty ruptures, pain ceases and resolution sets in.

If seen in time, pulsatilla or staphysagria will shorten their duration or abort them; if not, their removal is greatly accelerated by these remedies. Attention to the general health is often necessary to prevent their recurrence.

The term chalazion, or tarsal cyst, is applied to a small tumor caused by the obstruction of the orifice of a Meibomian gland, and sequent retention of the secretion, though some regard it as an aborted hordeolum, whence its common name of blind sty. It appears as a small elevation or tumor in the cartilage about the size of a pea, raising the skin above it. Entirely benign, it fills with a gelatinous material and by the inflammatory action may involve the connective tissue of the lid, or passing into a state in which its contents are converted into or replaced by this tissue, form a fibrous tumor.

While yet soft it may be removed by gentle evacuation through the natural channel, or if necessary, by puncture or incision; but growing hard or becoming firmly seated, the lid should be everted and a crucial incision made over the discolored spot. The cyst should then be thoroughly evacuated and its walls scraped with a curette, or touched with a mild caustic. The sac fills with blood so rapidly after this little operation that some considerable time usually elapses ere the tumor is reduced. The pain is alleviated and the free bleeding somewhat restrained by the local use of a solution of cocaine, but a specially designed clamp is generally used to prevent the blood obstructing the view of the operator.

A very similar tumor sometimes appears, but is easily distinguished from a chalazion by the fact that it causes no

discoloration of the under surface of the lid, and is freely movable over the cartilage, while a chalazion is not. This tumor should be removed from the dermoid surface, and by a linear incision parallel to the margin of the lid, care being taken that none of the fibres of the muscles be involved lest the lid droop as a result.

A little white tumor about the size of the head of a pin also appears in the skin, caused by the retention of the secretion of the sebaceous glands. The only other one which is likely to be met with, and which demands incision, is a molluscum, an angry looking umbilicated tumor about the size of a split pea.

Ptosis is either a drooping, or an inability to raise the upper lid. It may be caused by a congenital or acquired paresis or paralysis of the nerve supplying it, by a deficiency of the muscle controlling it, or by any adventitious substance in the lid itself, such as thickening from excessive granulation, etc. It is not infrequently congenital, and syphilis is often an important factor in its production.

When produced by the first mentioned cause, electricity and stimulants may benefit it, though rarely; the second cause is incurable but may be benefited by an operation hereafter mentioned; the third requires a careful diagnosis and an intelligent removal of the exciting cause. In case of excessive granulations they should be removed by the rules I have laid down under that complaint and the muscle toned up. Should a tumor be present, it must be removed; as must be done should any similar cause obstruct. But when all other remedies have failed, or such expedients as holding the lid up by a strip of diachylon plaster, or by a concealed suture, have become unsatisfactory, they are often all sufficient and are easily available, a radical operation may be performed by clamping a suitable piece of the skin of the lid in a crescentic forceps devised for this purpose, incising it, and securing the edges of the elliptical wound created by sutures. This eventually permits of a well formed cicatrix, brings the lid under the control of the frontalis muscle, and a result will be at-

tained proportionate to the judgment and experience of the operator and the availability of the latter muscle to the purpose. While the ptosis is mild and but a symptom of some disease, it will readily yield to the cure of such disease by an appropriate internal remedy. Thus alumina removes it when due to loss of power in old cases of granulation, while gelsemium is the remedy when due to a loss of power in the levator muscle. Rhus tox. and conium are also good remedies under characteristic indications, but all these remedies are usually powerless alone in severe cases.

When it is impossible to close the eye completely, there is a condition known as lagophthalmus. Usually this condition is the result of paralysis of that portion of the facial nerve which supplies the orbicularis palpebrarum muscle. Displacement or bulging forward of the eyeball, as in aggravated cases of exophthalmic goitre, may cause it, and it may also be produced by injuries which cause cicatrices involving the lids.

When lagophthalmus is due to a paresis or paralysis of the seventh nerve internal remedies are often potent. In all muscular troubles wherever located electricity is constantly recommended. I have used it for many years, and unhesitatingly place it second to the correct internal remedy.

Gelsemium, argentum nitricum, and aurum metallicum are among the best. Agaricus and physostigma venenosum are also very effective, and bryonia must not be forgotten. Starting with these, a careful search cannot be unavailing.

The treatment may be very simple, the cause of the exophthalmus being removed, or it may involve a plastic operation of the face to free the skin and tissues from a grasping cicatrix. Tarsorrhaphy may be demanded, and consists in narrowing the palpebral fissure by removing the skin from the edge of each lid near the outer canthus, and sewing them together. The resulting cicatrix firmly binds them.

Sometimes this latter condition for which we are striving is brought about by accident and is then designated as anchyloblepharon. It is usually only partial, and the remedy is obviously to separate the lids surgically.

But a far more serious condition is known as symblepharon, and constitutes one of the most troublesome conditions with which the operator has to deal. This condition is brought about by a union of the palpebral with the ocular conjunctiva, and is generally caused by strings or bands of cicatricial tissue resultant from burns by acids, lime, metals or fats. Disagreeable deformities or impaired mobility of the eyeball calls for the removal of the symblepharon by operation. The eye ball is much hindered, and its usefulness impaired by the harassing and not to be overcome tendency of the cicatricial bands to form over and over again after being operated on. All sorts of devices to prevent this, such as inserting glass and porcelain shields, and either wearing them continuously or sewing them into the wound, have been tried and discarded as failures. The best that can often be done is disappointing, but all plainly separate bands, if dragging, should be divided, and a systematic and careful attempt made to remove the most serious adhesions, and cover the resulting wounds with conjunctiva from the rabbit, which should be carefully transplanted from the living animal under the strictest antiseptic conditions.

Trichiasis is a turning in or distortion of the lashes, which stops short of an inversion of the lids, whence the lashes rub against the delicate surface of the eyeball. Distichiasis is the term applied to a similar affection where there are double rows of distorted lashes.

Many ways of a remedial nature have been suggested for the relief of this always annoying and sometimes serious affection, the object always being to turn the lashes into their normal position so as to keep them out of the palpebral fissure and conjunctival sac. This naturally leads to the consideration of the turning in of the edges of the lids, called entropium or entropion, and the opposite

trouble or eversion of the lid, exposing a portion of the conjunctival surface, and called ectropium or ectropion, the former of which is usually the cause of the trichiasis, and the remedying of which results in a cure.

Entropium may be caused by relaxation of the skin of the lid, as is often seen in elderly people, by spasm of the orbicularis palpebrarum muscle; by cicatricial contraction of any of the tissues of the lid; or by paralysis of the facial nerve.

When not severe the turning in of the lashes may be cured by drawing them out from their insertion, called epilation, or by tracing with a steady hand a furrow, about a line from the edge of the lid, with a glass pencil dipped in strong acid. The resulting cicatrix draws out and up the offending cilia.

Simple measures failing, however, and they usually do when the case is severe, or associated with or caused by entropium, an operation may be resorted to. In general all operations for these troubles consist of removing an elliptical or curved piece of skin, afterward a similarly shaped piece of the tarsus, and by sutures fastening the lower margin of the skin of the lid to the lower margin of the tarsus. The various operations differ in the method, but when successful, attain about the same result.

Ectropium especially when of recent origin may be often cured by the use of a solution of ten to twenty grains of silver nitrate to the ounce of distilled water painted on the exposed hypertrophied conjunctiva every day or every other day. Serious cases demand the knife, however, and often the results are not as good as we could desire. Usually of the lower lid, the removal of a triangular section of the tissue, the base toward the margin of the lid and the apex in the conjunctival sac, and the drawing of the wound together, are sometimes effectual, but generally the lid must be dissected free of all attachments and extensive skin grafting be done. Such operations are among the most difficult in which to attain good results, though the manual

dexterity may not demand so high a degree of skill as others seemingly less complicated.

Nævi resembling those found elsewhere on the body demand similar treatment. These elevated and often pigmented patches should not be confounded with xanthelasma, however. The latter patches usually occur at the inner canthus of the upper lid, generally late in life, and appear as small yellowish patches in the skin. Entirely harmless, they may be removed if too unsightly by excision of the skin containing them.

Papillomata are often found on the lids, and like warts elsewhere, may be snipped off if large or pendulous, or removed by thuja internally. Many surgeons think they should always be removed, surgically if necessary, as they are prone to take on malignant action.

When a condition exists by which the inner canthus of the eye is hidden by the skin at the base of the nose, it is called epicanthus, and is seen to advantage in the Chinese, giving them that peculiar almond-shaped eye-fissure. If seen in early life it usually disappears as the nose changes later, but appearing later in life an operation is the only relief. This is done by removing an elliptoid piece of skin from the bridge of the nose, the vertical axis the longer, and drawing together the edges of the wound by sutures.

Contusion of the lids are common and a so-called black eye has many domestic remedies; cold applications of arnica water at the outset is a valuable treatment; the effusion being limited usually in twenty-four to thirty-six hours, advantage will be gained by changing the cold to warm applications to promote the absorption. Temporary expedients are best confined to cold applications, though raw meats bound on have long had enthusiastic commendation by the laity.

I have dwelt on the operative side of the diseases of the lids, because you are entitled to the knowledge thus obtained, and because most of these diseases have become deformities before sent for treatment to an ophthalmologi-

cal specialist. But that many of the old and deformed cases might have been favorably affected by internal remedies in the earlier stages does not admit of a doubt in my mind. The indications are to be evoked for individual cases, after ascertaining their origin, and the remedy diligently sought out in the materia medica.

Our literature is replete with allied cases and their cure. Fibrous tumors have been dispersed by internal remedies after operative measures have been followed by a return of the original troubles. Chalazia are frequently unseated by the internal remedy indicated by general and local conditions, and its continuance is often essential to a prevention of the return of the tumors.

To the end that careful study of such remedies may be made, I have named, under the different diseases, the most prominent of the remedies I have found valuable, with a few guiding symptoms. On these alone dependence should not be exclusively placed, but the remedy fully examined with the aid of a good materia medica repertory.

But I warn you in conclusion, that mere symptomatic prescribing in these old and severe cases is nearly always disappointing, unless good judgment and a careful study of the case is made. This disappointing result lies not in the law, but in its erroneous application. Thus, in this case of ptosis before us, you may prescribe gelsemium without any result whatever, under an impression that the nerve is paralyzed, because the lid hangs so low and is seemingly without power. Not therein lies the cause. First stimulate to absorption this hypertrophied conjunctiva by local irritation, assist this process by such an internal remedy as mercurius; when in this manner this result is measurably accomplished, the administration of gelsemium will restore the power of the muscle, and the lid be elevated.

Always try to accomplish results by the use of internal medicines. No one likes the knife. But do not deceive yourself by accidental results. Every remedy is not valuable in all cases, and a single apparent cure is not a basis

for flaunting results. But as surely as you follow steadily in the narrow path, with no self-deception nor vain imaginings, so surely will your results be successful, and your power over disease gratifying.

THE NEUROLOGICAL CLINIC.

EXTRACTS FROM THE CLINICS OF PROFESSORS H. B. FELLOWS
AND O. L. SMITH.

MULTIPLE NEURITIS. *Case 16,016.* Mrs. H., æt. fifty. Dressmaker. For the past seven or eight years has undergone severe mental and physical overwork. Four years ago she was ill for some months with nervous prostration which left her with considerable pain in the occipital region. For the past year this pain has prevented her from getting more than four hours sleep each night. About November of last year she began to have neuralgic pains in right face which radiated from a sensitive spot in front of the ear. This persisted for about one month, and was succeeded by an eruption in the same location, which the attending physician believed to be erysipelas, it disappearing within four days. The right side of face now became paralyzed. Five days later the right leg began to feel numb and was soon partially paralyzed. This, however, is much improved at the present time.

This case was sent to the Monday morning neurological clinic by Dr. Kemp. In speaking of the case Prof. Fellows said: The attempt of the class in making an anatomical location not being satisfactory, let us look at the ætiological factors and see if we cannot get some light on the diagnosis from this.

Some three or four years ago after much mental worry she suffered with what appeared to be nervous prostration. This left her, as is the history in so many similar cases, with much pain in the occipital region. Latterly this pain has shortened the sleep of a night to three or four hours. The headache more and more involved the right side of the head, including the eye. In the late autumn of 1893, the pains seemed to have assumed a more decidedly neuralgic character, involving the right side of the face and

radiating from a point in front of the ear. This point was very sensitive to pressure. After this condition had existed for a time, inflammatory action set in about this sensitive point which the patient said the physician believed to be erysipelatous. A few days after the appearance of the inflammation, the facial nerve became involved, causing paralysis of the right side of the face. Some five days after this the right leg also became affected, but in a partial manner, neither motion nor sensation being totally paralyzed.

We have seen how difficult it is to locate any intracranial lesion which would produce these various conditions, and we must have further proof, which is lacking in this case so far as we have been able to learn, of a multiple lesion located within the cranium. But when we consider the history of the case, the anæmic and worried condition of the nervous system, the neuralgia, paralyses in different parts of the body, the hyperæsthesias and partial anæsthesias, we have the foundation out of which might grow the multiple lesions of neuritis, and such as we believe to be both the paralysis of the facial nerve and of the left leg.

If the diagnosis is correct, it should furnish us some hints for the proper treatment.

Were it possible, the first element of the treatment of this case would be to change the mode of life. A life free from carking cares and overwork would do much to bring back to her the sunshine of health. Change of climate and scene would add potentiality to this change of life. Unfortunately it is in this case impossible as it is in so many of our clinic patients to have this prescription carried into effect. Still we have to enrich this patient's blood and build up her general health to its best point. Her diet must be good, with not too long intervals between meals, more open air and less confinement and overwork. Nor must amusements with their pleasant variety of subjects for thought be neglected. No remedy seems more

indicated in a therapeutical way than ferrum et strychnia citras 3x which we will have her take four times a day.

FACIAL DIPLEGIA.—*Case 16,013*, William H., æt. sixty-two, layer of carpets. About the middle of October, '93, he became very much constipated and commenced to suffer considerable abdominal colic. One month later his face began to feel "stiff" and he was unable to whistle sufficiently to call the newsboy, as had been his wont. Soon the lips became paralyzed, and the corners of the mouth to droop, compelling him to use the hand in approximating them and to lie on his back while eating. While masticating, the food would collect between the teeth and cheeks, forcing him to extricate it with the fingers. Was also unable to close the eyelids and the tears would overflow on the cheeks. Eyes were much inflamed at that time. Tongue motions were somewhat, though not seriously impaired; deglutition and the sense of taste remaining normal. Incidentally he has now been given clinical attendance for one month, receiving causticum 6x, and has recovered sufficiently to resume his work.

PROF. SMITH said: You will agree with me that this rare case reflects the paramount importance of, and the necessity for rigorous training in the "A. B. Abs." of medicine—*anatomy, physiology and pathology*. Upon these elementary essentials depend the evolution of the logical mind in medicine. Such a one takes up each of the symptoms incident to a case, according to certain ones locative significance, others pathological importance excluding a third class as unimportant, thus satisfying. "The physician should discover what is to be cured in disease," when then and then only is he capable of resuming "and what is curative in drugs and adapt the latter to the former." But how many of us get the cart before the horse. Were this more fully appreciated and honest corrective endeavors instituted, perhaps it would not so frequently be "cast in our teeth" that medicine is far from being an exact science. These symptoms bespeak loss of function, dependent we should say upon some nerve derangement, but if motor or sensory, or both we could not so readily affirm. However, upon inquiry and applying the schoolboys æsthesiometer—a pin

—we find sensation unimpaired and this at once enables us to exclude any involvement of the first two branches of the fifth nerve, as they supply facial sensation, and thus we determine the lesion in or along some motorial trunk.

From the very first symptom complained of—the inability to pucker the lips to whistle—we are positive that the orbicular muscle of the mouth is “off duty” and we are equally as positive that it is at the instance of that branch of the facial nerve which supplies that particular muscle.

He also says that he was either compelled to lie on his back while eating or to place the food some distance within his mouth before it was grasped, which but confirms the foregoing.

While masticating, the food would accumulate between the teeth and cheeks, compelling him to extricate it with his fingers. This abnormal condition would not be present were the buccinator muscles in working order. The nerve supply of this particular muscle is a mooted point, some declaring it to be a branch of the inferior maxillary division of the fifth, while others maintain that it is the seventh, the weight of opinion rather favoring the latter. However, this is the only branch of the inferior maxillary division that could be possibly involved, inasmuch as the man can masticate as well as you or I.

The facial nerve is again to blame for the man could not wink, and the tears would overflow upon the cheeks which bespeaks a palsy of the orbicularis palpebrarum and the tensor tarsi muscles. The slight deviation of the tongue and comparatively unimportant involvement of its motility are referable to some morbid affection of the lingual branch of the facial.

The glosso-pharyngeal nerve is intact because deglutition is unimpaired, neither does the food regurgitate into the nostril, nor is the sense of taste abolished in the posterior third of the tongue.

Thus far the evidence declares for the seventh as the recreant nerve, but you ask, “how can that be when taste in the anterior two thirds of the tongue is present and why

are the secretions of the parotid and submaxillary glands not deranged? Simply that the lesion lies beyond or peripheral to the point at which these nerves are given off.

From this alone we might conclude that the lesion is not central, but to make it sure we have ascertained that there exists no irregular pupil, ptosis or hemiplegia.

"So far, so good" but why do not the corners of the mouth droop in the characteristic manner? Because such time has elapsed that secondary contraction is in progress and thus partially robs the symptom of its usual prominence.

Now we have proven the lesion to exist somewhere along the course of the facial nerve. Where is it and what is the nature of it? This man lays carpets, constantly holding tacks in his mouth and that more frequently of the tin variety, into whose composition enters lead, so we need go no further for we have a toxic neuritis of each facial nerve extending to and including that point of the facial nerve at which the lingual filaments are given off, or in other words to just this side of the stylo-mastoid foramen. As the resultant of this pathological condition we have a facial diplegia, otherwise known as Bell's palsy, which latter method of naming disease appears to us scarcely less egotistical than idiotic.

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

APRIL MEETING, 1894.

The regular monthly meeting was held as usual in the new Hahnemann Medical College building, on Saturday evening, April 28, the President in the chair. The Bureau of Diseases of the Throat and Nose, Dr. Wesley A. Dunn, Chairman, was called for, and reported as follows :

XI. SOME CASES OF SERIOUS NASAL HÆMORRHAGE. By WESLEY A. DUNN, M. D. *Case r.* A. M., age sixty-five, was brought to my clinic by Dr. Pratt, of Streator, Ill., in 1889, suffering from nasal hæmorrhage of several months duration. For three months he had suffered daily from severe hæmorrhage from the right side of the nose. The blood was bright red and came freely from the end of the nose, much of the time in a small stream. In time, it would form a scab in the nose, together with a small clot, and be held in check for a few hours only to recur in the same manner.

The patient was very much reduced in strength, pale from loss of blood and apparently in a serious condition. Many physicians had tried to stop the discharge by plugs and styptic solutions, hot water, ice and other applications, but to no purpose.

An examination of the nose showed the septum to be markedly deviated to the right side, while on the anterior portion was a black, dry scab composed principally of clotted blood, upon the removal of which the hæmorrhage recurred.

I could plainly see the bleeding point which was situated on the anterior superior portion of the cartilaginous septum. The hæmorrhage was from an artery, as shown by the pulsation in the exuding stream, as well as the bright appearance of the blood.

Pressure on the bleeding point immediately stopped the hæmorrhage, and gave me the indication for controlling it.

I dressed the wound, after making it antiseptic, with calendula cerate on a properly applied cotton tampon, which fitted over the cavity in such a manner that pressure could be applied on the wing of the nose directly over the wound. In this manner the hæmorrhage could be controlled at any moment, if necessary, and in that way further hæmorrhage was avoided. The wound was dressed daily for two or three weeks, after which time there was no more trouble. The patient gained rapidly in flesh and blood, and still remains in health.

Case 2. This case is of similar nature and occurred in private practice. The patient was referred to me by Prof. J. E. Gilman. J. M., forty years of age, slight build, nervous temperament, has suffered for four years from frequent attacks of hæmorrhage from the right side of the nose. Formerly, it would occur from time to time, but did not develop into a serious condition until four months ago, since which time he had suffered from frequent hæmorrhages daily; sometimes lasting for ten or twelve hours, during which attacks the loss of blood was extreme. The flow was incessant, and flowed in a rapid stream in spite of all efforts at his command, and at the command of his former physicians to control it. The anterior portion of the nose was tender to touch, especially when the pressure affected the septum. He was at one time confined to the bed for a month, and was only restored by going south, which gave relief from the hæmorrhage, and allowed him to recuperate in general health.

A remarkable feature in this case was the relief of hæmorrhage, while in the south for a month, during which time he had no attack, due no doubt, to the lack of irritating material inhaled in the nose, which is so copious in Chicago.

The dust, smoke and severe atmosphere of Chicago, predisposes to ulceration in the nose, because of its drying, irritating and septic nature, producing thereby, continuous dry, septic wounds that require much care both on the part of the patient and the physician before they heal.

He was finally prevailed upon by friends to consult Prof. J. E. Gilman, who kindly referred him to me. A careful examination of his nose revealed a similar condition to that of the former case except a lack of deviation of the septum; similar location, with a similar freely bleeding wound on removal of the scab.

A peculiar symptom in this case was a reflex congestion of the supra-orbital nerve on the right side, causing a sense of fullness which the patient thought to be due to the retention of blood in this region. This symptom was always made worse by the attempts to plug the nose, and the many efforts caused more or less irritation of the nerves in the anterior nasal meatus. He was extremely exsanguinated and weak. A carefully applied tampon with carbolized calendula cerate enabled pressure to be applied in the proper direction so that no trouble was experienced in controlling the hæmorrhage. At no time did he lose more than ten drops, and only during two attempts at hæmorrhage. The first dressing was changed after three days, and daily thereafter for two weeks, at which time the wound was entirely healed and the hæmorrhage controlled. His general health rapidly improved and no further trouble was experienced.

These cases teach the necessity of a careful examination and how easy it is, when properly skilled, to relieve conditions that would ultimately prove fatal if not removed. Hæmorrhage from the septum is not infrequent, and is of times serious as seen by these cases. The septum is supplied by the artery of the septum, a branch from the superior coronary, which is in itself a portion of the facial artery. In all serious cases of hæmorrhage from the septum I have observed that hæmorrhage has occurred on the cartilaginous portion in the superior anterior region, about three-quarters of an inch from the opening, and one-eighth of an inch from the front of the nose. The artery in this locality is imbedded in the mucous membrane, and surrounded by inelastic tissue so that a wound in the artery can only close by its own contraction without the support of contractile tissue about it. It, therefore, bleeds with ease, and can only be closed by pressure from without. In these cases I believe an atheromatous condition of the artery had caused a rupture, while the local irritation from without had kept it continuous. No logical method had been put forth to stop the hæmorrhage or heal the wound. It had been closed from time to time by a clot, only again to recur upon removal of the dry mass covering the opening. This dry scab prevented the

healing process by its irritation and septic nature. Cleanliness and mild dressing which avoided the formation of crusts over the wound were quite sufficient to remove the difficulty.

Case 3. Another case of hæmorrhage from the nasal septum occurring from traumatic origin was that of a medical friend on whom I had operated for nasal hypertrophy of the anterior portion of the middle turbinated body. A large hypertrophy in this region had been removed two weeks before with the electro-cautery snare without inconvenience or hæmorrhage.

I thought it advisable to more thoroughly cauterize the base of the tumor and therefore made a moderate cauterization of the middle turbinated tissue in the anterior portion, but on account of a sudden movement of the patient the knife penetrated the septum very slightly. No immediate hæmorrhage occurred and with but a moderate plug, he left the office for luncheon in my company. During the luncheon his nose began to bleed and he went to the wash room and in a few moments sent for me, because of the severity of the hæmorrhage. I found him bleeding copiously. I hurried to the pharmacy, secured some cotton and an applicator and plugged the nose well backward with an anterior plug. Unfortunately he had a prominence on the septum which threw the plug away from the septum at the point of hæmorrhage, which I was unable to see during such a copious discharge. The hæmorrhage slowly ceased but he had lost enough to almost produce syncope. On the following morning, the hæmorrhage broke out afresh, anteriorally and posteriorally, in a very rapid manner. It had broken through the clot and I found it necessary to remove the plug and introduce another which controlled the hæmorrhage. It was necessary in this case to keep the nose tightly plugged for ten days before the wound healed sufficiently to allow its removal. Several attacks occurred during the week which were extremely active and much blood would be lost before it could be properly plugged. There was no future recurrence, however, and the patient has since remained well.

Case 4. This case was a young man suffering from reflex hæmorrhage due to gonorrhœal inflammation of the prostatic portion of the urethra, accompanied by frequent painful urination. He had suffered from gonorrhœal inflammation for some time which had developed an acute

cystitis and proctitis attended by frequent painful urination which caused the peculiar reflux congestion to the head. He was a young man about twenty-five years of age, of light complexion and nervous temperament. He had never suffered from nasal hæmorrhage nor from gonorrhœa. The discharge had about ceased, but the inflammation of the deeper portion of the urethra was severe.

When he applied to me for treatment he had lost considerable blood and was quite anæmic therefrom. Five or six days before, while attempting to urinate he observed an active congestion of the whole head which produced a violent attack of hæmorrhage from the nose, lasting several hours, and from that time every attempt at urination produced a similar result. Only by keeping the nose plugged could he avoid a severe hæmorrhage with every urination. He was confined to the bed a week from prostration and anæmia brought on by the loss of blood. He finally got relief from the irritation of the bladder and was restored to perfect health.

This is an illustration of many cases of reflex hæmorrhage of the nose, due to functional paralysis of the vaso-motor nerves of the face and head, resulting in over distention and rupture of the vessel walls. Should the hæmorrhage occur in a more serious locality, as the brain, more unfortunate consequences would be the result.

The reflex nature of some of these cases is not usually taken into consideration in treatment; which accounts for the ineffectual results of the treatment. It is essential in such cases to remove the cause of irritation whether it be from the urethra, the uterus, the rectum or other organs prone to produce reflex irritations of the vaso-motor nerves. So-called vicarious menstruation is exactly similar to the case described. The irritation from the ovaries and uterus produce the requisite reflex which is always transmitted to some vaso-motor, producing hæmorrhage from the lungs, nose or other vascular organs. In all cases of nasal hæmorrhage it is essential to find the primary lesion, whether it be due to a local cause or reflex irritation. If it be purely local, no treatment is equal to properly applied tampons which may be retained from two to five days. The fluid extract of ergot applied locally, is of very great value in the

immediate control of violent hæmorrhage. It causes contraction of the vessel which will frequently stop a violent hæmorrhage the moment of application. Posterior plugging is seldom necessary except in some peculiar deformity of the nose where it is impossible to introduce the proper plug through the anterior portion or where the hæmorrhage occurs from the posterior end of the septum or turbinated body.

The hæmorrhages following operations seldom produce serious results because the operation is performed by one skillful enough to properly treat the resulting hæmorrhage but it sometimes happens that copious hæmorrhage follows operations at a time when the physician cannot be within reach and unfortunate consequences may follow.

My method of plugging the nose is different from any I have seen described and I believe more effectual and rapid and easy of application. The cotton applicator, as you see, is a flat smooth probe with proper handle for manipulation. A flat pledget of cotton one inch and a half in length and of sufficient diameter to completely fill the nasal chamber is placed flatwise on the applicator, allowing the end of the cotton to project slightly beyond the end of the probe. The cotton may be covered with vasoline, saturated with ergot or any styptic solution, or whatever application is deemed desirable to apply. The end of the nose should be elevated and the cotton carrier inserted easily and quickly through the anterior opening into the cavity of the nose keeping the applicator well toward the septum and the bottom of the nose to facilitate its passage. It should be carried well through the nose in order to make the pressure well back in cases of posterior hæmorrhage. The plug may be introduced through the speculum if desirable. It should be as large as can be introduced into the nose with facility. No inconvenience is felt from the retention of the plug, except the nasal stenosis which it necessarily produces. It should be removed with care not to fracture the covering of the wound which might again produce the hæmorrhage. By carefully soaking the plug with an antiseptic solution

and using but slight pressure in extracting it no such accident need happen.

DISCUSSION: Dr. SHEARS: I am very sorry that I could not have come earlier and heard all of this paper. I understand from what I have heard that the paper is on nasal hæmorrhages on account of reflex disturbances.

I have had very little experience with nasal hæmorrhage as the result of reflex trouble, except that which has arisen from some interference with the menstrual function, or if they were, I did not recognize the reflex as the cause of the hæmorrhage. I have been obliged to plug the nares a number of times for severe hæmorrhage; one case I remember occurring during the progress of typhoid fever. The patient had had a severe hæmorrhage which had been arrested by the means of anterior plugs, but it recurred and they were unable to control it in that way. The patient was very weak at the time I was called. I plugged the nose posteriorly and anteriorly, and I may say that the plugging of the posterior nares seems to be much more difficult than one would think. I did not have any instrument except a catheter into which I introduced a small ligature, passed the catheter through the nares and as the end of the catheter came through the pharynx I caught it with a little hook. As it came out through the mouth I put on a pledget of cotton, and by means of the string and finger was enabled to put it nicely in place. That stopped the hæmorrhage and the patient eventually recovered from the typhoid fever. I have been obliged to plug the posterior nares in a case of cancer of the nose in which the hæmorrhage was very severe, in which case I plugged it somewhat in the same way. I had one case which was plugged after an operation for the removal of polypi a number of years ago. A little accident happened in one of my cases in which I plugged the posterior nares for one of our physicians. I left directions to have the plugs removed and they were removed. The patient came to me some six months afterward to pay my bill and desired me to look into

the nose on account of a so-called catarrh accompanied by a very bad odor which had been prescribed for without relief. I did not care to interfere with the doctor's patient, but she insisted; upon looking into the nose I saw a foreign body in there and found some of the old cotton which had been introduced and the removal of this, a piece of cotton, showed what was the cause of the severe catarrh from which the patient suffered. She had been prescribed for during many months. This was before we had specialists in our college and I was doing some special work.

DR. C. J. SWAN: With regard to the location of hæmorrhage within the nose I think it will be interesting to note the statistics upon the subject. Dr. Dunn says that in his experience the bleeding point is most often located in the triangular cartilage of the septum. This agrees with Bosworth who quotes twenty-five cases in twenty-two of which hæmorrhage occurred from that point. Ivins states that in ninety per cent of cases of epistaxis the hæmorrhage comes from this location. Now it seems to me if these statistics are trustworthy, and I believe them to be so, for my own experience corroborates them, other means less disagreeable to the patient than plugging might be used. In fact I think nearly every other method of controlling the flow should be resorted to before a plug is inserted. I have had some experience with nasal plugs in my own anatomy, and know them to be exceedingly uncomfortable. After exactly locating the bleeding point I have often been successful in checking the flow by the application of chromic acid crystals fused upon a probe.

In the paper there was mention made of epistaxis from reflex causes. A source of reflex hæmorrhage not noticed in the paper is strain of the ciliary muscle consequent upon astigmatism or hypermetropia. Therefore it would be well in cases of epistaxis to have the refraction of the eyes tested.

DR. O. L. SMITH: I have seen one thing used in a case of nasal hæmorrhage and perhaps it is a quick and ready

method. That is, a clothespin. I saw a fellow come into an office once in the country and the doctor snapped a clothespin on his nose and stopped the bleeding.

MRS. DR. SHEARS: I remember in a country school that whenever a scholar had nosebleed, one of the other scholars took pains to take a large key which belonged to the school house and when the scholar was not looking to drop that key down the back of the neck and it invariably stopped the flow.

DR. O. L. SMITH: Another was used in a school and that was to place a large compress of the usual writing paper or brown paper and to put it beneath the upper lip and draw it down. I have had no personal experience with it but have seen it done.

DR. THOMPSON: I had a case of an old patient who had severe nasal hæmorrhage and I stopped it with ice bags on the back of the neck. Mrs. Shear's door-key recalled that to me. I had tried some styptics but they did not work and the patient would not let me plug her nose, saying I should not do anything of the kind.

DR. LUDLAM: I have not had much experience in this line but have had some trouble. I was reminded that perhaps age might have something to do with some of these severe cases and that possibly old people are more given to atheromatous condition of the nasal arteries than younger ones. There might be syphilitic disease or cancerous condition; and I also thought in case one was called to a very bad attack of nasal hæmorrhage he might resort to the trick of Péan for removing a nasal polypus dry and clean without any hæmorrhage. He clamps the facial artery on the side affected with one or two of his forceps and locks it before he does anything with the polypus, and then takes it out nicely, and that the same thing would stop a case of nasal hæmorrhage is suggested to my mind.

DR. HARVEY: Suppose it was a very severe case from venous system?

DR. LUDLAM: It might answer in some cases and would be worth thinking of.

As to reflex cases I do not know about the theory that the nasal hæmorrhage is reflex when it is vicarious menstruation, but there must be some cause which gives rise to the flow when it does not come in the natural way. There are some remedies that will have a very good effect if applied directly to the bleeding part. Dr. Craig reported a very good case of hæmorrhage occurring in typhoid fever. A little tampon of erigeron stuffed into the nose stopped a very bad hæmorrhage. Calendula is one of the best hæmostatics we have. Do not think constitutional remedies for a severe case would be worth very much.

I am glad Dr. Dunn has brought up this very interesting subject for I am sure that this will not only be of use to us but to the readers of the CLINIQUE as well. And I am also glad the hot water idea has been brought to our notice.

Dr. DUNN: So many things have been brought up that I do not know what more to say, but will give you some ideas in regard to these things.

As to post nasal plugging, I think with proper understanding of the nose and exact location of the hæmorrhage spot, that post nasal plugging is a very rare necessity; certainly it is not a comfortable one and is one that I delay to the last moment, because it is extremely disagreeable to a patient to have it performed. Of course it is rather quickly done, but it is necessary to introduce the finger behind the soft palate and bring it forward to get the plug up quickly, which is anything but comfortable. The most convenient way, if the instrument be at hand, is Bellock's canula which puts the thread exactly where you want it without any fishing to get it. The trouble with a catheter is that it is so difficult to get the thread after you get it into the throat. With this canula the tip is thrown out into the mouth and the thread that is already in it is easily brought out.

I always have the tampon ready with plenty of thread attached to it so that instead of tying the thread which I bring into the nose, I simply tie the two ends together and pull it all back. Then I introduce the anterior plug with

the cotton applicator. Between the two threads I always use a double thread with the posterior plug and bring it forward and separate the two ends of the thread, placing one on each side of the anterior plug. When I take it out I cut the thread. It is not comfortable and I think only three times have I found it necessary to resort to post nasal plugging and I have had a good many cases of bad hæmorrhage. It comes in my way a little too often to be welcome.

It is absolutely necessary in order to do good work in this way to make a correct diagnosis. It is just as important to diagnose hæmorrhage as liver disease. Hæmorrhage is not always the same thing.

Dr. Shears suggested that we should also try other methods than the plug; that depends entirely upon what the condition is. There are certain conditions in the nose, two cases of which I have described, that are absolutely impossible to help without the plug. That is where the artery breaks out on the septum. While it may be possible that you destroy the artery you may have a bigger hole than before. I do not believe in the cautery for this kind of a case.

You must know before attempting to treat such a case what it is essential to do. In this case it is necessary to heal up a broken artery and in my experience it is always successful by plugging, keeping it clean and making soothing applications of carbonized calendula cerate; these cases are always forward and the patient is able to make pressure on the outside of the nose when the plug is in, and the plug must be large enough to allow the patient to make pressure on the wing of the nose. This will prevent breaking out of the hæmorrhage from day to day.

It is this that keeps it from healing and it never can heal without proper support and being antiseptic and in that case the treatment is plain and easily followed out.

Both of these cases I have given had been treated for months while the most simple thing would have stopped the hæmorrhage. Simply a piece of cotton rolled up and

plugged into the end of the nose is not sufficient. An anterior plug is no good unless properly applied, because the blood easily escapes from behind. You must put the plug beyond the place of bleeding, and if it be not possible, a posterior plug is necessary.

If you are able to diagnose your case and know where the point is, you make a plug that you think is large enough and long enough to fill the space. The plug should be long and fill up the space lengthwise; not just the end of the nose, and in that manner you will very easily get pressure and a body to form a clot. The cotton acts as a clot producer and you must have it beyond the wound; if you do not you are doing no good whatever.

Hot water in my experience has been no good in bad cases. In simple cases, where it is due to simple congestion of the nose and rupture of not a very large vessel, then it will do, but from a large vessel I do not think it could be stopped.

Another point in diagnosis of nasal hæmorrhage is to determine if possible whether the hæmorrhage is due to over-distention of the vessel, from relaxation of the vessels, or to an open vessel without the congestion. Many times the hæmorrhage is the result of purely over-distention of the vessels with only a weakened wall. Sometimes it is due to hæmorrhagic diathesis where there is very little over-distention. The blood is so disintegrated that the hæmorrhage takes place readily. The treatment in such cases is different. If it be due purely to congestion there is no remedy like ergot; this will stop it at once if applied locally. It is of no value in a case where there is a large vessel which it cannot contract.

Venous hæmorrhage in my experience has been an extremely rare thing. I do not consider a so-called nose-bleed much; I have never seen a serious hæmorrhage due to venous congestion. When you have a serious case it is always due to an active congestion. I think that we have many constitutional conditions producing nosebleed, reflex irritation, etc., and remedies that fit the general condi-

tion will cure the nosebleed. What we have to do with to-night is to prevent this serious condition, to illustrate the methods of tiding over the dangerous attack and healing them when due to local causes.

My experience is that a properly applied anterior plug is the first and most satisfactory condition of all, because it is quick and not uncomfortable if properly applied. It can be retained for two or three days if necessary. The patient can go home and feel very sure of being safe.

If the hæmorrhage has been stopped by hot water, or other similar measures you cannot feel sure that it will not return. Am always afraid to send a patient out after stopping the hæmorrhage in that way for fear it will return and they will not be where they can have some one stop it again.

XII. EPITHELIOMA OF THE NOSE AND LIP. REMOVAL OF A PORTION OF THE LIP, AMPUTATION OF THE NOSE, SUBSTITUTION OF AN ARTIFICIAL NOSE. BY DR. G. F. SHEARS.—Mr. B., æt. 60 years, brought to Hahnemann Hospital by Dr. Beach. Uncle and sister died of a malignant growth. In the uncle's case it was situated on the forehead; in the sister's, in the breast. Twenty years ago he first noticed a small nodule at the right angle of the mouth, which was removed with caustic. Shortly after he noticed a nodule upon the nose. Several of these nodules have been removed from time to time by the local application of arsenic. At first cicatrization took place soon after the removal of the nodules, but lately the remedy seems to have lost its efficacy, and the ulceration has grown very rapidly. Present condition at the time of operation: The tip of the nose is destroyed, the alæ are nodular and indurated, the septum is eaten away. At the right angle of the mouth there is an indurated mass of irregular shape extending outward and upon the upper lip to the alæ of the nose. Several little moth patches are situated upon different parts of the face. The nose was so destroyed that I deemed it best to amputate it at the junction of the bony and cartilaginous portions. The nasal bones were trimmed in such a way that the mucous membrane could be stretched over and attached to the skin. The indurated tissue at the angle of the mouth was removed, the parts brought together by harelip pins. Union took place promptly by first intention. Two weeks after the wound



FIGURE 7.



FIGURE 8.



FIGURE 9.

was all healed an artificial nose was fitted. The accompanying three cuts show the condition of the patient before the operation (Figs 7, 8, 9); the induration at the angle of the mouth being covered by a beard; the condition after the removal of the diseased tissue, and his appearance with the artificial nose in situ. I am indebted to my skillful dentist friend, Dr. Charles M. Thompson, for the making and fitting of the artificial nose.

VOLUNTEER PAPERS. XIII.—SUPRA-PUBIC CYSTOTOMY FOR THE REMOVAL OF A RETAINED CATHETER. By Dr. W. S. HARVEY, of Chicago.—I desire to report a recent supra-pubic cystotomy because of the practical lesson which a presentation of the case involves, and the unusual circumstances that rendered the operation necessary.

Case. Mr. T. was admitted to the Baptist Hospital April 4, and gave the following history: Age twenty-five; American; carpenter by occupation; unmarried; family history good. Had suffered for a year with severe cough and pains in lungs and chest. Diagnosis had been made of acute pulmonary tuberculosis and had been under treatment for same. For two months this condition had been complicated by complete paraplegia, the paralysis implicating the bladder and rendering the periodic use of the catheter necessary. Four days prior, while the attending physician was in the act of relieving the bladder, the catheter broke. The part retained in the deep portion of the urethra was pushed on into the bladder without any attempt at extraction, and the accident dismissed with the remark "that there was only an inch left in and it would only make a few days' difference with the patient anyway." The presence of the foreign body in the bladder excited an acute suppurative cystitis rendering catheterization exceedingly painful. He suffered constant pain, and had no rest day or night.

Upon personal examination of the patient, I found his *status præsens* as follows: Great emaciation and prostration, pulse 120, feeble but regular; hectic fever every afternoon, temperature rising to 102°. Severe cough, with profuse muco-purulent expectoration; marked œdema of feet and ankles. Urine contains four per cent albumen. Paralysis of lower extremity and bladder. Suffers great pain in the hypogastric region, aggravated when catheter is passed. Although recognizing the fatal nature of the constitutional

complications and appreciating the probable prognosis of the operation, I was, nevertheless, induced to urge surgical measures on account of the extreme suffering of the patient.

Operation.—The patient, having been prepared in the usual manner for a laparotomy and chloroformed, suprapubic cystotomy was performed by the following method, assisted by Drs. Owsley and Evans, Dr. A. C. Cowperthwaite being present. The bladder was emptied, washed out with a five per cent solution of boracic acid and injected with ten ounces of the same fluid through a soft rubber catheter. A gauze ligature being tied around the penis with catheter *in situ* to prevent the fluid from escaping. An incision three inches in length was made along the linea alba, beginning at the upper margin of the symphysis pubis and carried directly through all the tissues down to the surface of the bladder, which was now recognized as an oval fluctuating body above the symphysis. The anterior surface of the bladder was now transfixed by a sharp tenaculum near its upper border, and the organ steadied by an assistant while a vertical incision was made through the median line of the viscus, the index finger inserted, and five and one-half inches of hard rubber catheter extracted. The ligature around the penis was now removed, the opening in the bladder stitched to the deep edges of the abdominal wound by catgut, two sutures on each side. The two extremities of the parietal incision were closed by silk worm gut, a large sized drainage tube introduced into the bladder long enough to pass into a urinal at the side of the bed; the edges of the wound dusted with iodoform and an antiseptic dressing applied, with dressing perforated for the passage of the drainage tube. Time of operation, fifteen minutes.

Subsequent History.—After the operation there was prompt relief of all vesical irritation. Drainage being entirely satisfactory, it was decided to retain the tube *in situ*, and thus establish a permanent vesical fistula. We were led to this decision on account of the paralysis of the bladder, the ease and comfort with which the organ was drained, and the gloomy prognosis of the case. The bladder was washed out each day with a warm boracic acid solution, the tube removed, cleansed, and reintroduced. The extremities of the abdominal wound, which were closed with silkworm gut, having healed by first intention, and everything having progressed favorably as far as the operation was concerned, the patient was discharged on

the tenth day. He died, however, about a week later, from the ravages of the pulmonary disease, his death undoubtedly hastened by the cystitis excited by the presence of the foreign body in the bladder and the shock of the operation and anæsthetic.

I have described the operative technique of supra-pubic cystotomy in order to call your attention to the simplicity and safety of the high operation for the removal of foreign bodies from the bladder. In the majority of cases Petersen's colpeurynter bag, which can be introduced into the rectum and injected with water, will greatly facilitate the operation by throwing the bladder forward against the abdominal parietes and forming a firm foundation for the bladder to rest on. In children, where the bladder is essentially an abdominal organ, and in patients having very thin bellies, this expedient is unnecessary. The two dangers that beset the operation are injury to the peritoneum and urinary infiltration. The former can easily be avoided if the bladder is injected and the peritoneum held up and protected at the upper angle of the wound by a blunt hook or gauze sponge. This complication rarely occurs, as injection of the bladder carries the vesicoparietal fold of peritoneum up out of harm's way. Petersen reports twenty-one operations in which the peritoneum was not even seen. The second danger will be averted if successful drainage has been established, and if the tissues have not been torn or damaged in the dissection, a condition that favors infiltration.

From my own observation I am convinced that such cases as this occur far more frequently than one would naturally suppose. Many mistakes of this kind are concealed from the patient by deception on the part of the attending physician. Such blunders, however, sooner or later bring grief to the patient and chagrin to the conscience stricken doctor.

I present this piece of defective catheter for your careful inspection. It points its own moral and adorns its own tale.

Dr. SHEARS: Dr. Harvey's interesting case emphasizes

a warning which I have been giving in my lectures for the last ten years, that a rubber catheter should never be used until it has been inspected and tested as to its integrity and flexibility. Some twelve years ago I had an experience which impressed this fact upon my mind. I had made a lithotomy, and in one of my subsequent visits found it necessary to use a catheter. I had in my pocket a soft rubber catheter which had been in use for some time. I introduced it, but on attempting to remove it, it broke, leaving a portion in the bladder. Upon examining the withdrawn portion I found it very fragile and easily broken. Observation has since taught me that this is very commonly the case when the catheter has been in use for some time.

In the case referred to I still had a perineal wound through which I introduced the forceps and removed the broken portion. Since that time I have opened the bladder a number of times for the removal of foreign bodies, including such articles as portions of catheter, slate pencils and wisps of straw. In one very interesting case I was able to remove the foreign body without opening the bladder. The young man had introduced into the urethra, while indulging in the practice of self-abuse, a piece of small rubber tubing. This had escaped from his control and slipped into the bladder. I disliked very much to subject him to so serious an operation as cystotomy, and determined to make an effort to remove it by some less severe measure. Accordingly I introduced a small lithotrite, with which I succeeded, after careful manipulation, in grasping the rubber and removing it with only a very slight laceration of the urethra. In regard to the choice of methods, the smaller bodies are best removed by the perineal method. This method is also better suited to those cases in which there is a pronounced inflammation of the bladder, the drainage being at the more pendant point, and therefore more easily maintained. Larger and more irregular bodies, especially if incrustated with a calculous deposit, may be removed by the supra-pubic method.

XIV. FIBROID CYST OF THE INFERIOR APONEUROSIS OF THE RIGHT RECTUS ABDOMINALIS MUSCLE. BY DR. W. M. THOMPSON, OF CHICAGO. *Case.*—Mrs. B., æt. 28 years, German. During the latter part of October I was called to attend this patient in what had been diagnosed as a case of multiple pregnancy. She was of that sturdy, muscular type commonly found among the German peasants. She appeared somewhat exhausted, having been in labor several days. The attendant told me that the amnion had been ruptured thirty-six hours before my arrival. This was her third pregnancy. In the two previous pregnancies craniotomy was performed because of the small diameters of the pelvic outlet.

Examination. Abdomen extremely large. To the right and half way between the umbilicus and the pubes a large tumor, resembling in shape a child's head, presented. Beside this, the outline of a fœtus could be clearly defined. The tumor was immovable, and did not change its position during pains. Vaginal examination found the os dilated about two inches. Head in first position of vertex. Pains feeble. After vainly trying to stimulate uterine contraction, it was deemed necessary because of the worn-out condition of the patient, to complete labor instrumentally. By means of dilators and long forceps the fœtus was removed with some considerable difficulty because of the small outlet. The cord had ceased to pulsate and the child was cyanotic, but was resuscitated, to live only twenty-four hours.

After delivering the placenta I thrust my right hand into the womb and with my left on the abdomen endeavored to ascertain the exact position of the tumor. The uterus was perfectly normal and could be moved from right to left without disturbing the growth. It was decided that the tumor must be attached to the abdominal wall.

The patient gave the history of a fall some two years before, striking a stick in the region where the tumor had developed. Because of the rapid growth we decided to operate as soon as her condition would permit.

She was prepared as is usual in laparotomy, and on December 7, with the assistance of Dr. Sheppard, of Elgin, an incision was made through the linea alba down to the peritoneum. After dissecting the rectus muscle from the peritoneum the tumor about the size of a child's head was disclosed beneath and attached to the rectus abdominalis. During the dissection, the peritoneum being very thin, it was torn in several places, but was carefully stitched up

with fine catgut. The rectus muscle was found to be very much atrophied as a result of pressure. After ligating the pedicle securely and removing the tumor, the wound was closed according to the method employed by Prof. Ludlam in his clinic.

The convalescence was uninteresting. The highest temperature, $101\frac{1}{2}^{\circ}$, was registered on the fourth day, and on investigation was found to be due to the taking of some so-called "beef tea." The wound healed without a sign of sepsis, and an abdominal band was fitted in order to prevent ventral hernia. The patient sat up and ate Christmas dinner with the family and was discharged on January 1.

XV. APPENDICITIS.—By E. E. HOLMAN, M. D., of Englewood, Ill.—I have read with no little pleasure and profit the very interesting reports of cases of appendicitis in the March issue of the CLINIQUE. A goodly number of cases in which surgical interference became necessary having fallen to my lot, I have selected the following case from among that number because of its typical character; and although the patient unfortunately died, its clinical value is none the less significant.

Case. March 8, I was called in consultation with Dr. A. F. Harris to see Frank A., æt. 20, whose case the doctor had thus early diagnosed as appendicitis, although he had been ill only twenty-four hours. All the symptoms were quite pronounced, but in view of the fact that a thorough evacuation of the bowels had not yet resulted from the laxatives already administered, I advised that the operation be postponed until the following day. Examination of the patient the next morning revealed a marked improvement, except the pain and tenderness. There was no tumefaction, dullness, vomiting nor fever. The bowels had moved copiously during the night. The general condition of the patient was better, yet I deemed it my duty to operate at once, although the well defined tumor, so apparent the day before, had disappeared.

The adhesions were very extensive, certainly as far up as the lower margin of the kidney, which was as far as I explored. The cæcum and colon were firmly adhered to the posterior abdominal wall. The cæcum was gently detached, rolled out, and the appendix exposed. Its free end pointed upward and its entire surface was enveloped by a

mass of spongy, mesocolic tissue, binding it snugly to the cæcum. Perforation had already taken place about one-third of an inch from the intestinal attachment, at which point was a concretion of dry, hardened faecal matter one-half inch in diameter. Gangrenous ulceration extended along one side of the appendix two-thirds its length.

The accompanying excellent cut illustrates this very nicely, also the concretion and its location. (See Fig. 10.)



FIGURE 10.

For three days following the operation the patient's condition was favorable in every particular. At no time was the temperature above 99° . There was no abnormal distention, no peritoneal complications, and the bowels performed their functions admirably. On the fourth day there were marked symptoms of uræmic poisoning. The urine was analyzed showing fully thirty per cent albumen, blood and pus in proportionate quantities. The patient died the fifth day.

I regret that urinary analysis was not made subsequent

to the operation. Indeed this should be done before undertaking any important surgical operation.

In this case I believe that the inflammatory process, which undoubtedly began at the point of appendicular obstruction and extended along the cæcum and colon, finally invaded the kidney, causing its disorganization.

In regard to the medical treatment of cases of suspected appendicitis, in addition to the indicated remedies, it is my practice to administer pure olive oil in half pint doses every three hours, or until complete catharsis is produced. The oil should be given in this manner: Rinse out a large tumbler with whisky, fill with oil, having the patient chew a bit of lemon before and after drinking the same. It is wise not to let the patient know what is being given, for the simple suggestion of oil often produces nausea. The gentle but efficient action of this harmless remedy, homely and ancient though it may be, has caused many cases of supposed appendicitis to "slip" quietly and serenely from underneath my scalpel, to come up smiling with a few paltry dollars for my professional advice, while the visions of gold and glory which surgical measures promised, faded away like the lines of a dream.

When should we operate? I am certain that the honest, conscientious, devoted surgeon often decides this matter by his "sagacity" and a nameless something more—let us call it *intuition*. The "unmistakable signs" are more often absent than present. One year ago I operated on a case which, at the time, presented not a single symptom calling for surgical aid, although there was a previous history of probable appendicitis. I found an abscess, two ounces of pus and a fæcal concretion the size of a small hazelnut. The patient made a rapid recovery and now enjoys excellent health.

I was called to my first case of appendicitis December 25, 1891. I mention this as my first case because it was the first time I had recognized the disease. The occasion is quite fresh in my memory for it cost me my Christmas dinner. At that time the profession was alive to the fact that the poor, despised appendix, the remnant of the monkey in man, deserved thoughtful and careful consideration. The public press had so thoroughly advertised the case of Mr. Gage and Dr. McBurney that the laity even became interested in, and manifested a reverence for the frolicsome appendix. So true was this that the midnight-rounder, the free-lunch fiend, the partaker of lodge ban-

quets, or the man who ordinarily ate enough for himself and a whole family of tænia; who on the morrow found himself in the toils of the colic, pure and unadulterated, readily imagined that his miserable appendix had opened up and swallowed half the contents of the alimentary canal.

—R. *Ol. Olive* ʒ *vi*.

XVI. THE MEDICAL TREATMENT OF APPENDICITIS. By F. E. NICHOLS, M. D., of Plano, Ill.—From a recent observation of a few cases presenting all of the symptoms which usually lead to a diagnosis of appendicitis, and, looking over the literature of the subject, I have been able to form some conclusion as to the possible nature of the disease and its treatment. Not that the few cases which I have seen are sufficient to establish any facts conclusively, but presenting such marked uniformity, they are enough for a practical suggestion.

These cases were four in number. The patients, all men, ranging from thirty-five to sixty years of age. All were accustomed to hard labor and hearty living.

The attacks in every case came on during a period of idleness when shops were closed, and in one case, that of a farmer, the attack came on after a storm, when he was compelled, by the unfavorable weather, to remain in doors for several days. In three of the cases there was a history of constipation.

The symptoms in every case which led the patients to consult me, were prominently pain in the right iliac fossa, at McBurney's point. The area of tenderness was variable in extent, all exceedingly sensitive, with a tendency to flex the right thigh. Either partial or complete obstruction of the bowels in every case.

The temperature at my first visits ranged from 101° to 103°, the average length of attack was eight days, which was very uniform. The fever was very soon controlled by the use of the remedies in each case. The pain also was relieved after a free movement of the bowels was secured, and in two of the cases before that time.

Opium in every form was avoided; the chloral hydrate was given in one case; bryonia and mercurius corrosivus were the principal remedies used.

Applications of heat to the surface. Large enemata of hot water, decoctions of slippery elm, flaxseed and olive oil were variously used, in quantities varying from one to three quarts, as the patient could bear them. These were intro-

duced through a Wales' rectal bougie, massage being applied over the colon.

□ In two of the cases all means of arousing the peristalsis of the colon failed until I used the strong faradic current. In one of them the patient stated that while applying the battery he felt the substance raise from the cæcum, pass over and lodge for a time at the sigmoid, with almost immediate relief of the pain at the original site of the trouble.

In this case I had arranged to operate the following morning, being in despair of securing relief otherwise; but the timely use of faradism saved me the trouble of an operation and the embarrassment of finding an infected cæcum instead of an ulcerated appendix.

The observation of these cases suggests that perhaps a large share of cases which are diagnosed as appendicitis, are in reality, at least in the early stages, acute catarrhal inflammation, or an acute exacerbation of a chronic catarrh of the cæcum, which inflammation may extend to the appendix and surrounding tissues as a secondary condition. This I am induced to believe from my own observation and study of the literature of the subject, is the usual order and condition of things, which, if true, argues strongly in favor of the medical treatment and against the indiscriminate early operation.

The dependent position of the cæcum, it being the most dilated portion of the colon; the circular and longitudinal fibres of the muscular coat being interrupted and weakened by the two orifices, viz., the ilio-cæcal and the opening into the appendix, renders the peristaltic action of the gut less effective than at any other point of the colon. Gravitation exercises its share of opposing influence. In the presence of an atonic colon, it is not difficult to see how a residuum of fæcal matter could remain in this pouch, exciting catarrhal inflammation, as often occurs from like accumulations at the sigmoid and in the rectum.

In the cases observed it would seem that an overloading of the alimentary tract by these hearty men had much to do with bringing on the attacks. I therefore feel justified in concluding: That if prompt and proper measures are employed in every case during the first twelve or twenty-four hours of the attack, a very large per cent of all the cases will be stopped short of the condition calling for surgical treatment, and the black record of mortality following this disease will give place to a more hopeful one, while the annoying condition of ventral hernia, which so

frequently occurs in cases that are reported as cured by an operation will be less frequently seen.

XVII. THE OLD AND THE NEW TREATMENT OF APPENDICITIS. BY J. D. CRAIG, M. D., of Rogers Park, Chicago. I have been much interested in the papers and discussion on appendicitis in the CLINIQUE and have been asking myself the reason why this disease should occur so frequently at the present time in the practice of our young surgeons, while some of us who have practiced medicine for the greater part of half a century could count the cases that we have seen on the fingers of one hand, and I can only account for it on the supposition that many cases that were diagnosed *and cured too*, as colic, were really that most formidable disease. I can recall many cases where the pains were located in the region of the cæcum, some of which recurred from one to three times, but as they yielded promptly to treatment and finally disappeared entirely, I classed them at the time as colic, but I am now convinced from the demonstration that modern surgery has supplied, that they were appendicitis; and I feel myself, justified in this opinion because there is no reason why the disease should prevail more at the present than in the past, and if this is true, then it follows that, although the removal of the appendix may save many lives, surgical interference is by no means as often called for as some overzealous operators would lead us to suppose.

Of the five cases that I have been willing to diagnose as appendicitis in a somewhat extensive practice of thirty-six years, there was but one death, and I do not pretend to greater skill than many other homœopathic physicians of the last generation. One of the cases referred to, is a good illustration of what may be done with medicine and the recuperative forces of the body, even in desperate cases and under adverse circumstances.

Case. In the summer of 1875, Dr. Aldrich, of Allegan, was attacked with appendicitis and recovered under his own treatment of more than a week's duration. Not realizing the gravity of his ailment, he resumed work as soon as he

was able to ride, and a relapse speedily followed, resulting in suppuration. He became much emaciated and there appeared a well defined swelling in the lower part of the right side of the abdomen which his physicians, the late Drs. A. B. Botsford and Whitfield, of Grand Rapids, could not positively determine the nature of. At this time he was removed to Niles by his brother, the Rev. Mr. Aldrich of the M. E. church, and came under my care. My diagnosis was that suppuration had taken place and the pus was confined to the region of the cæcum because of adhesions, caused by inflammation, but unfortunately the physician whom I called in counsel could not agree with me and I was left to my own resources except that I was supported by the patient who agreed with me, and with his approval I proceeded to make an opening into the pus cavity when gas followed by a copious discharge of pus confirmed our opinion.

A few days after the operation I was suddenly summoned to his bedside because there had been discharged from the opening in the abdomen some fæcal matter followed by intense pain. Before my arrival he had turned on his right side when the pain and fæcal discharge had ceased and the attendants were instructed to keep him in that position as long as possible with the hope that sufficient inflammation had been set up to cause the ruptured gut to adhere to that part of the peritoneum on which it evidently was resting. Late the next day his position was carefully changed and no further trouble was experienced and he began slowly to improve. Soon after this I removed to Grand Rapids and the patient was transferred to my successor at Niles and recovered so as to resume practice.

In reviewing the treatment of these cases I cannot recall all of the remedies used, but one remedy stands out as prominently in this as bryonia in hepatitis, and that is dioscorea. Although it will by no means either cure or even relieve all cases, it is indicated more frequently than any other remedy and when it is required the cure is prompt and permanent, and whatever success I have had in the treatment of this disease has been largely due to the use of dioscorea.

The principal indication for this remedy is that although the pains often remit, the patient is never entirely

free from them. In one case of colic (not appendicitis) that I had there were decided intermissions of pain, but when the paroxysms came on they were always attended by stretching, and as I remembered that symptom in one of the provers of dioscorea, it was administered and gave very prompt relief.

CONCLUSIONS.—The Transactions of the Clinical Society as they have appeared in this volume, have furnished a large number of practical papers and discussions upon the subject of appendicitis, more especially upon its medical and surgical treatment. Other communications upon this very interesting subject are still in hand, but, as they are of the text-book order, and thrash the same straw over again, we withhold their publication. Besides, there are other subjects that are pressing, and which also merit careful consideration by the members of the Society as well as by the readers of THE CLINIQUE.

Concerning the medical treatment of appendicitis, however, two expedients have not been emphasized as they deserve, viz.: the castor oil treatment, as advised by Dr. M. O. Terry, and the use of terebinth, or its equivalent. **Kerosene**, to the extent of hypercatharsis.—EDITOR.

Hospital Notes.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

REPORTED BY CORNELIA S. STETTLER, M. D.*

TUBO-OVARIOTOMY TO PRECIPITATE THE MENOPAUSE IN A CASE OF INTERSTITIAL FIBROMA. April 9.—*Case 22,032.*—After removing the tubes and ovaries from a woman \ae 40, to arrest the menorrhagia and a post-menstrual discharge of pus from the fallopian tubes, Prof. L. said: This operation was a compromise, for, with a fibroid in its walls, and lying half above and half below the superior strait, the uterus should also have been removed. But neither the patient nor her husband would consent to it. They were willing the appendages should be taken, but nothing more, and preferred having a second operation, if it becomes necessary, rather than a hysterectomy now. It was an awkward alternative, but may prove to be best in the end.

Wednesday, April 25. You remember what was said of the thick abdominal wall in this case; of its being an almost constant condition in uterine fibromata that are not very large, and of the consequent liability to stitch-hole and mural abscess during the convalescence from a laparotomy made under these circumstances. The formation and discharge of pus in this instance is not attributable to defective asepsis during and after the operation, but to the retrograde changes in the adipose tissue that was included in the sutures. This patient is well enough to go home now, but will wait until her three weeks are up. Her physician, Dr. Horsch, will watch the case and keep us informed of its future progress, for, if despite the precipitation of the menopause, that tumor continues to grow, it may yet require another and a more serious operation. Here are the diseased appendages that have been prepared and preserved for your inspection.

VENTRAL HYSTERECTOMY FOR LARGE DEGENERATING FIBROIDS. Monday, April 25. Two specimens of large

* Continued from page 184.

fibromata were shown in illustration of the tendency of these tumors to undergo retrograde changes that may make them very dangerous. In *Case 22,025*, brought to the hospital by Dr. I. W. Johnson, of Peoria, a fifteen-pound tumor, in which the uterus was imbedded, was removed by a ventral hysterectomy, April 4. When cut open the larger growth was found to be undergoing a fatty and cystic degeneration which accounted for its semi-fluctuation while in situ. That symptom, which is something between elasticity and actual fluctuation, when taken with the history of a recent rapid growth in a tumor that has been carried without any perceptible change in its size or relations for months, or perhaps for years, is suggestive of a uterine fibroid. But it may happen, as in this case, that the growth shall begin laterally in the inguinal region, and the early symptoms may all be indicative of ovarian dropsy. In which case a thick cyst-wall that is œdematous, or boggy, may yield the same symptom on palpation. Three weeks have passed since this unsightly and unpromising mass was removed, and the patient is almost well again.

Case 22,036. A patient of Dr. E. R. Jackson, of Dubuque, from whom this other tumor was taken, had first observed a growth in the abdomen six years ago. The tumor had slowly and steadily increased in size during all that time, but six weeks ago it began to change rapidly, and in that interval had grown as much as in all the previous period. I made an abdominal hysterectomy in this hospital, April 20, and removed the uterus, tumor and appendages weighing eighteen pounds. The patient is now at the sixth day, and doing well. A careful inspection of this tumor will show you that it was in process of degeneration, like that taken from the other patient. Both were from unmarried women, one of whom was forty-two, and the other forty-four years of age. Both had the same significant physical symptoms and the same relatively rapid growth of the tumor after it had existed for a long time without any apparent change; and both suggest the folly of trusting too implicitly and for too long a time to palliative measures of any sort in old cases of uterine fibroids. This is no reflection upon the physicians who brought these cases to me, for they know their business, and their action proves it; but it does involve a decided lesson for you in what I call conservative surgery of a radical kind.

□ In the last case there was an extreme varicose condition of the ovarian veins, and of those within the broad ligament that is not frequent, and which I never like to encounter. It is apt to accompany the very rapid changes that have taken place in the later stages of some of these tumors, and has a decided squint toward malignancy. Besides, one learns to be suspicious of almost any kind of ligature when applied to such large veins as were at the right side of this tumor especially.

LAPAROTOMY FOR OLD PLASTIC PERITONITIS IN MORPHINE SUBJECTS. *Case 22,037*, æt. twenty-six, came to the hospital by the advice of Dr. B. D. King, of Muskegon, Mich. Puberty at twelve; married nine years, but never pregnant. She menstruated normally for two years, and then took cold while the flow was on and has never since been well. First she had dysmenorrhœa for a long time; then for a season, and without cause, the flow became almost painless; but three years ago the dysmenorrhœa returned, and has been growing in intensity until it became atrocious whenever the flow recurred. For four months there was no flow, and for the past two months it has been very scant and extremely painful. There is almost constant pain in both ovarian regions, in the back and down the thighs. The digestion is weak, she is full of colicky pains, the bowels are moved with great difficulty, and while not albuminous, the urine is diminished in quantity by about one-half. She is a victim of the morphine habit.

Operation. April 23 a laparotomy was made before subclass two. The most firm and intimate peritoneal adhesions were found binding the pelvic organs in one mass. When they had been broken up, a thin-walled cyst was found behind the right broad ligament. This was ruptured while being enucleated and its clear serous contents extravasated. The adhesions being separated and the pelvis flushed and cleansed the ovaries could not be found. A careful toilet of the peritoneum followed and the gauze drain was left as a safeguard against hæmorrhagic oozing and adhesive peritonitis.

Wednesday, May 9. You remember my guarded prognosis of this case (1) because of the severity and the relapsing nature of the peritonitis; (2) the impossibility of removing the post-ligamentous cyst entire, and of finding and taking the ovaries; (3) the possible complications from the morphine habit. She is convalescing rapidly.

THE CHILDREN'S CLINIC.

SERVICE OF PROF. JOS. P. COBB, M. D.

REPORTED BY H. J. PAYNE, CLERK OF THE CLINIC.

ARTICULAR RHEUMATISM. *Case 619*, æt. two and one-half. For five days this little girl has been suffering with some fever and pain; the right knee and hand are swollen, hot, and sensitive to the touch. She has no appetite for anything but milk, but is very thirsty; she is restless and does not sleep well; sweats about the head and feet especially while asleep. Her bowels are moving three or four times daily, accompanied with pain; movements are green. Her temperature is now $100\frac{3}{4}$. With the outset of the attack, she had a high fever and a convulsion.

So far as we could learn, the family history was good, except that an older brother had suffered with the same kind of attacks.

These cases are one of the forms of illness which may be traced to improper infant feeding. Children of this age are not prepared to digest meat and vegetables, and yet we learn that this little child, like many others of her age, is accustomed to come to the table and eat anything and everything; as a result, there is imperfect digestion, the absorption into the blood of imperfectly oxidized food products, irritation of nerves and nerve centers by these abnormal factors and overwork imposed upon the organs of elimination. So long as these excretory organs perform this extra work no ill effects are noticed, but anything which serves to upset the normal rhythm of any of these organs is attended by pathological results; frequently this exciting factor is so trivial that it is lost sight of. We will give this little patient bryonia 30 x, and regulate her diet.

Five days later she reported at the clinic markedly improved; the knee is much better, and she is able to walk; the hand is still somewhat swollen but less sensitive; the bowels are regular and stools normal. For three mornings she has had the nosebleed when waking. She will be given saccharum to-day, not because we consider that she has had too much medicine, but because we consider that the proper regulation of her diet is responsible in part for

her improvement, and that under it she will continue to improve.

Under the saccharum Px she reported continued improvement for two weeks, and was discharged.

ARTHRITIC DIATHESIS.—*Case 689.* Robert æt. fourteen years. Between the ages of four and five this boy had mumps, measles and whooping cough. Since this time his health has been excellent until about six months previous to his appearance at the clinic. During this period he has had little appetite and has been listless and "out o' sorts." For the last few days he has been complaining of a severe pain in the chest through the right side during every inspiratory effort. For two days he has had a frontal headache. The bowels are regular.

The urine is high colored, deposits a reddish sediment on standing, on examination it showed a sp. gr. of 1028 and an excess of urates. The tonsils are large the mucous membrane of the mouth and throat is pale; a tenacious mucus secretion adheres to the tonsils and uvula. He sleeps well. The family history is fairly good.

Bryonia 3x will be given him four times daily. One week later he reported at the clinic with record of better appetite; no return of headache; no pain in the chest. He complains however of a pain in the muscles over the sacrum so intense that he has not been able to sleep.

The bryonia 3x was continued.

Two weeks later he reported that there had been continued improvement until two days ago when he took cold. Since then he has been coughing mostly during the day and raises a little white mucus. Some pain in the chest when coughing and a tight constricted sensation. There is an accumulation of gas in the stomach and eructations while eating which give relief. The bowels are constipated, stools hard and passed with difficulty. Is troubled with frequent attacks of nosebleed which are scanty in amount.

Phos. 6x was given four times daily. After the use of this remedy for two weeks he was discharged feeling well.

PHIMOSIS, INDIGESTION AND DIARRHŒA.—*Case 691.* Albert J., æt. three years and nine months. Family history good. When one year old he had two convulsions thought to be due to teething. About that time he is said to have had malarial fever, and was also troubled with retention of the urine.

For two weeks now he has had a loss of appetite, talks and cries in his sleep. The bowels move four or five times daily, the movements being thin, white, and offensive. The urine is profuse and excoriating; is cloudy and deposits a reddish colored sediment which adheres to the vessel. Upon examination a condition of phimosis was found to exist. The adhesions are said to have been broken up at the age of one month but are very firm at present.

For two days he had a fever come on in the afternoon at about three o'clock. Circumcision was advised and sulphur 6x was prescribed.

It is not at all improbable that the adhesions between the glans and prepuce were broken up as reported, but if the prepuce fits tightly over the glans and no care was given it, there is no reason why they should not again become firmly adherent.

The eruption of the teeth may have been an etiological factor in the production of the convulsions mentioned, but they were probably due more to the irritation caused by the condition of phimosis, to which cause also we may safely charge, in part at least, the retention of urine. The fever which is described both at the present time and that which occurred when he was a year old and was called malarial, may also be largely due to the local irritation and the reabsorption during retention.

He reported one week later an improvement in the condition of the bowels and some improvement in the character and amount of the urine. He has, however, continued to have a fever which has occurred every second day. He was given sulphur 30x. Four days later an operation to relieve the phimosis was made and from that time there was immediate marked improvement, with no recurrence of the fever.

THE ALUMNI ASSOCIATION.

The eleventh annual meeting of this Association of the Hahnemann Medical College and Hospital, of Chicago, was held in the large clinical amphitheater on the evening of April 4, 1894. The attendance of old and new graduates was much larger and more enthusiastic than ever before. The first business was the hearing of

THE REPORT OF THE SECRETARY,

DR. F. H. HONBERGER.

The Secretary's report of the work done by this Association during the past year is as follows:

In accordance with instructions given to the Executive Committee at the last annual meeting a circular letter was issued calling a special meeting of the association to be held in Chicago during the World's Congress of Physicians which was mailed to some sixteen hundred alumni. As a result of this call and the active work of the executive committee we had the largest number of alumni in assemblage that has ever attended a meeting of this association, there being about 300 members present, after the enrollment of twenty-eight new members. The policy of the college and the support of its alumni were discussed, the following members responding with enthusiasm: Dr. A. K. Crawford, Chicago; Dr. O. W. Carlson, Milwaukee; Dr. Higbee, St. Paul; Dr. Stearns, New York; Drs. E. S. Bailey, G. F. Shears, M. J. Moth, J. P. Cobb, H. P. Skiles, H. B. Fellows, Chicago; Dr. Barrett, of Iowa; Dr. Carl Fischer, of Australia; Dr. Applegate, of New Jersey; Dr. Spring, of Iowa; Dr. Roberts and Dr. Roby.

Dr. J. P. Cobb then on behalf of the Executive Committee extended an invitation to the members and their friends to be present at the Christening of the new college building on the following afternoon, where a lunch was served to a large number of visitors, some of them being from foreign countries. All present were enthusiastic in their praises of our progressive institution and after some timely remarks a very generous and general subscription to the alumni fund was made. The total amount subscribed at this meeting footed up to about \$1,200. One member who has interests in institutions in his own town not only subscribed but promptly paid \$100 and furthermore said as soon as the new hospital is completed, draw upon me for enough to furnish one private room entire. If every alum-

nus could be induced to attend these meetings and see the need of his moral and financial support of his alma mater old Hahnemann would feel an impetus that would send her far in advance of her present high standing.

The Executive Committee, Secretary and Treasurer have during the past year made vigorous efforts to materially increase the alumni fund. Class Secretaries were appointed to solicit from their respective classes. Many of them did excellent work, meeting with a hearty response from their classmates, while some others labored hard, and met with little encouragement from their class. The Treasurer's report will show a substantial increase in subscriptions, notwithstanding the financial depression which we have all felt to greater or less extent.

You that have taken the pains to come here to-night will be given an opportunity to inspect the building and see for yourselves how the alumni fund has been expended.

The college building was completed and turned over to the trustees at a time when the whole country was shaken by the financial stringency. They had no money in the treasury with which to furnish the building, and none could be obtained at any price; then the question arose how can the college building be furnished that it may be in readiness for the opening of the college term, which was fast approaching. The prospects looked rather gloomy until the Executive Committee came forward in the emergency and said the alumni association would undertake the furnishing. Then in conjunction with a committee from the faculty immediately began the purchase of gas fixtures, seats, etc., in fact you, "The Alumni," have purchased everything under this roof in the way of furnishings except supplies used in the laboratories.

The library has a good nucleus about which to build. There now nearly one thousand volumes upon the shelves, and the library of the late Dr. Laning has been promised, and will soon be added to the list. Any of you that have volumes to spare for use of the library can send them to the Executive Committee in care of the Superintendent of the college. Express charges will be paid on the same and they will be placed upon the shelves in their proper places and not allowed to be taken from the building. Specimens for the museum can be forwarded the same as the books, and the Executive Committee will see that they have their proper place and are carefully preserved.

THE TREASURER'S REPORT.

By DR. JOS. P. COBB.

*Mr. President and Members of the Alumni Association of the
Hahnemann Medical College and Hospital of Chicago:*

In submitting his annual report the Treasurer desires to inform the association that all expenditures for furnishing the new college building have been made by the committee appointed for that purpose, in connection with a similar committee from the faculty, and that all bills have been countersigned by the Chairman of the Executive Committee.

DR.

March 23, 1893, balance on hand as per last report,	\$1,170.35
April 1, 1894, total amount received on subscriptions since,	974.50
Total amount received in fees and dues,	64.00
Received for surplus bottles sold,	12.87
	\$2,194.22

CR.

April 1, 1894, general furniture for the college,	\$1,244.25
Gas and electric light fixtures,	510.84
Dispensary,	181.48
Shades for college,	80.25
Dissecting room tables,	86.16
Postage, including annual notice and letters to Alumni in "The Pulse,"	53.00
Buttons for subscribers,	45.00
Stationery and printing,	87.25
Collections on drafts,	1.25
Expressage on books donated,	1.00
	\$2,190.48
Balance on hand at date,	8.74

ASSETS.

April 1, 1894, notes matured and payment deferred,	\$418.00
Notes unmatured,	1,622.50
	\$2,040.50

LIABILITIES.

April 1, 1894, "The Pulse" for call of 1894,	\$17.00
A. H. Andrews & Co. balance on furniture,	111.63
Treasurer's bill for postage and stationery,	10.00
	\$188.63
Excess of assets over liabilities,	1,901.87
April 1, 1894, total amount subscribed to date,	\$4,866.60

New Members. The following alumni of the "Old Hahnemann" were then elected to membership: Drs. W. C. Wise, Joseph Lewis, Jr., J. Corey, M. G. Owen, Mary O. Hoyt, E. E. Vaughan, Anna C. Bigelow, C. E. Kohlka, H. F. Spaulding, E. M. Spaulding, Frank O. Higbee, O. G. Tremaine, J. M. Hicks, D. M. Nottingham, A. F. Harris, Mary J. Wright, May Warren, E. S. Foss, Elizabeth Almond, Sarah B. Duncan, Grace A. Rowley, Minnie M. Hopkins, Anna L. Wilson, S. D. Ebersole, Arthur Emmons, H. P. Skiles, E. E. Holman and C. A. Emmons.

Officers for 1894-'95. The following officers were elected for the ensuing year: *President*, Dr. O. G. Tremaine; *First Vice President*, Dr. C. G. Higbee; *Second Vice President*, Dr. Kate I. Graves; *Secretary*, Dr. F. H. Honberger; *Treasurer*, Dr. M. J. Moth; *Necrologist*, Dr. E. S. Bailey; *Executive Committee*, Drs. A. K. Crawford, Jos. P. Cobb, O. W. Carlson, with President, Secretary and Treasurer. The meeting then adjourned to another room, where a lunch was served and a general good time enjoyed by all. Short speeches were made by Drs. E. E. Holman, Nottingham, Dr. Skiles, C. T. Canfield, C. G. Higbee, O. W. Carlson, Jos. Lewis, A. K. Crawford, J. P. Cobb, E. M. Bruce and others. The serving of lunch at these meetings is a new feature which affords an opportunity of a good social evening, where you can renew your old acquaintances and feel perfectly at home. It is to be hoped that the future annual gatherings will be of the same free social character, that they will be looked forward to in anticipation of the relaxation and pleasures they bring to all who attend.

THE ALUMNI ADDRESS.

BY O. G. TREMAINE, M. D., OF CHICAGO.

Mr. President, Ladies and Gentlemen, Members of the Alumni Association: This is a glad reunion hour. We are here to talk of our grand old alma mater, her past, present and future.

I am glad to belong by birthright to this circle and am profoundly grateful for the honor bestowed upon me to-night. Most of us went out from this college, boys and girls. We return men and women of more mature years. Our lives have broadened. We, most of us have left our own hearthstone to meet here, and around it are gathered those dearest on earth to us. No more boarding house grub. No more discussions of the nature of the beefsteak. No more singing of the old time songs. Now every day day we find cares mingled with our joys. We are now working for others as well as ourselves. We may seem more sober, but I trust and believe that these later days are bringing something of fruition of our hopes and plans. In those early days we talked much of what we were going to do. Now we are in the midst of the doing. We stand at the beginning of a new era for our college. I have cast many a hopeful glance into the future. I see bright prospects and the fulfillment of fond hopes and large plans for this institution.

The history of homœopathy has been a history of struggle. At no time has our school had anything like a fair chance. The dominant school has been able, with their superior numbers and prestige, to monopolize very largely the hospitals. Chicago has never had, until now, a large and complete homœopathic hospital.

It has always seemed, judging by what homœopathy possessed or controlled in hospitals, as though it did not amount to much. These conditions have been serious and ever present obstacles to our progress. Now the Hahnemann college has a hospital completed, save some finishing touches in the interior, that, in point of size, elegance and completeness is one of the finest in this country.

The completion of such a grand hospital redounds to the honor of homœopathy, the great good of our school, and is a perfect demonstration of the devotion, zeal and splendid fitness for the work of the men who have had it in charge. The Hospital Board has labored under great and unusual difficulties. The phenomenal financial de-

pression of last year, and the strike of the early winter, made it impossible to complete it so soon as contemplated, even after they thought all difficulties had been overcome.

Now, after years of wearisome waiting, of planning and of hoping, the long felt want is supplied. The hospital in all its completeness is finished. Everything that human ingenuity could invent or experience suggest, that tends to make a modern hospital perfect, has here been utilized. May the angels of peace, prosperity and enterprise ever hover with the angels of mercy over it. May God's blessing be upon it, and upon the men who shall labor therein.

It stands upon a quiet street, just in the rear of the college, facing the lake. The entrance is elegant. It is seven stories high ; has twelve wards of ten to twelve beds each, forty-eight private rooms ; parlors, laundry room, large elevators, etc. On the first floor are the offices and children's wards ; the second, the general surgical department ; the third is devoted to the medical and surgical diseases of women ; the fourth, to general medical diseases ; the fifth, to diseases of the eye, ear, nose and throat ; the sixth, to the lying-in department ; and on the seventh is the kitchen and laundry.

Each of these departments, even the kitchen, has a special sub-clinic room. Thus seven sub-clinics can be going on at the same time in the hospital, and four in the college.

The contract for furnishing the entire hospital except the private rooms, has been let. The forty-eight private rooms will be furnished by the friends of the institution. This will give a pleasing variety and make it more home-like. A large proportion of these rooms have already been selected.

The private rooms have an east front, and in addition to fine furnishings, there is a lounging room on each floor for the use of patients who are able to leave their rooms. The wards are all well aired and lighted. The executive committee have recently decided not to open the hospital this spring, but to furnish it, and during the summer to

gradually move into it, so that everything will be in readiness for the class of '94-95.

The great amount of available clinical material can then be utilized for the benefit of the class to perfection. Magnificent are the opportunities offered the coming classes.

The old time didactic lectures were above criticism and students were, when they graduated, scholars in medicine. Now they graduate both scholars and practical physicians, having seen and examined more cases, under the direction of the most competent instructors, than they will see and treat in several years of private practice. Thus they are possessed of experience when graduated, thoroughly equipped for earnest and responsible work. Would I were an orator, while I talk of our college and the new hospital. Then, perhaps, I could paint a word picture of it as it is and will be.

The cause of homœopathy in Chicago, and in the entire northwest, is advanced by the completion and use of such a large and complete hospital. Now we need not go to hospitals under old school control and say, please may we bring our patients here, thus being compelled to admit that our school lacked even suitable places for our patients. Now we have as good as the best. Now we are independent, and independence always leads to greater—more successful effort. No longer must we apologize for our hospital. Thanks to the faculty, the board of trustees, the whole-souled men and women who have aided so liberally in this grand work. They surely believe that "a man's true wealth hereafter is the good that he does in this world to his fellowmen."

Hahnemann College has always been a leader in lines of progress. She was one of the first to admit women on equal terms with men. *She has led in practical clinical teaching.* The entire faculty are progressive as is shown in each year's work. In the year just closed Prof. Crawford inaugurated a course on the physiological anatomy of the thorax. Prof. Bailey gave several lectures upon the cadaver, demonstrating what he had taught in a most satis-

factory manner and in so doing delivered the most instructive lectures on gynæcological anatomy I have ever heard. I believe Dr. Bailey is the first professor of gynæcology in an undergraduate school to do this in a systematic way.

Let the work of these men prove but the beginning of much that is demonstrating what is taught to the senior class. The classes in the junior and middle years are taught anatomy and physiology systematically and thoroughly. The seniors are focusing their powers upon practical medicine. The practical teaching in all the departments, in the sub-clinics in Hahnemann College is immense and is rapidly being increased. Thus the professors are during the senior year crystallizing the knowledge gained by the students, in the several years of study, into gems of practical available knowledge. While this is being so well done I would suggest that the viscera of the abdomen and pelvis be studied entirely from a practical standpoint; a kind of review of the anatomy and physiology of these organs, a grouping and analyzing of pathological conditions, with the cadaver before them. Let the students see and handle the tissues. Let a sufficient number of cadavers be furnished so that the object teaching may be complete.

It is extremely difficult to acquire a comprehensive knowledge of the organs of the abdomen. There are so many organs and they are so crowded together. While differing so widely in function they are so closely connected by vascular and nerve supply as to be dependent one upon the other. This greatly increases the difficulty of accurate diagnosis. So many conditions develop that are not clearly understood.

To illustrate. What are adhesions? Theoretically we all know, but how do they look, how feel, to what extent are they elastic? How do they cause obstruction of the intestine? What are the real supports of the uterus, and what is their relative importance? How do they act? How many of us would agree if I should ask what are the functions of the greater omentum? Why is it that those

who suffer from chronic interstitial nephritis are so liable to pneumonia, and if fully developed so certain to die? Why are young children so much more liable to invagination of the intestines than adults? In this line of investigation we find the sympathetic nervous system must be exhaustively studied. It alone I think holds the key that can unlock many a knotty diagnostic problem.

Object teaching is now the order in many great schools devoted to other subjects. In view of its complexity, the difficulty of learning and understanding it, the wonders of its organization and the mysteries of its functions, it is more important that the human body be studied objectively than anything else.

Whether this additional teaching intended only for senior students, can best be accomplished by the different professors each in his own line; by the senior professor of anatomy, or by having a special professor for the viscera, I cannot say; I think; however, that this method will be found to meet a long felt want, and that it will, in the near future, become common. I predict that our alma mater will be a leader in introducing it.

It was well said last year by Dr. Abell "that our mother school had not passed the climacteric." Let me say that not within the range of human vision can I see her passing the menopause. She has been, it is true, a prolific mother, but such is her constitution and capacity that her strength is increased and vigor renewed just as her family increases in numbers and excellence. While the alumni continue to cherish her, while enterprise and progress mark her footsteps, while *excelsior* is her motto, her fame shall extend and her influence increase. She shall be during all the years of the future, as she has been in the past, a benediction to the human race.

The history of Hahnemann College is worthy of close study. What made it great? Not endowments, not buildings, not large laboratories nor a great library. Not large salaries that induced the faculty to be abundant in labor.

The opportunity was present, the need for such a school

existed. Yet several other schools had equal opportunities and the same need was present. So that a critical, impartial study shows that in a very large measure it was the faculty, their labors, their wisdom in planning and in executing that made our alma mater great. I cannot tell with sufficient emphasis of the grand work and self-denying workers of this school. Go where you may you cannot find anywhere a college that presents so great self-sacrifice by teachers and such magnificent results. For of a truth our school is first among all colleges that upholds the glorious banner of *similia similibus curantur*.

Let me repeat it. It was the faculty who made the college what it is. Then all honor and praise where it is due. "The place honors not the man, 'tis the man who gives honor to the place."

Without money and without price, the entire faculty have labored all the many years of the past. They were and are high minded, brave and self-sacrificing, devoted to the college in face of all opposition. They indeed believed that "work is not man's punishment, it is his strength, his glory and his pleasure."

Every great and commanding movement in the annals of the world is the triumph of enthusiasm. What we need now is a little more enthusiasm on the part of the alumni.

My thoughts and feelings upon first inspecting the new college and the newer hospital, were those of real inspiration. I was glad so many of us had given our mites, a few noble, generous souls have given liberally and I wished I had been able to give more. We should not forget the ladder by which we climb. It appears to me that if only we could take each alumnus through the well appointed college, let them see how thoughtfully and well the money has been expended, and then escort them through the many rooms of the new hospital, recall what an enormous amount of good work had been done in the small old one, contrast future opportunities with past ones, they would feel not only that they ought to give, but that it will be a

pleasure to do so. The ability, fidelity and zeal of the men, who with a small college building and without an adequate hospital have placed Hahnemann College at the head of homœopathic schools, ought to put such of the alumni as have not lent a helping hand to same. Is there any good reason why they should do it all, and we who have so greatly profited by their teaching, nothing?

Let us be helpful to the cause that interest us. It greatly adds to our interest in the causes we wish to see advanced, if we are in some way helpful to them. Some enterprises are advanced by work, some by influence and some by money. Hahnemann College has ever had your influence; now in this, her hour of need as well as of triumph, I would urge her claims upon you.

Laboratories and a complete library cost much, but they are invaluable. When our laboratories, chemical, physiological, microscopical, bacteriological and biological are completely fitted out; when the college has every aid and appliance that can be useful in teaching; when there is a library fund sufficiently large so that the interest will supply the yearly needs; then and not until then shall we have discharged our full duty to our alma mater. In thus giving I am sure that we can feel that we are giving where it will be of real benefit; money planted where it will surely grow, and great shall be the increase.

I fully believe that the alumni have and will give sufficient to this school so that it is fitting and proper that they live up to their privileges, and have a voice in the policy of the college and hospital. The college invites our coöperation. Let us accept the invitation.

About one thousand dollars is needed to be expended this coming summer and fall. Most of this amount is for the library and museum. They are now gathering in as many books as possible. All works are wanted, old and rare ones especially so. The library of the lamented Laning is greatly desired. It is still held for the school. The library, let us say, our library, receives all the homœopathic journals, and many of the old school, on the ex-

change list. Money is needed to bind them. Those who have not given can easily give ten dollars a year for three years. We now number nearly fifteen hundred, so that this small sum would give the college, in three years, more than \$45,000. The subscriptions to the alumni fund to date amount to \$4,056.60. Amount paid, \$2,234.10.

The average annual income of the physicians of the United States is about one thousand dollars. The average yearly income of the alumni of this college is several times that amount, therefore it is a reasonable thing that we stand by our college, and we can well afford to help her.

A few thoughts for the graduating class and those young in the profession. In your work do not forget that you have responsibilities outside of those involved by your duty to your patients. We must remember that as educated men and women, our influence increases with our education. We are, whether we will or no, potential factors in the educational forces of the community in which we live. Let us see to it that our influence tends to build up and sustain the things that are noble, pure and good. Let there be no doubt as to where we stand on questions of morality or of education. It is often said that the study of medicine tends to infidelity, makes men hard hearted, etc. I deny the statement. Nowhere, save in the ministry, can be found such a wide, open field for the exercise of all the higher, nobler qualities of mind and heart. Nowhere, such a field for usefulness in educational, moral and religious work. He who practices medicine for money only, loses sight of the richest rewards, the best compensation. Let us practice our profession with pure hearts and a broad philanthropic love for humanity. Be enthusiastic and earnest in your work. These qualities are contagious. Who does not like a large hearted, earnest and enthusiastic physician. I do not mean to carry simply an apparent enthusiasm. I mean to cultivate such an interest in your profession; give yourself so unreservedly to your work; make the desire to succeed of supreme importance so that the

enthusiasm is a natural result. I would not belittle the value of scientific acquirements, but rather emphasize them, but those of us who have labored a goodly number of years in the medical field know full well that personality is a potent factor in acquiring and retaining practice. The surgeon of to-day thinks cleanliness is almost everything. He can tolerate anything that does not soil or contaminate. I want to say that in the practice of medicine, when, with a clean hand there goes a clean conversation, a clean mind and a clean life, the value of things clean is almost beyond comparison.

We should always put manhood first, in all of its essentials. First prove ourselves men, then physicians. Above the desire to stand well as a physician, above the ambition to take high rank as a surgeon, I would place the desire, the ambition and the determination to be a true, noble, generous man. Be prompt in responding to calls. The idea that an apparent indifference to work shows a superiority is a mistake. People are anxious when one of the family is sick, and usually want a physician, at once, when called. So far as is possible be faithful to your office hours. It is better to make the hours less and have it known that you will be there.

Rapidity in practice can be greatly cultivated. You can learn to make haste by directness of work, by conciseness of speech, by giving all your attention to your patients. An apparent haste is not wise, it looks like neglect. Discourage night calls. Do it by often speaking of the necessity that a doctor sleeps the same as other people. Do it by larger fees for work done after 10 P. M. Do it by showing appreciation when people have considered your welfare and have called you before bedtime, or waited until morning. Physicians are often advised to take more journals; that is right. Take several of the leading homœopathic publications, and at least two of the old school.

But journal reading, even of the best journals, tends to one-sided education. The latest and best books written

by men who are leaders in practice, are far more complete educators.

I would urge that more attention be paid to the financial part of our work. Most of us are poor business men. This ought not so to be. As a profession we are short-lived. Many are obliged to retire early from active practice, their health impaired by the slavish work and exposure. Let us see to it that our families, as well as our patients profit by our work. I do not counsel turning a deaf ear to those who cannot pay, but I do say keep accurate books, and, when people are able to pay collect your bills. Collect as closely as the merchant does. It is your duty to your family to require an adequate equivalent for your services. It is undignified to keep your accounts as though you hardly knew how much you ought to charge, or when you should collect. People will not place a higher value upon your services than you do. Let us remember our duty to our own households.

In most cases do your own collecting. You will be able to do it more closely, and with less offense, than a collector can. Be kind and conscientious about it.

Remember that your work is needful only when people are in trouble. We have to do with those who are anxious and careworn. Cultivate cheerfulness and hopefulness. Let it be your delight to be both physician and friend.

" He liveth long who liveth well !
All else is being flung away ;
He liveth longest who can tell
Of true things truly done each day.
Fill up each hour with what will last ;
Buy up the moments as they go ;
The life above, when this is past,
Is the ripe fruit of life below.
Sow love, and taste its fruitage pure ;
Sow peace, and reap its harvests bright ;
Sow sunbeams on the rock and moor,
And find a harvest home of light."

THE NECROLOGIST'S REPORT.

Since the Alumni Association met in its last session, the number of deaths occurring in the profession has been unusually large. April 4, 1893, this college lost one of its very best supporters and friends—Prof. G. A. Hall. While not a member of the Alumni Association we could hardly name a person whose interest so centered in the welfare of this college as did Dr. Hall's, and I venture to say that it would have been one of the proudest moments of his life if he could have stood in this new college building this winter and could see the new hospital in its present state of completion. As an associate we owe a debt of gratitude to the memory of Dr. Hall. Some day in the future it may take a more tangible form than mere words or expression of gratitude. One of the monuments that should be raised to his memory is the endowment of a room in the new hospital to be known as the "Prof. Geo. A. Hall Room" and it would be in exact keeping if the room were to be occupied with the unfortunate poor or those maimed in accident, or to the homeless ones. So great was Dr. Hall's generosity that he was constantly supporting this class of patients and he took endless pleasure in caring for those whose misfortunes were a little more than they could bear. His was a noble and generous nature. He had a capacity for large ideas, was a genuine leader and in his loss we scarcely know where to turn to find one who will fill his place.

C. L. Crandall, M. D., graduated in class of '79 and located at Burlington, Wis., practicing a good many years with great success at that place. He removed to Salt Lake City, Utah, three or four years ago and died in that city March 22, 1893. At the time of his death he was President of the Utah Homœopathic Medical Association, having been one of the enterprising physicians who had established this State organization. Dr. Crandall was always respected as a student and as a practitioner. His death occurred suddenly from apoplexy.

H. M. Hobart, M. D., graduated in the class of '76, died Nov. 5, 1893. Dr. Hobart remained in this city since his graduation and because of his real worth, his high sense of duty both public and private, his skillful practice and studious habits, he had placed himself in the front rank of his profession. Dr. Hobart was markedly successful in a financial way. Although a young man, he had accumulated property amounting to nearly a quarter of a million dollars. At the time of his death, he was considering plans for the erection of a private hospital, large, commodious, modern and to be devoted exclusively to the care of

patients requiring medical attention only. Such an institution in this city is a great necessity. He died of appendicitis and it seems all the harder to give him up as no effort was made in a surgical line to reclaim him.

Dr. Otto Hottleman, Lyons, Iowa, graduated in the class of '88; died of diabetes, April 22, 1893. Dr. Hottleman, I remember as a student of great perseverance. It was difficult for him to understand enough of the English language to enable him to progress rapidly in his medical studies. Nothing daunted, however, with most patient plodding he came to be a bright, successful practitioner. He was a good citizen and dying at the age of thirty-three, was mourned by a very large circle of admiring patients.

Dr. C. M. Babcock, of Irving Park, Ill., graduated in the class of '83, died November 28, 1893. He located at Columbus, Wis., where he practiced many years. He also pursued the study of law and engaged in legal practice. This he soon abandoned for literary work and for three years prior to his death was an editor. His death occurred after an operation for appendicitis, the surgeon, however, remarking at the time of the operation that it was done too late—a large portion of the intestine being gangrenous.

Dr. Helen M. Heffron died February 1, 1894. Soon after her graduation in 1883 she located at Washington Heights, and by a skillful, earnest, patient and persistent endeavor she won a large number of neighbors and friends over to the firm belief in her ability to practice her chosen calling. She was one of the pioneers in maintaining the right of women to study and to practice medicine. She did not fight but rather won her way to success, clearly demonstrating that she was competent to compete with her brother physician. A cruel form of peritonitis caused a very sudden death. She is much missed and universally mourned among those to whom she had ministered to for years.

Dr. Chas. N. Dorion graduated in the Class of '69; died February 4, 1893. He was for two years house physician of the Hahnemann Hospital, and for two years teacher of anatomy in this college. For a number of years he enjoyed the reputation of having a very extensive practice in St. Paul, Minn.

Dr. J. L. Leffingwell. Students of the present class have this young man in memory. After graduating in the class of '93, he became associated with Prof. Shears. He commanded entire confidence of those with whom he came in contact, and would have succeeded well in his chosen profession had his life been spared. He died of fever.

Dr. G. H. Morrison, class '81, of Winnetka, Ill., died January, 1894, after a brief illness.

Miscellaneous Items.

Four of the great trunk lines between Chicago and Denver offer to members of the American Institute and their families round-trip tickets to the semi-centennial at Denver for a single fare, the same to be good for thirty days from the date of purchase. The following named roads are in this arrangement: Chicago, Rock Island and Pacific; Chicago, Burlington and Quincy; Chicago, Alton and Missouri Pacific; Chicago, Union Pacific and North-Western. Each of these roads also offers a free, special complimentary excursion into the Colorado mountains.—Prof. Laning's collection of 300 volumes is now in the College library.—The Wisconsin Homeopathic Medical Society meets in Milwaukee, May 29-31, and the Illinois Homeopathic Medical Society, Prof. Crawford, President, at Quincy, May 15-18.—Dr. Cornelia S. Stettler succeeds Dr. Lelia G. Bedell at 181 Dearborn Avenue, Telephone, North, 694.—Dr. L. A. Shultz is at 338 East 63d Street, and Dr. Ellen F. Hancock has removed to 39 Bellevue Place.—Dr. Robina N. Henry, '94, has located at Odell, Ill.; Dr. Culver, late House Surgeon, at Sandwich, Ill.; and Dr. S. G. MacCracken, 43d and Calumet Avenue.—The Eighteenth Annual Meeting of the Clinical Society of the Hahnemann Hospital will be held in the College amphitheater May 26, 1894.—The Alumni should take special note of the doings of their Association given in this issue, especially of the Secretary's and the Treasurer's annual reports, and of the Address by Dr. Tremaine.—The Journal of the British Homœopathic Society for April, Dr. Richard Hughes, editor, is a most excellent issue, and furnishes a royal contrast to some of our very sloppy periodicals.—This is the season for a great crop of papers that will be hurried up for the State Societies.

THE CLINIQUE.

Vol. XV.]

CHICAGO, JUNE 15, 1894.

[No. 6.

Original Lectures.

PHARYNGITIS.

BY C. GURNEE FELLOWS, M. D., ASSOCIATE PROFESSOR OF DISEASES OF THE THROAT AND NOSE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

From the fact that the pharynx is not only a part of the respiratory, but also of the alimentary tract, it is not strange that it is a frequent seat of disease. Through this orifice the germs of various diseases are both inhaled and swallowed, and here lies a most fertile soil for their propagation.

Disease of the pharynx may be either primary or secondary; it may be a local disease with constitutional symptoms present as a result, but more often the local manifestation in the pharynx is but one of the phases of a constitutional disease. I wish to direct more especial attention to the examination of the pharynx, as a means of assisting in our general diagnosis, and to its treatment as a part of the general disease, strongly assisting in the cure. Sore throat is an easily recognized symptom of many diseases, but its treatment is as varied as the disease of which it is a part.

It still seems to be an unsettled question as to whether diphtheria is a local disease with constitutional manifestations or a constitutional disease with local manifestations,

but whichever the practitioner may believe, he endeavors as a rule to combat it by both local and constitutional measures. By some physicians the internal medication is considered of the greatest importance, nevertheless, there are but few who do not add to it energetic, local treatment. Others, believing only in the local origin of the disease, add the general to the local treatment. True it is, that in diphtheria the diagnosis is perfected by pharyngeal examination, and a cure assisted, if not completed by local treatment.

This much is generally recognized, but I want to call attention to some of the forms of disease as presenting a similar condition. Scarlet fever is, I believe, considered a systemic disease, but with local pharyngeal manifestations, and yet few practitioners pay much attention to this part of the disease, except as to diagnosis.

At a meeting of the pathological society of London, in 1893, it was advocated by Dawson :

“1. That the primary local lesion of scarlet fever is in the tonsils.

2. That this disease is a local disease of these parts and associated lymphatic glands, the general symptoms being caused by the absorption of toxins produced by the microbial growth at the seat of the local lesion.

3. That the incidence of the disease and the subsequent immunity are related to the structure and life history of the tonsils.”

I do not bring forth the advanced theory as a proven fact, but merely to show analogy to diphtheria and suggest that as the pharyngeal symptoms are of so much importance in the diagnosis, so they may be in the treatment; and as the antiseptic local treatment is of undoubted value, to suggest its use and all that may be done to prevent aural inflammation, one of the dreaded sequelæ.

If more frequent examinations of the throats of children were made, abnormalities discovered and corrected, we probably would have less trouble with the pharyngeal manifestation of measles, scarlet fever and diphtheria.

The pharyngeal manifestation of tuberculosis is not an every day occurrence, yet it is seen often enough to prove its existence, frequently as a primary affection, or at least coupled with laryngeal manifestations alone.

Early diagnosis and treatment will retard the pulmonary invasion, if not prevent it. Recent writers aver that when primary in the throat, tuberculosis may be cured.

Heryng, of Warsaw, in a recent report on the treatment of two hundred and fifty-two (252) cases, reports benefit or cure lasting for months and up to five years. Lennox Browne also publishes decidedly favorable results.

For the ulcerative stage lactic acid holds a deservedly high position, as measured by the successful results.

Syphilitic pharyngitis is an even more common example of a local and systemic disease. Who has not looked for and found the mucous patches upon the arches of the palate, the tongue and the pharyngeal wall, and the other well-known local signs of the dreaded disease? Some physicians may claim that local treatment is useless, that the medicated remedy will cure; but I have seen so many cases which have been relieved of continually distressing symptoms by judicious local treatment, that I cannot but advocate it. Antiseptic washes, and stimulation by the galvanic cautery have been followed by the happiest results in the general improvement of the patient.

A sufficient number of diseases has been cited, I believe, to prove the following points: (1) That the local pharyngeal manifestation of disease is often of undoubted value in the perfection of the diagnosis. (2) That which are termed constitutional diseases having local manifestations, may be materially benefited by local as well as general treatment. (3) That on the other hand primary, local, pharyngeal disease with systemic manifestations may be cured by conjoined local and general treatment.

The head mirror and tongue depressor are assuming a greater importance than formerly, and should be used intelligently along with the stethoscope and the speculum. The special knowledge of the throat is not a fad of to-day, but a legitimate aid to the deeper and wider study of disease.

EXOPHTHALMIC GOITRE.

BY HOMER V. HALBERT, M. D., PROFESSOR OF DESCRIPTIVE AND PRACTICAL ANATOMY IN THE HAHNEMANN MEDICAL COLLEGE, OF CHICAGO. *

The title of this paper is limited to the word "study" from the fact that, with the exception of a few clinical and pathological certainties, exophthalmic goitre is still a diseased condition without a settled history.

Protrusion of the eyeballs, cardiac palpitation and enlargement of the thyroid gland are so thoroughly characteristic that they are accepted as definite symptoms; and yet each or all of these may appear in such a varied degree as to render it difficult to assign to any of them an accurate clinical importance.

For that reason we are relegated to the consideration of the normal sympathetic nervous system to deductively find some explanation of the clinical symptoms already in our possession.

Originally it was supposed to represent a grouping of symptoms associated with severe neuroses and the "various psychoses." In other words it was thought that it involved, simultaneously or by regular gradations, the medulla, the cervical cord or the sympathetic. Lately it is assumed, arbitrarily perhaps, to start from the sympathetic, and whatever then reflects the influence of the cerebro-spinal system must be purely reflex or secondary.

With this premise, our investigations must be confined to the larger sympathetic ganglia or to the "abdominal brain" as a whole.

In the first deductions of Eulenberg and Guttman the lesion was located in one or all of the three cervical sympathetic ganglia, while the inferior was presumed to be the seat of primary affection. The same morbid change, sooner or later involving the ganglia above, gave the cardiac, thyroid and ophthalmic derangement in their natural sequence. From the absence of thyroid enlargement, which is frequently the last symptom, or in fact often entirely absent, it was anatomically averred that the irritation or paresis had omitted the middle or lesser ganglion and spent its force more thoroughly upon the upper and lower ones.

* Read before the Illinois Homœopathic Medical Association, Quincy, May 10, 1894.

What then are the pathological changes observed? Is it an irritation or paresis of the sympathetic segments? These have been the puzzling questions in all theories, and to answer compromisingly all phases of the interrogation we may safely accept both conditions as true.

If it is purely a state of irritation then it must be constant and this is contrary to physiological experience. If it is a complete paralysis syncope would be a natural result. There is, however, less objection to the assertion that it has its origin in irritation and terminates eventually in paresis if not in paralysis. Prolonged irritation of any ganglion must in all cases end in some permanent perversion of its function. This would substantiate Guttman's hypothesis that the cardiac involvement is due to vasomotor dilatation of the coronary arteries which, permitting a greater flow of blood to the muscular tissue of the heart, naturally stimulate the cardiac ganglia to abnormal activity. This same vasomotor dilatation, with the overactive heart, would easily account for the thyroid enlargement later on.

We may also continue further—starting with the parietic influence of the upper cervical sympathetic ganglion and explain the ophthalmic involvement as follows: Spasm of the orbital muscles and the muscles of Müller, which run from the eyelid to the membranous lining of the orbit; dilatation of the radiating fibres of the iris; distention of the orbital vessels, and a deposit of fat behind the eye. All of these changes may be systematically traced back through the carotid and cavernous plexuses to a paresis of sympathetic influence and an interruption of the ophthalmic vasomotor distribution.

These pathological expressions may vary in degree according as they may affect the different cervical ganglia. For that reason the clinical revelations of exophthalmic goitre, while they comprise this chain of evidence, may yet suffer a wide variation in their symptomatic indications.

In accepting the above view it is necessary first of all, to combat the theory that the cardiac features are due to paresis of the pneumogastric. This would naturally be the most plausible cause were it not for the fact that we do not find the necessary central involvement to inaugurate such an insidious disease. Were it entirely from the interrupted control of the vagus the cardiac and other symptoms would appear suddenly and with more serious onslaught and this certainly is not the history of the disease.

There is no doubt however that there is partial infringe-

ment of the vagus but it may come from the sympathetic communication of the first cervical ganglion with its root and trunk. This will give an anatomical proving that the lesion of the vagus may be secondary to that of the sympathetic.

Another claim is that it involves the vasomotor center of the medulla; but the same result can be accounted for by the disturbance of the sympathetic vasomotor function especially in that portion from the lower cervical to the vertebral artery.

The fact also that exophthalmus co-exists with cerebral phenomena is by no means a just intimation that it is primarily of that localization, for the cerebrum readily responds to any nervous error.

The defect of coördinate movement of the upper eyelid with the eyeball would be the strongest evidence of central origin. Still the third nerve, which controls the levator palpebræ, is possessed of sympathetic association from which it may receive a parietic influence.

It must be remembered that the pathology just stated is indicative of the disease at its height and to establish proof of the sympathetic lesion we must take into consideration the earliest possible symptoms. These I firmly believe in a majority of cases are found first in some perversion of the sexual function which shows a disturbance of the prostatic plexus in the male and the corresponding ovarian plexus in the female.

Incident to this it is most natural for the irritation to follow the renal plexus causing excessive secretion, and later, disproportionate secretion in the kidneys. This is clearly observed in the polyuria, glycosuria or albuminuria which precede the exophthalmus possibly for a year or more.

The hepatic plexus, being so closely allied with the renal is the next in the line of morbid advance and is recognized by the frequent and exhausting clay colored stools.

The solar plexus proper seems to be the last resort of the paresis in the abdominal cavity. This is observed by the pronounced nausea—even to an odor—by the disturbed digestion, accompanied by abnormal abdominal distention, or pain from intestinal contraction; and, lastly, it is perceived by the constantly recurring diarrhœa due to hypersecretion from the overdistended intestinal vessels.

At this point the progressive irritation or paresis of the

abdominal sympathetic is apparently interrupted and the morbid development of the cervical ganglia begins; and from this time on the characteristic cardiac, thyroid and ophthalmic indications are developed.

In the final stages, general erythema accompanied often by urticaria, pigmentation, and even myxœdematous swelling, illustrate the peripheral vasomotor interruptions.

Tremor, of a regular form which simulates paralysis agitans or irregular, like chorea, may be a persistent symptom when the rami communicantes are involved. This demonstrates the reflex or progressive transportation of the paretic form from the sympathetic to the cerebro-spinal system.

As the disease matures tremor gives place to irritability, restlessness and depression. Hallucinations alternate with melancholia until simple or recurrent mania terminate the complicated malady.

The aim of this argument is to present a pathological picture of exophthalmic goitre in its entirety, not intending thereby to ignore the local lesions of its final stages. It is an attempt to show the conditions which lead up to disease before the actual diagnosis can be made. It is a claim that it is a disease of the sympathetic system as a whole and not of some particular part; that it is a lesion starting in the lower plexuses and systematically progressing toward the cerebrum, just as we find disease of the brain developing toward and through the cord. It is therefore a disease of middle or later life, excepting the rare occurrence in children of syphilitic dyscrasia, and it is dependent upon the healthy function of every sympathetic ganglion and plexus.

To illustrate the above I will briefly quote the characteristic case of Mr. S., fifty-two years of age, a man of most robust physique and of remarkably exemplary habits. The first sign of nervous error was noticed in a sudden and bothersome attack of spermatorrhœa. This was attended with all the mental hallucinations incident to a younger man in the same condition. After an intermittent existence for six or seven months it was supplanted by a decided polyuria which soon verged into glycosuria. In about the same length of time this was followed by frequent passages of gray colored stools which were perfectly devoid of odor. Very soon this condition gave way to gastric involvement of the most pronounced type. Neuralgic pains, alternated with nausea and gaseous distention. Food, or even the odor or thought of food, would bring on the most violent

fits of retching. Along with this there would be frequent spells of diarrhœa, but with a darker and more natural stool. After these systematic stages had reached the region of the solar plexus there was a perfect interregnum of all the previous symptoms. In the next two years the cardiac, thyroid and ophthalmic symptoms of Basedow's disease were gradually but surely recognized and the termination came in an agonizing death.

The remedies which followed the regular gradations of these symptoms were lycopus, apocynum, chionanthus, colchicum and belladonna.

MENTAL WORRY AS A CAUSE OF CANCER.—In a very remarkable paper contained in the *Monthly Homœopathic Review*, Dr. C. H. Blackley states that, in all but three of the cases of cancer that he has seen and treated for thirty years past, the disease was preceded by losses of money or property, or by some anxiety on account of money. The list includes five cases of schirrus of the breast; two of medullary sarcoma of the bones in the hip joint; three of uterine schirrus; five, do. of the stomach or bowels, or both; three of medullary cancer of the liver; one of mammary schirrus followed by encephaloid cancer of the liver and colloid cancer in the thoracic cavity; two of cancer of the bones of the lower extremities; one of the cheek, and one of schirrus of the œsophagus.

The fact that very many persons who have the misfortune to lose money or property are exempt from cancer shows, he argues, a similar immunity to that which protects the majority from the common cause of other diseases. So far as he could ascertain, heredity had very little influence in originating cancer in his cases. In only three of them could he trace any previous history of the occurrence of cancer in the patient's family.

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

MAY MEETING, 1894.

The Eighteenth Annual meeting of this Society was held in the Hahnemann Medical College, Saturday evening May 26, with an unusually large attendance of the members.

THE ANNUAL ELECTION OF OFFICERS.

The following were duly and unanimously elected as officers for the ensuing year: DR. B. S. ARNULPHY, President; DR. CORNELIA S. STETTLER, First Vice President; DR. C. J. SWAN, Second Vice President; DR. MARY H. LANDRETH, Corresponding Secretary; DR. ORRIN L. SMITH, Recording Secretary; DR. W. P. McCracken, Treasurer; and Drs. H. B. FELLOWS, ISADORE GREEN and the two Secretaries, Board of Censors.

REPORT OF THE RECORDING SECRETARY,

DR. O. L. SMITH.

In submitting his annual report the Recording Secretary begs leave to say that during the year, or since June, 1893, there have been twelve regular monthly meetings of the Clinical Society, the majority having been conducted in the clinical amphitheatre of this new college building. The attendance of officers and members has been quite gratifying and very uniform. During the college session we were pleased to note many student faces in the audience and the society meanwhile has been honored with the presence of many distinguished visiting physicians and surgeons. These were both numerous and welcome during the great Columbian Exposition held in this city in the summer of 1893.

The number of clinical papers and essays presented during the year was thirty-nine, averaging, you will note, more than three papers for each session. From this number there were eleven set essays contributed in order by Drs. Evans, Ludlam, Arnulphy, Lewis, Leavitt, Crawford, Chislett, Shears, Dunn, Swan and Smith.

In every instance these papers were interestingly and profitably discussed, including very frequently the essential detail of hitherto unpublished clinical cases. Other valuable papers were contributed and were highly appreciated, consisting of the report of rare cases, translations, etc. The transactions have appeared without exception in the monthly issue of the CLINIQUE.

Respectfully submitted,

O. L. SMITH, *Secretary*.

The following papers were submitted and discussed:

XVIII. REFLECTIONS ON A PROBABLE CASE OF ENDOCARDITIS OF ERYSIPELATOUS ORIGIN.—By Dr. B. S. ARNULPHY.

Case. The patient, Mrs. —, æt. thirty-six, the wife of a Sioux chief, had undergone an abdominal hysterectomy by Prof. Ludlam in his clinic, on account of two very large fibromata weighing forty-five pounds. After five weeks of steady convalescence, without any untoward symptoms except two or three attacks of dyspnœa induced by turning herself or trying to sit up in bed, she was well enough to walk about the ward a little each day, when without warning or apparent cause, she became very drowsy, her pulse increased from 77 to 114, and her temperature from the normal to $103\frac{3}{4}^{\circ}$. Four days later it was $105\frac{1}{2}^{\circ}$, and she had developed a very severe attack of facial erysipelas of the vesicular type. There was no suppuration, and no spread of the eruption, which ran its course in a week. Meanwhile, as she had repeated attacks of dyspnœa, brought on by the slightest exertion, my colleague requested me to visit her.

When I saw the patient the eruption was on the wane, and the fever had abated, so that the results of the examination to which I proceeded are not so satisfactory as they might have been two or three days before. Never-

*See, page 115 of this volume.

theless, they are possessed of sufficient clinical value to warrant their being recorded.

I could find nothing particular on palpation. The apex beat was not easy to locate on account of the reclining position of the woman, and she being weak and excitable I judged it best not to have her sit up. Still I had no difficulty in ascertaining that no cardiac enlargement was present.

Upon auscultation I could discover no murmur over any of the orifices; but the first sound was certainly prolonged and somewhat rough in character, especially over the mitral area. Moreover, this modification of the first sound was not propagated along the vessels of the neck, a fact from which it is permissible to infer that it was rather due to a slight alteration of the mitral orifice, than to a pathological change in the blood. In fact, I am strongly inclined to think that such a typical prolongation, almost murmurish at times, with such a touch of roughness about it, and so well limited to the mitral area, can safely be considered as a remnant of a full-fledged systolic murmur which in all likelihood was present a few days before, as the fast disappearing witness of an attack of acute endocarditis of erysipelatoous origin.

It was my intention to make a second examination a few days afterward, with a view to clear up the problem a little further, but the patient had so far recovered as to leave the hospital for her home in Dakota.

Under the circumstances in spite of the shortcomings which beset our diagnostic evidence, being able to exclude the rheumatic taint, and renal alterations as well as any pleuro-pulmonary complication, it seems to me that the pathogenic link between the exanthema and the heart symptoms cannot easily be disregarded in the present case. Moreover such occurrences are far from being exceptional, and here lies the clinical interest of this very remarkable case.

Some twenty years or so ago no one suspected the relationship which exists between facial erysipelas and the heart. Prof. Jaccoud, of Paris, was the first to point it out, in the course of his clinical lectures at the Lariboisiere hospital, and since then numerous observers in various countries have confirmed the exactness of his conclusions.

It would seem *a priori* that it is only in the more severe forms of erysipelas that cardiac complications are apt to be encountered. Such, however, does not appear to be the fact. And Jaccoud cites a case in point, which he goes on describing at length in his inimitable style: A student, an abortive attack of facial erysipelas. The subject is forty-six years of age, affected with obesity; the eruption invades the face and neck, but no fever is noted, and in the course of four days the disease had spent itself. While it lasted the heart showed signs of acute endo-pericarditis; there was a to and fro friction sound at the base, and a loud and rough systolic murmur at the aortic orifice.

Were it not for the great authority of the man one might be tempted to question whether this was erysipelas at all.

In most cases, erysipelatous endocarditis seems to be willing to disappear without leaving any trace of its passage, very much as happens with the endocarditis of chorea. But it is now well demonstrated that at times it may assume a malignant character and be fraught with fatal consequences. This is the *infectious* form, in which fungoid vegetations are developed, giving rise to multiple embolic infarctions, and attended with symptoms and lesions comparable to those of pyæmia and puerperal infection.

Now if in the light forms the direct action of the *streptococcus erysipelatosus* may be doubted (although the specific microorganism is found in the blood in almost every case), in the severe forms its pernicious influence becomes self-evident.

Nor does erysipelas confine its cardiac mischief to the endocardium; for the pericardium and myocardium may also be involved in the process. Dr. L. Gaillard (*La Médecine Moderne*, February, 1894), who has had a large experience with erysipelas in the Paris hospitals, reports several cases in which the pericardium was more or less affected. One case is especially interesting, as it presented great thermic oscillations, varying from 100° to 104°. On

the fourth day of the eruption a pericardial friction sound could be plainly made out. No albumin in the urine. No rheumatic history.

Later on when the exanthema was receding, the heart became arrhythmic, and several spells of violent præcordial pain were noted; later still, when all fever had disappeared, recurring attacks of tachycardia (160 to 180 pulsations a minute). The patient made a perfect recovery.

The case is instructive in more ways than one. It shows that facial erysipelas may affect the pericardium, without touching the endocardium, and that it may do so irrespective of any rheumatic affinity, or of any nephritic complication. We must also conclude that the symptoms of arrhythmia, præcordial pain and intermittant tachycardia pointed to a temporary alteration of the myocardium.

Ponfick, Hayem, and Achalme describe cases of suppurative pericarditis of erysipelatoous origin. Gaillard, however, thinks that those cases are very rare, and as his opinion is based upon 350 cases of facial erysipelas, it certainly possesses considerable weight.

Jaccoud draws attention to the fact that a slight degree of glycosuria may accompany facial erysipelas. But here I would present a point of far greater practical importance. I refer to the possible involvement of the kidney. We cannot afford for one moment to forget that that organ is eminently sensitive to the inroads of the streptococcus, and that its alterations have a far reaching pathogenic meaning.

I well remember a case of scarlet fever toward the close of which a very slight touch of nephritis became apparent, and which, no doubt, would have disappeared very rapidly had it not been for the untimely supervention of an acute outbreak of erysipelas. As a consequence, the nephritic symptoms became considerably aggravated; hematuria, heavy deposits of casts, threatening signs of pulmonary œdema, then pericarditis followed by effusion. The patient rallied after a long convalescence, but I fear the kidneys must have retained the seeds of future trouble,

as a slight degree of albuminuria occurs every now and then.

Therefore, if in the course of erysipelas we are bound to watch the heart and its envelope, it is still more imperative to keep an eye upon the kidney.

Now, in what measure does erysipelas affect the heart? The various authorities are not quite agreed on that point, and no wonder, since even the degree of affinity between rheumatic affections and cardiac involvement is still a matter of dispute. Taking a broad view of the matter, one might say that while rheumatism affects the heart in a goodly half of the cases, erysipelas confines itself to a modest proportion of one or two per cent.

No physician endowed with a grain of philosophy can remain indifferent to the questions pertaining to the filiation and affinities of disease. Nor are those problems purely of a doctrinal interest. They find their application at the bed-side every day at the hands of all thoughtful practitioners.

But these attempts at generalization require careful discrimination, as they are apt to lead up to very ridiculous conclusions when carried too far. Such was the case, at one time, with the remarkable affinity which rheumatism evinces for the heart. The clinical fact was so obvious, so easily verified every day in thousands of cases, that it created a sort of a craze. I remember that time well. It was early in the 70's, when I was a medical student in Paris. Some of the best minds in the faculty were biased by it, and a few entirely off their base.

Proceeding by syllogistic reasoning these enthusiastic pathologists put it this way: "in almost every case endocarditis is of rheumatic origin," therefore, scarlet fever, which sometimes causes endocarditis, is of a rheumatic nature. The same reasoning applied to erysipelas, and proofs were not wanting to show that there is a close correlation between erysipelas and rheumatism. Even Trousseau had occasionally been led to lend the authority of his genius to those vagaries. Why then leave out in the cold

variola, typhoid fever, Bright's disease, and all the affections possessing more or less cardiac repercussion? We students, of course, made a good deal of fun of all this, and lost no time in including gonorrhœa and pregnancy in the list of rheumatic affections, since both would produce endocarditis!

And have we not seen scores of able medical writers treat in all seriousness of the rheumatic manifestations of gonorrhœa? Now it is well understood that these articular determinations have no more to do with rheumatism than the suppurative arthritis which sometimes develops in the course of erysipelas of the limbs, or than the more or less severe arthritis observed in the course of scarlatina.

DISCUSSION: Dr. CRAWFORD: I am somewhat loth to enter upon a discussion of this paper, not because it is not worthy of it but because the doctor has so fully covered the subject that there is nothing left to discuss. I regret, quite as much as the essayist does, that he did not have further opportunity to examine and investigate this case so that the data upon which he bases his diagnosis could have been filled out where now it is short. It is more than likely that the changes in the short sounds, so carefully noted by the doctor, were due to an inflammatory condition of the endocardium, and that the inflammation was localized about the mitral orifice; but as all such acute investments are liable to give forth more definite physical signs during the decline of the disease, than when the inflammation is at its height, you can understand what satisfaction a later examination would have afforded.

While it is true that in the smaller works upon diseases of the heart erysipelas is not even mentioned as an etiological factor, a group of diseases somewhat like it in character are so frequently referred to that the possibility of its occasionally being the cause is a natural inference.

Osler claims that eleven per cent of his cases of septic endocarditis were connected with puerperal fever; and abundant evidence has been found to prove the existence

of pus-forming microorganisms, such as the *staphylococcus* and *streptococcus* on the endocardial vegetations in post-mortem examinations of these subjects. We are all aware of the relationship existing between the streptococcus and erysipelas. Consequently in the progress of a case of this kind the physician should bear in mind the mischief it may play with the heart.

No one can forget that rheumatism begets endocarditis and pericarditis, because it is, by long odds, the greatest factor in their production. Both the English and continental writers attribute from forty to sixty per cent to this cause; and one author, I remember, says that beyond the fifty per cent of rheumatic cases which show signs of inflammatory heart trouble, he believes that half of the other half suffer likewise but in a less degree.

Even granting this, there is still a large fourth of cardiac cases whose etiology must be referred to other maladies, like septic and pyæmic conditions, puerperal fever, diphtheria, scarlatina, variola, gout, renal disease, and the one which Dr. Arnulphy has been reminding us of—erysipelas.

XIX. IS EPILEPSY EVER THE RESULT OF EYE-STRAIN?
By C. J. SWAN, M. D.—(Part I.) In presenting this initial paper to the society I wish to explain, that in writing it I have in a way anticipated myself. For several months past I have been making an earnest effort to collect a sufficient number of epileptic cases to give me the material for a comprehensive report; one from which some definite conclusions might be drawn. Unfortunately, the past season has not been a good one for epileptics, and three cases is the net result of my effort. Therefore, this first paper will not be so much a report of my own cases as it will be a review of the literature on the subject, of which there is quite an amount, all of which, however, has appeared within a little over one year.

It is offered with the hope of awakening some interest among our doctors, in the eye treatment of epilepsy. There is no doubt that anything which gives us hope of rescuing even a small per cent of our patients from the grip of this malady should receive attention, and especially in view of the discouraging nature of the statements made

in regard to drug treatment by both the homœopathic and allopathic schools.

Epilepsy is so serious and widespread a disorder that to-day our legislative bodies are taking cognizance of it, and are erecting asylums for the exclusive use of those who are afflicted by it. Only a few weeks since, Governor Flower, of New York, signed a bill appropriating \$140,000.00 for the purchase of lands, and for the erection of buildings for the exclusive treatment and care of epileptic patients.

All of us are so familiar with the manifestations of this horrible disease that it seems hardly necessary to describe it; yet, it may not be out of place to give a concise definition of the term epilepsy. Foster gives this: "It is a morbid condition characterized by paroxysms of general clonic convulsions," but I think it better to say that it is a group of phenomena which is merely a symptom of a pathological condition that is capable of releasing stored nerve force in an explosive manner. Its pathology is unknown.

Epilepsy is given various descriptive prefixes corresponding to the supposed seat of the lesion causing the disorder, such as gastric epilepsy, cerebral epilepsy, syphilitic epilepsy, and so on through a long list numbering about fifty different sorts. Among these is also aural epilepsy and retinal epilepsy, but, strange to say, we find no mention of ocular epilepsy proper in any of the ancient or modern works on the disease.

In the New York *Medical Journal* Dr. R. K. McAllister makes an extensive report upon 250 cases treated in Prof. C. L. Dana's clinic in the New York Post-Graduate School and in his private practice. In 120 of these predisposing and exciting causes were found. The most frequent cause was excesses. This cause was found in forty-five cases, either in the patients themselves or in their parents. Alcoholism, excessive smoking, sexual excesses, overwork, and mental strain each played their part.

The causes in the remaining seventy-five cases were about equally divided, and were as follows: Infantile paralysis, traumatism, phthisis, acute febrile diseases, infantile hemiplegia, fright and shock, gastro-intestinal affections, exposure to high temperature, chorea, syphilis, pregnancy, the menopause, rachitis and vaccination poisoning. In the remaining 130 cases it is claimed that no exciting or predisposing cause could be found.

No record is made in the report of examination of the

eyes, and in view of the great interest taken of late by our most learned neurologists in this line of investigation, I consider the notes curiously incomplete. Evidently, no examination of the refractive and muscular condition of the eyes was made in any case. Now, the point to which I wish especially to call the attention of the society is the preponderance of cases due to excesses, and to ask whether the constant strain of the ciliary, or one of the motor muscles of the eye is not as great an excess as any of those mentioned? In view of the large per cent of people who suffer from eye strain, is it too much to say that had Dr. Dana had the eyes of his 250 patients carefully and systematically examined, he would surely have found among them many cases in which there was excessive use of the eye muscles, and in which those excesses could be stopped and thereby the exciting cause removed?

Now, let us see what our medical writers are saying in regard to the drug treatment of epilepsy. First, I will quote from an article in the May number of *Hahnemannian Monthly*, entitled, "Convulsive Affections," and written by Weston M. Bailey, M. D., of Philadelphia, a clever writer, and a physician of good standing in our school. I quote literally: "From my own experience, and that of others whom I have consulted, the homœopathically selected drug is of very little use in epilepsy. Cēnanthæ promised much but accomplished nothing. We must frankly acknowledge that our old school friends do better with the bromides judiciously used. Of these, the bromide of potassa, the saturated solution (of which one drop is equivalent to one-half gr.) is most generally useful. This should be given in from 10 to 100 drop doses in water, three times a day. Probably one-third of the cases of epilepsy are considerably benefited, and not a few regain their memory and intelligence under the proper employment of this medicine. The attacks are staved off and the damaged cells have a chance to recover themselves. I do not believe the statement commonly made (usually by those who have never used this treatment) that the bromide impairs the intellect and produces other bad effects. It does not if judiciously used. Mental impairment results much more positively from repeated severe convulsions than even the most careless observer could attribute to bromide."

Thus speaks our esteemed co-laborer in homœopathy; but now let us look at the picture from another point of view; from the point of view of the reputable old school

neurologist, one who has probably given the bromides from the first day that he left college, in large doses and small doses; singly and repeatedly, and altogether has probably used enough of it to sink a ship. What has he to say upon the subject?

Dr. Ambrose L. Ranney, in the January number of the *New York Medical Journal*, says: "It has taken many years to convince most of the leaders of professional thought in this country and in Europe that too much should not be expected from the bromide salts; that the beneficial results obtained from them in epilepsy are not permanent, as demonstrated by the frequent attacks that follow a complete cessation of the drug; that the constitutional effects of the bromide salts may in chronic cases of epilepsy prove serious; and that epilepsy is an incurable disease when treated exclusively by drugs except in the rarest instances. To benumb the cerebral centers by a drug so that they cease to respond to reflex irritation from any peripheral source is not curing a disease." The last sounds like the words of a live homœopath, and this opinion, coming from the pen of Dr. Ranney, as it does, ought to dig the grave of the bromide salts as used in epilepsy, and bury them so deep as to avoid the possibility of a resurrection. Were it not for the gravity of the subject, the diametrical opposition of the views just quoted might be calculated to bring a smile to the lips of the least humorous of us. The most remarkable part of it all is that each decries the method most in use in his own school!

This is a sad commentary upon the results of the use of methods most in vogue, and, while it serves to discourage us in regard to the drug treatment of epilepsy, it also serves to emphasize the point which I wish to make, which is that, before drugs of any sort are administered a determined, systematic, and thorough attempt should be made to find the causal lesion; to discover or remove conditions that can be accurately shown to be related to the cause of epilepsy.

The reports of the orificial surgeons are overflowing with cures of epilepsy and kindred nerve disorders and in my mind there is no doubt that there is a small per cent amenable to their treatment; but I am unwilling to believe that more cases find their source in the lower orifices than in other points of irritation.

Martin, of Bordeaux, has an article in the March and April numbers of the *Journal of Medicine*, of Bordeaux, in

which he discusses the relation of epilepsy to eye-strain. He found astigmatism and hypermetropia no more frequent in epileptic patients than in the nonepileptic. Where he found a refractive error he corrected the manifest error with glasses, but without any effect upon the epileptic attacks. Martin's reports prove nothing. First, because he never corrected the total error, and next because no attention was paid to the condition of the orbital muscles, which latter is quite as important as the refraction.

In reading any paper by a foreign author we must remember that our brethren across the water are slow to accept the results of American investigation and experiments. The existence of esophoria, hyperphoria and exophoria is acknowledged by them, but the possibility of correction by prisms, ocular gymnastics or graduated tenotomy is denied. The reason is simply this, that their own investigators have not yet done any work in that particular line. Therefore, Mr. M. Martin's report is worthy of very little consideration; his treatment was incomplete.

English ophthalmologists seem to be slowly waking up to the subject of the relation of eye-strain to epilepsy. Mr. H. Work Dodd published the results of the study and treatment of 100 cases in 1893, in the winter number of "*Brain*." Of the 100 cases, twenty-five did not need glasses and twenty-three were lost sight of. Among the remaining fifty-two there were thirteen who had no fits after wearing proper correcting glasses for periods varying from one year to four months. Three were unimproved and thirty-six were improved. Bromides were continued in all cases. The results are wonderful but misleading, as the use of bromides would serve to mask the true conditions, and many patients go for months without fits who are far from being cured. As with other foreign writers, Mr. Dodd makes no mention of the muscular conditions of the eye. Had he made an investigation of the condition of the orbital muscular I believe many of the "improvements" would have been changed to cures.

In the New York *Medical Journal*, January 13, 1894, Dr. A. L. Ranney begins a report upon the eye treatment of epilepsy which extends through three numbers of the journal. The report includes twenty-five cases, picked cases I should judge, for the paper gives no idea of the total number of his epileptic patients or the per cent of such cases that suffer from eye-strain. If one reads the paper *without* thought and *with* faith the conviction is

forced upon him, that all epileptics suffer from eye-strain and all are amenable to treatment with chances good for relief or cure.

But the most unbelieving cannot read such a report without feeling that in the eye treatment of epilepsy there is hope for at least a per cent of those afflicted.

In every case heterophoria, or muscular error, was found, and in twenty-three of the twenty-five cases refractive errors were present. In all cases where bromides had been used its administration was stopped at the beginning of the eye treatment. Where refractive errors were present the total error was corrected by proper glasses. The heterophoria was treated by prisms, ocular gymnastics and graduated tenotomies; indeed, from one to four graduated tenotomies were performed in every case. Some of the cases have been under observation for six years, and some for only as many months. In every case except one there was either improvement in the general health and lessened frequency of the attacks, or total cessation and entire cure of the disease, so far as a chronic disease can be said to be cured before the death of the patient.

The foregoing is the most extensive and complete report that has been made upon the subject. Upon this report further comment would be superfluous; it speaks for itself.

Several reports of single cases of cures of epilepsy by eye treatment have also been made, notably one by Dr. Beard, of Chicago, in the *Archives of Ophthalmology*, 1893.

In regard to my own cases I will state briefly that in two of them muscular and refractive errors were found, while in the remaining case the eyes were perfect. The treatment of the first two cases has been too recent for me to draw anything stronger than inference as to results. The most I can say as yet is that there appears to be improvement in both cases. In the near future I hope to be able to gather and to present to this society a better array of clinical proof that a share of epileptic cases originate in eye-strain and should be treated accordingly.

DISCUSSION: Dr. H. B. FELLOWS: There is no question but that brain irritation may result from eye-strain. This strain does not often result in epilepsy. While it is sometimes possible for it to precipitate attacks of fits, it is very doubtful if it ever does so where there is not already

a predisposition, or an actually developed epileptic condition. We must always clearly distinguish between epileptiform conditions and true idiopathic epilepsy. Any peripheral irritation may develop fits in the epileptic, and possibly in some cases develop what was before a mere predisposition into the active disease. A cure of genuine epilepsy has been spoken of by the much talked of "official work," including the so-called "American operation;" yet according to my observation it is an extremely rare occurrence. Even if it takes place the ultimate result is that the latter end of the patient is worse than the first.

Ranney's statistics read like the plea of a hired lawyer and cannot be taken as demonstrating anything. It looks like another fad that is to go up like an eagle and come down like a goose. Almost any operation will often have the effect of suspending the attacks for a time. In some cases the bromides have appeared to me to have a positive curative action. In many they will suspend the attacks for a time, but in the long run they do not diminish the number of attacks, and too often seem to hasten the seizures. In treating the case with homœopathic remedies we do stop some of the attacks permanently, and benefit others. The benefit is often marked not only in the general health, but especially in the mental sphere. The accumulation of facts in reference to this matter of controlling the curing of epilepsy by operative procedure to relieve eye-strain is certainly desirable, and it is to be hoped that Dr. Swan will continue these observations and report at some future meeting.

Dr. B. S. ARNULPHY: I am not an oculist nor an "officialist!" but I am interested in these cases. I remember a case of hystero-epilepsy that had been treated by many physicians, and finally came under my care. Amenorrhœa had existed for eighteen years, but under the administration of sulphur and pulsatilla the flow was partially established in two months time, the attacks occurring only every two weeks. Then the bromide of strontium, five grains daily, was given, and there has now been no return of the

attacks for two years. However, I do not think the bromide would have done so nicely had not the previous prescription acted favorably.

Dr. C. GURNEE FELLOWS: I am very interested in this subject of muscular errors and examine all eyes closely to see if they exist. I am not surprised to hear this opinion expressed by the neurologist, and it only helps to throw a shadow of doubt over Ranney's wonderful results. In my reading to-day I ran across some comments on Ranney's work and claims. The most recent number of the *Annals of Ophthalmology* suggests that Ranney's cases are too few and decidedly "picked" to prove his points; and that to help his side he does not even quote Dodd correctly. However that may be—in examining cases by the hundred we are about as apt to find cases with abnormal muscle tone in which there are no symptoms present as we are to find these extreme cases of epilepsy depending upon muscular insufficiencies.

We all see wonderful results in the general condition of the patient after having corrected errors of refraction, or the balance of the ocular muscles; and I should not be the one to deny the possibilities of such work. But as the gas bag treatment of consumption had its day, so is this fad having its day, and I fear that our claims will not stand if we try to prove too much.

Many neurotic cases, and possibly epilepsy itself, may be modified by the correction of ocular defects—they are temporarily benefited by any operation, upon the foreskin, nose, ovaries or eyes, but are not such results negative?

If the same patient should be examined every day in the month, you would find that as his general health varied, so would the balance of his ocular muscles. We must also recognize a neurotic habit in such cases and not blame the eye for it all.

I prescribe glasses, ocular gymnastics and operate as enthusiastically as my friends for existing troubles, and am delighted with the general improvement of my cases, often when least expected, and am willing to class eye strain as

one possible cause of epileptoid attacks; but I think we all should be chary in claiming too much for any one procedure.

THE PRESIDENT thought that the object of this Society was the presentation and discussion of new and interesting subjects of a clinical nature. The essayist had wisely put the title of his paper in the interrogative form, and certainly had stuck to his text. The question being strictly clinical, could not be properly answered by any kind of generalizing statements, or opinions. We are not here to discuss the credibility of Dr. Ranney's experiments, or those of anybody else, but to hear the paper and to say whether we really know anything, *pro* or *con*, of the subject under review. And, moreover, it is not a matter for the neurologist any more than for the gynæcologist, or for the common surgeon to decide. Nobody can answer this question fully until we have more data and more recorded experience from the oculists themselves; and the way to get that information is, not to throw a doubt over the work that others have done, but to do better things ourselves. It is becoming a very common habit among physicians, as well as with the laity, to say that this or that new thing is a "fad" because they happen to know little or nothing about it. In such matters, however, we may do well to remember the adage: "All that is new is not true, and all that is true is not new."

Dr. C. J. SWAN, in closing the discussion, said: I do not believe it was Dr. Ranney's, and I am sure it is not my own intention to prove that all cases of epilepsy are the result of eye strain. If we are successful in demonstrating that there *is* a definite relation between eye strain and epilepsy, and that a percentage, no matter how small, *can be cured by eye treatment*, we have accomplished no small thing.

Prof. Fellows is mistaken in regard to the length of time that has elapsed since the treatment was completed in some of Ranney's cases. Two of his cases that were cured date back to 1888, six years. A patient ought to be satisfied that he is cured after going six years without an attack,

when previous to the treatment he had had from six to ten of them each week.

In regard to the utility of the operation called "graduated tenotomy," I agree with Dr. Gurnee Fellows that it is having its day, and is perhaps being overdone; but I deny that it has not a place in ophthalmological surgery. There are many instances when latent convergence or divergence is present in which no milder measures will answer the purpose. Ocular gymnastics and prisms should be first tried, and if these fail to accomplish and maintain a proper balance of the muscles, a graduated tenotomy should be performed, and it will be found to produce the desired results.

Most of you are familiar with the technique of that operation. The conjunctiva on the stronger and offending muscle is seized with a pair of fixation forceps, a slit is made with a pair of scissors, the conjunctiva is dissected away from the muscle and sclera, and a button-hole is made in the muscle. The eyes are then again tested, and the button-hole enlarged. If necessary, this is repeated until a proper balance is secured. I have done two of these operations with eminently good results in cases suffering from muscular asthenopia, and I have also operated my two epileptic cases, the returns for which have not yet come in.

XX. THE HOT SPRINGS OF SOUTH DAKOTA AS A HEALTH RESORT. BY JOSEPH P. COBB, M. D.—It is but a comparatively short time since Hot Springs, South Dakota, has been known to possess any qualifications as a health resort and it may be of interest to the members of the Clinical Society and of value to us all, to discuss some of its attributes.

The Hot Springs are located in a veritable valley with hills on all sides broken only by deep and narrow gorges; these gorges are winding and irregular in conformation thus tending to prevent too sudden changes of temperature by windstorms. The elevation of the valley is about 3,500 feet above the sea level or 2,500 feet above the level of Chicago, what is known to climatologists as a mean altitude.

The hills immediately around the Hot Springs valley are not mountains, being all less than 800 feet above the level of the valley and while they form a nearly complete circle, they are broken and intercepted by irregular gorges. This conformation results in producing a climate that is singularly free from extremes of heat and cold with a remarkably dry atmosphere.

From reports kept during the year of 1893 with daily observations at 9 A. M. and 5 P. M. I learned that the average temperature in January, February and March 1893, was 42° F., being but slightly in excess of that at the Hot Springs in Arkansas; that the total precipitation of moisture was but 17 inches and the total number of cloudy days for the year was 33½.

While winter rules for nearly nine months of the year in the country around outside, a severe snowstorm is unknown in the valley; the ground is free from snow and dry the greater part of the winter. The Black Hills with their pine forests intercept the wet winds and rid them of their moisture so that when they reach the valley they are dry, laden with balsamic odors and ozone from the pine forests, and exceedingly pure and exhilarating. In the summer the temperature in the sunshine ranges high, but the air is fresh and bracing, while at night it is cool enough to make warm clothing a necessity.

An important factor of the Hot Springs as a health resort are the mineral springs of thermal water. The principal springs are six in number and have a temperature varying from 96 to 98° F. They vary somewhat in their constituency but all resemble the noted springs of Arkansas. The water from the Minnekahta spring supplies the principal hotel and also the extensive bath-house connected with the hotel.

The Mammoth spring supplies a plunge bath 50 by 250 feet in size varying in depth from four to eight feet: the water in this bath is never still, the inflow and outflow being about 100,000 gallons per hour; its temperature is 98° in summer and 96° in winter, the water serving to keep the the immense room always at a comfortable temperature.

The classes of disease which accounts show have been the most benefited by sojourns at the Hot Springs are such as the character of the climate and water would be expected to help, viz.: rheumatism, skin affections and catarrhal troubles of the respiratory, alimentary and genito-urinary tracts. These especially are the forms of disease

where a dry, bracing air, mean altitude and gentle, continued stimulation of the excretory organs are of most value and the ones we can confidently expect to be improved by a visit to this locality.

I find no positive evidence of help having been given cases of phthisis pulmonalis, although the resident physicians at the Springs recommend sending those in the incipiency of the disease. The altitude at the Springs is not high enough to be dangerous for them, and the highest altitude reached on the way is about 6,000 feet, so there should not be on their return to lower levels the dangerous reaction that there frequently is in coming back from resorts of high altitudes such as we find in Colorado, New Mexico and Texas. This must also be an element for good in certain forms of nervous disease, neurasthenia and threatened nervous prostration.

The marked difference in temperature between the midday and night atmosphere in summer, stimulating and exhilarating for a sound pair of lungs, must be trying for those impaired by even the incipiency of disease and should make us cautious in advising those affected with pulmonary troubles to visit the Springs in summer.

The State Soldiers' Home has been located here, and a visit to it and its company of 125 old veterans demonstrated the fact that the old soldiers' enemy, rheumatism, is here comparatively robbed of its power. No bad and painful forms of rheumatism were seen in or about the Home or its hospital.

The National Government, as an experiment, sent a detail of seventy men from the Soldiers' Home at Leavenworth, Kansas, last summer to undergo treatment; we are informed, and it is a matter of record, that the results obtained were so satisfactory that "on March 15, 1894, the Military Committee of Congress designated Hot Springs as the best location in the United States for the proposed National Sanitarium for Veterans."

The ailments of these old soldiers were very varied, but from what I learned without actually looking up the records, they were mainly forms of rheumatism, skin diseases and cases of hepatic, nephritic and cystic disease. The hotel accommodations are good; the objects of interest sufficient to occupy one's attention for some time, and of such variety and ease of access as to be of value in this respect for both those who are well and those partly disabled.

XXI. COMPARATIVE PULMONARY TUBERCULOSIS: BY A. K. CRAWFORD, M. D., CHICAGO.*—Tuberculosis in animals, lower than man, is receiving a good deal of attention at present in connection with the question of its communicability, and the light which has been thrown recently upon its widespread existence in bovine herds is startling in significance. Not much has been said, however, about its prevalence among apes, and having had a case in question under my care I will briefly relate it. Of course there are not as many monkeys in this country as cows, and under ordinary circumstances, we do not eat the monkeys, nor drink their milk, therefore the conclusion may be drawn that it is of little practical consequence whether the "marked images of ourselves" have tuberculosis or not. That might be so if the bacillary theory could also be disposed of. But now that these minute organisms are accredited with having more tenacity to life than a cat, and that they take wings unto themselves and fly in our face with the dust, the proximity of an animal alive with the germs may become one of serious import.

The little chap that was sent to me was a "girl" monkey about one year of age and was of a very intelligent species. When full grown, its kind possesses a bushy mane and tufted tail, a body considerably larger than the South American varieties and a projecting muzzle, from which they are sometimes titled "dog-faced." Moreover, they are tractable, amicable and teachable, and I found it a very pleasant pastime and study during the summer months of '92 when it was my pet. Those claiming to know say that this species of African ape is very brave withal, and that it does not hesitate to drop down on the neck of a foraging lion and sticking on like a bur, gnaw away until a blood vessel is bitten through and the "king of the forest" dies exsanguined. Baby Jocka had well-formed thumbs for a monkey, which played the same role as our own, and as pretty a set of milk teeth as was ever seen in a healthy child.

She was supposed to be in perfect condition when she reached me, but in the course of two or three weeks an occasional cough was noticeable, then a sudden attack of pleurisy, with elevated temperature, rapid pulse, short and shallow breathing, anorexia, and distressed visage, to-

*Read before the Illinois Homœopathic Medical Association, Quincy, Ill., May 15, 1894.

gether with the stethoscopic signs of to and-fro friction murmur and clicking rales of plastic origin.

Three such attacks occurred within three months, and I hardly think there was any coincident pneumonia with them, on account of the shortness of the duration of the spells. All this time it was very evident that the pulmonary capacity was becoming gradually less, emaciation progressed apace, clavicular sinking became more apparent, with contraction of the interspaces, any exertion was attended with great breathlessness, and yet there was no elevation of temperature nor sweats, nor disturbance of nutrition, excepting during the periods of acute pleurisy. The little patient would have nothing but the most refined homœopathic treatment.

Fond as she was of sugar the least odor of anything medicinal, or even alcoholic on a lump, would be sufficient reason for her to discard it.

By diluting well in water I could administer almost any remedy about the third potency on sugar, and the effect on the acute attacks was fully as satisfactory and pronounced as seen in the human subject. Cantharis and phosphorus did good service in this respect, but for the chronic condition upon which the pleurisy was imposed nothing tried had the least apparent influence. My creosote preparation was repeated with disgust, and the tuberculin treatment seemed to hold the disease in check for a few days only, then the end came rapidly by asphyxiation.

There was at no time any disturbance of the digestive tube, nothing whatever in the way of a diarrhœa or sign of dyspepsia, and at the very careful post-mortem examination made, the last meal eaten was found to be well along in the process of digestion. The peritoneal surface was found to be peppered with small, cheesy, white tubercles, the capsules of the kidneys were in a like state, as well as the mesentery and omentum, and surface of the liver. But with this widely scattered tuberculous deposition there was not a sign of inflammation, exudation, nor plastic adhesion. The abdominal and pelvic viscera were apparently as healthy as though no tubercular matter was in their vicinity.

In the chest cavity the effect of the pleurisies was very evident in the roughened and adherent surfaces. Both the costal and pulmonary pleuras were nodulated with caseous tubercles and the right lung was absolutely solid from base to apex with the same material. This lung went

bodily to the bottom of a bucket of water, and all but a section of the apex of the left lung gave the same test of impermeability. Evidently for days prior to the end aeration of the blood had been sustained, however poorly, by a fraction of one lung, not as large as the little monkey's fist. Several peculiarities have already been noted, but the strangest of all was the absence of all moisture in the lung tissue or bronchial tubes, no ulceration, no necrosis, no vomicae, no cavities. Nothing but consolidation, and as this consolidation advanced unattended with fever, it could not be charged to pneumonic origin.

Even granting that pneumonic hepatization undergoes a grayish change, due to caseous metamorphosis, it does so without involving a single serous surface. Here the serous surfaces of both the thoracic and abdominal cavities were affected widely. On the other hand, is not rapid deposition of tubercle always attended by a febrile movement, largely of an intermittent character, and later, does not this class of case always show signs of destruction of tissue and develop cavities, with attendant hectic?

Then what was the true pathology of this monkey's malady?

If I might be allowed to attempt the answer to my own query, I would say that there exists tuberculosis, and tuberculosis both in the monkey and in the man. That all tuberculous affections are not bacillary in their origin. That two distinct varieties of tubercle were described and insisted upon by the past generation of pathologists. That these two forms are just as distinct, one from the other, to-day as they were fifty years ago. That the larger, cheesy white tubercle is neither in macroscopical appearance, nor in construction, like the minute gray tubercle. That the clinical courses of these two forms of tubercle in the body are not in the least alike. That the modern craze for foisting upon minute germs the burden of all diseases has led to forgetfulness of many things which the fraternity formerly knew. And, lastly, that I consider this case of the ape to be similar to many such in the human family, and to be a non-bacillary and non-infectious form of pulmonary tuberculosis.

XXII. CLINICAL EXTRACTS FROM FOREIGN JOURNALS. BY R. LUDLAM, Jr., M. D.

GLYCERINE IN GALLSTONE COLIC.—Dr. Ferrand has arrived at the following conclusions based upon experiments

relative to the use of glycerine in the above named affection: 1. Glycerine administered by the stomach is readily absorbed by the lymphatic system; more especially by the vessels which lead from the stomach to the hilum of the liver and to the gall bladder. It has been found in the blood even in the upper hepatic veins. 2. It is a wonderfully efficient cholagogue, and a valuable remedy in the treatment of gallstone colic. 3. In doses relatively large, from 20 to 50 grammes, it will arrest the attack. 4. Small doses, from 5 to 15 grammes, given each day in a little alkaline water will prevent future seizures. 5. Glycerine while not a lithotriptic, is the remedy *par excellence* in biliary lithiasis.—*La Médecine Moderne*, 5 Mai, '94.

SURGICAL ECZEMA.—In *La Semaine Médicale* for April 28, 1894, Dr. Lassar, of Berlin, called attention to the frequency of eczema among surgeons. He says: Eczema is often found among surgeons in active practice who use some of the various antiseptic solutions for cleansing the hands and instruments. It is well known that those who have had eczema are not exempt because of using these solutions, but that they are rather predisposed to future attacks. The skin is left in a changed condition which is hardly noticeable after eczema, but it is very susceptible to any irritation. Frequently it is only necessary to change the antiseptic solution to relieve the eczema.

As a preventive I have found the following very efficient: After washing the hands with water and good soap, rub them while damp with a mixture of olive oil, glycerine, vaseline and lanoline in equal parts. The general internal treatment should also be given during an attack.

GASTRO-ENTEROSTOMY IN ULCERATION OF THE STOMACH.—According to Dr. Kuster ulcers in the stomach demand surgical interference in the the three following conditions: (1) when it gives rise to dangerous hæmatemesis; (2) when it causes peritonitis resulting from perforation, and (3) where the subsequent cicatrization produces a stricture of the pylorus.

Last year I operated upon a patient suffering from an ulcer which caused hæmatemesis. The young woman was twenty-one years of age, and had suffered with gastric disorders for a long time. As she was also troubled with a floating kidney this was thought to give rise to her symptoms.

I made a nephrorrhaphy, which relieved her condition greatly. Nevertheless, she continued to present signs of dilatation of the stomach. During the fall of 1892 she had several severe attacks of vomiting blood. This continued during the following summer, and her condition became very grave. It was then that I decided to operate. I made a large transverse incision on the anterior wall of the stomach, and found on its posterior surface an ulcer, in the bottom of which a cherry stone had lodged. The ulceration extended to the pylorus and was cauterized with the thermocautery. Extirpation of the diseased portion was impossible. To prevent a stricture of the pylorus, which would complicate the case, I decided to make a gastro-enterostomy. The incision was larger than is usually made to establish an anastomosis. Nevertheless, I did not think it best to diminish it, knowing from experience that it would eventually decrease in size. The operation was a marked success. The patient improved rapidly, and gained seventeen and a half pounds in a few months. There was no further gastric trouble or any more hæmatemesis.

This case is interesting for many reasons. It suggests gastro-enterostomy in similar cases; the large opening for anastomosis is the best; besides, it is a satisfaction to know that the cauterization of the ulcer put an end to the vomiting of blood.

Dr. Schuchardt reminds us that these ulcers are usually multiple. He reports having lost a similar case. In one case he removed the ulcer and the patient recovered from the operation, but the severe gastric disturbances continued and the patient finally died of inanition. On post-mortem another ulcer was found which had escaped the surgeon's notice during the operation.—*Ibid.*

STROPHANTHUS IN DIPSOMANIA.—Skworzow publishes a complete cure of this disease by strophanthus in seven drop doses of the tincture given three times a day. The subject was a fat old fellow of sixty-five, who had cardiac adynamia and an intermittent pulse. After the first dose he was seized with nausea and an insuperable disgust of alcoholic drinks. This disgust continued and the cure was radical.

Two other patients were similarly benefited. In all three of the cases the use of this remedy had for its first effect to induce nausea and a profuse perspiration, symp-

toms that do not follow its use in those who are sober. Another interesting fact is that in these cases the abrupt discontinuance of the drinking habit, while taking this drug, was not followed by the usual drunkard's delirium under similar conditions.—*Wiener. Med. Presse*, 17 p. 653.

PULMONARY SCLEROSIS OF MALARIAL ORIGIN.—At a late meeting of the Hospital Medical Society, of Paris, M. Laveran said: At our last session Dr. Galliard presented a patient suffering from pleuro-pulmonary sclerosis and tuberculosis, which he thought was entirely free from paludal complications. But cases of pulmonary sclerosis of malarial origin are not so rare as our colleague supposes. Heschl has already spoken of the frequency of chronic pneumonia in those who have had ague. In Algeria I have had occasion to note the alterations in the lungs in malarial subjects. * * * * *

The pathogenesis of the paludal pneumonia appears to be very similar to that of splenitis, chronic hepatitis and interstitial nephritis from a similar cause. The irritation caused by the hæmatozoaries, or blood parasites, first gives rise to congestion, and then more slowly to the lesions of chronic inflammation. Acute pneumonia is also a very frequent accompaniment of paludism.—*La Semaine Médicale*.

THE PREDOMINANT ROLE OF THE LIVER IN THE FORMATION OF UREA.—Dr. Kaufmann draws the following conclusions based on experiments: (1) The formation of urea is not entirely due to the liver, but all the tissues yield a certain amount; (2) in a fasting animal the liver gives off the greatest portion, and (3) the production of urea is associated with the phenomena of nutrition which is carried on by all the tissues, and with those of the preparation and elaboration of the different nutritive elements that are constantly poured into the blood by the liver.

GERSONY'S METHOD FOR CURING INCONTINENCE OF THE URINE.—M. Hofmokl presented a little girl who for this condition had been treated by torsion of the urethra. The after symptoms were not troublesome, and some weeks after the operation the child could retain the urine from six to eight hours.

M. von Frisch regarded the interval since the operation as too brief to test its value. In a case upon which he had

operated in the same manner, after six weeks of complete continence, a slight incontinence returned, continued for six months and finally disappeared. In such cases he thought Gersuny's method preferable to all others. *Vienne*, 5th Mai, 1894.

THE LOCAL TREATMENT FOR CHRONIC SALPINGO-OVARITIS. —Two years ago Dr. Auvard proposed a plan of treatment for chronic inflammation of the appendages by intermittent compression of the ovarian region by means of a sac filled with small shot. Recently, however, he has devised a simpler and a more successful method for the treatment of these cases. After having cleansed the vagina thoroughly, a bivalve speculum is introduced and 20 to 30 grammes of glycerine, to which a pinch of powdered boric acid has been added, are poured into the vagina. Cotton tampons are then placed in the Douglas pouch and in each of the lateral culs-de-sac. Three or more of the these tampons are necessary to distend and press upon the canal on all sides. These are left in place for two or three days at most, when they are withdrawn and others substituted for them. If there is a troublesome odor of fermentation on their withdrawal, especially in case of an abundant leucorrhœa, iodoform may be added to the glycerine, unless it happens to be repulsive to the patient.

This form of treatment seems to act like an emollient bath, and as a kind of internal automatic massage through permanent vaginal distention. From its first application the patient experiences a decided relief, which is afterward increased. The pains become less and less, and the thickening of the roof of the vagina diminishes rapidly and may entirely disappear. The pus in the tubes is emptied; and the prolapsed ovaries lose their painful sensibility, decrease in volume, and finally become imperceptible to the touch. Besides, the uterus, which was fixed by the tumefaction of its appendages, recovers its normal mobility. These results, which may be considered as a more or less perfect cure, have sometimes been obtained in cases that were supposed to be serious enough to demand operative interference.—*La Semaine Médicale*, 12 Mai, 1894.

THE INFLUENCE OF BACTERIAL ASSOCIATION TO INCREASE THE VIRULENCE OF CERTAIN PATHOGENIC MICROBES.—In an interesting paper upon this subject presented to the Academy of Sciences, Paris, M. V. Galtier reached the following

conclusions: (1) Those microbes which have been so attenuated that they cannot alone give rise to a fatal disease may recover their virulence when two species of them are introduced into the same organism; (2) Both these kinds of microbes may multiply side by side, but usually one of them disappears, or tends to do so, while the other becomes again pathogenic; (3) When two varieties of microbes are thus associated sometimes one and sometimes the other recovers its virulence, according to the method of its introduction into the organism, and the species of animal that is the subject of the experiment; (4) Advantage may be taken in the laboratory to utilize these facts so as to obtain a return of virulence to attenuated microbes; (5) These facts not only explain the renewal of certain epidemics, but also the aggravation of inoculations made with a benign virus; (6) Finally, we can see how the passage of a microbe which confers immunity from one disease may increase the susceptibility to another affection.

SPURIOUS CANCER OF STOMACH.—Dr. Terrier called the attention of the Surgical Society of Paris to this subject as follows: Last year we had a patient in our service who presented all the symptoms of gastric cancer, pain, vomiting, bad general condition and a tumor in the epigastrium. An explorative laparotomy was made for a positive diagnosis. The incision revealed numerous firm adhesions between the stomach and the left lobe of the liver, the epiploon and the abdominal parietes. These attachments were separated and a bit of tissue taken to be examined histologically. That examination proved it to be of inflammatory origin. A year has passed and the woman is perfectly well.

Some years ago we had another patient who had all the symptoms of this form of cancer including the epigastric tumor. He was put upon a simple milk diet and was completely cured in a few months. There can be no question that there are cases that present the rational symptoms of gastric cancer in which the trouble is due to adhesions of this to other organs, and that these are amenable to surgical treatment.

Hospital Notes.

THE CHILDREN'S CLINIC.

SERVICE OF PROF. JOS. P. COBB, M. D.

REPORTED BY H. J. PAYNE, CLERK OF THE CLINIC.

SYPHILITIC DIATHESIS. *Case 264.* Edith H., æt. four years, first reported at the clinic May 6, 1893.

The mother's age is thirty-eight. She has been married eighteen years. Previous to her marriage she had always enjoyed good health. About one month before the birth of her first child she showed evidence of syphilis, and has never been well since that time. This child, from all that we can learn, developed no syphilitic symptoms, was well, strong and well nourished, but died of measles at about one year of age.

After the birth of the first child the mother had two miscarriages, and following that a child born dead at term, which was described as "being entirely mortified." Then another miscarriage, and one year and a half afterward this child was born.

This child has at times been stupid, but is generally bright and active. She has dark rings under the eyes, frequently has earache, and for two years had a constant discharge from the ears. She has had recurrent superficial abscesses on the back of the head; is subject to pains in the legs during bad weather; her appetite is good, and her bowels are regular. Her teeth are in very bad shape; stained, broken and decayed. She is only fairly developed and nourished. She was given syphilinum 30x four times daily.

This case illustrates the value of obtaining not only the personal but also the family history. There is nothing upon superficial examination, except the appearance of the mouth, that would suggest syphilis. The child's history would warrant a strong suspicion of the dyscrasia, but the mother's post-marital history could not be misinterpreted. Bear in mind that the mother has not told us that she had syphilis, has not described any primary sore, and may not

know the cause of her illness and miscarriage, but the evidence she has given us is conclusive.

This history would seem to be an argument to support the theory that a syphilitic mother may give birth to a healthy child if the date of infection is late in the course of pregnancy. This question is still unsettled, and we must not be influenced too strongly by one case, especially when the case is not before us as a witness, and the history is gathered more than ten years after date.

One week later the child reported improvement in appearance, disposition and health, and the remedy was continued.

For several weeks she continued to report, and was given saccharum, as she seemed to be doing well. The stupid spells ceased to recur as formerly, now showing only as sleepy spells, which the mother was advised to encourage.

ENURESIS.—*Case 301.* Ethel H., æt. ten years. She is of a nervous temperament. The family history is good. She has had whooping cough, measles and mumps. She has always been troubled with enuresis both nocturnal and diurnal, and of late it has seemed to grow worse. The mother says she passes twice as much urine as a child of her age should, voiding it eight or ten times a day voluntarily and many times involuntarily. Urine has a strong odor and stains the clothing but slightly.

She is very restless at night; is easily frightened; vomits readily; is fond of sour things like pickles. Her tongue is coated on the back part. She has dark rings about the eyes; cries easily; does not like to go to bed early and is very tired in the morning.

She was given *pulsatilla* 3x four times daily, and requested to send in a sample of the urine for examination.

Examination of the urine gave the following result: Urine acid, heavy deposit, color pale amber, odor sweetish and foetid, sp. gr. 1026, excess of mucus, large amount of imperfectly oxidized urates and small amount of albumen were present.

In this case we have reason to believe that the nervous element is a factor in the etiology, but only one factor; it undoubtedly renders the bladder more irritable and makes it harder for the centres of urination to control the act.

But the composition of the urine points to imperfect digestion, faulty liver action, a waste of energy in that the urates are not perfectly oxidized and a catarrhal inflammation of the bladder. One week later she reported no improvement and in view of the information gained by the examination uranium nit. 3x was given. After two weeks of this treatment she reported some improvement. Appetite is better, sleeps better. She has been going to bed earlier and gets up earlier in the morning; wets the bed between three and four o'clock in the morning. She is not troubled so much during the day time. Her nervous condition is better, but we learn that she is very much afraid of the dark, and dislikes very much to get into a crowd. Still wants to drink a great deal.

She was given aconite 3x four times daily. One week later reported she was much better of the enuresis. She has, however, had a headache over the eyes for three days, so severe that she could not sleep. The headache was better in the house and when it was warm, accompanied by some nausea. Aconite was continued and there was a steady improvement in the urinary trouble until she was discharged cured three weeks after the first prescription of aconite.

ECZEMA RUBRA.—*Case 712.* Scrofulous diathesis. Thomas T., age two years, was brought to the clinic April 18, 1894. Family history, good. He had cholera infantum when six months old and measles when one year.

When three months old an eczematous eruption appeared and lasted for five months. Four months later the eruption reappeared and he has never been free of it since. He has been constipated since birth and Rochelle salt has been used to move the bowels. Stools, dark brown and hard. Several days would pass without a passage unless a cathartic was used.

The rash is mostly on the face and head, but sometimes appears over the body. There is a sticky exudation which itches a great deal. Appetite is good and he sleeps well.

He was found to have a hernia and phimosis. He was given sulphur 6x four times daily and referred to the surgical clinic for operation which was performed April 25.

May 5, he was brought to this clinic again. The wound had healed well. He was still constipated, but the stool was not so hard and not so long a time intervened between movements. The eruption is worse, is very irritating, so bad that he does not sleep well at night. It has spread over the whole body and there is a sticky discharge. Sometimes it almost disappears and then reappears in aggravated form. The irritation seems to be worse at night. His appetite is good. Bowels move with difficulty, sometimes blood passes with stool. Tumenol ointment was applied externally and sulphur 30x was given four times daily.

May 9, Tom again appeared at the clinic. He was still troubled with constipation for which he has been given a small dose of senna and figs every night. Stool hard, round and dark colored. Urine dark colored; urine at night without waking. Still has the eruption which is very irritating. The senna and figs were ordered discontinued, tumenol ointment and the remedies were continued.

May 16, the eruption was very much better, sleeps well. seldom urinates at night. Bowels move twice a day and stool is normal. The remedy, sulphur 30x was continued.

I would like to call your attention to the marked improvement manifested since the use of the tumenol ointment; also to the fact that the constipation was relieved when sulphur 30x was given rather than 6x of the same remedy and that as long as cathartics were administered we obtained no benefit from any remedy.

CATARRHAL BRONCHITIS.—*Case 717.* Ruth Anderson, of scrofulous diathesis, age two years was brought to the clinic May 2. The family history is good. Ruth had whooping cough last September and since then has always had a cough. It is worse in the morning and much worse when she has a cold. She catches cold easily. There is no discharge. The trouble is limited to the trachea and larger bronchial tubes. Her appetite is good, sleeps well, bowels are regular and the stool is normal.

Hepar sulphur 6x was given four times daily.

May 9, the cough was reported not improved. The remedy was continued and May 16, the child was reported again with cough much better. Coughs very little and otherwise well.

The remedy was continued.

*THE CLINIC FOR THE SURGICAL DISEASES
OF WOMEN.*

SERVICE OF PROF. LUDLAM.

REPORTED BY CORNELIA S. STETTLER, M. D.*

CHRONIC OVARITIS, RELAPSING PERITONITIS, AMENORRHŒA, MENORRHAGIA.—*Case 22,038.* Mrs. —, æt. 38; mother of two children; the youngest being sixteen. Puberty at 17, the periods being normal in every way until five months ago, when they became extremely painful, the flow lasting for three weeks. Then she had amenorrhœa for three months after which the menses returned and continued for five weeks without cessation, and with much pain in the left ovarian region. Last August, or nine months ago, she had a severe illness, said to be typhoid fever, after which she had peritonitis. She is very constipated and has been told that she has ulcers in the rectum. Local examination showed the cervix retracted and almost obliterated; the left ovary swollen and anchored by post-inflammatory adhesions. Trillium 3 and after a while curetting and drainage, with a possible tubo-ovariotomy later.

The fact that this woman had passed the first twenty years of her menstrual life without any incidental suffering or derangement is proof that during all that period she was exempt from the usual causes of such disorders. And the fact that she escaped them for fifteen years after her last child was born also proves that her present troubles are not strictly speaking post-*puerperal*.

It is possible, however, that the menstrual arrest may have been due to conception, and the menorrhagia to an early abortion. In that case the ovaritis and the peritonitis might have been of septic origin and in consequence of an infected endometrium. Some of these cases are very obscure. If she really had typhoid fever with peritonitis as a sequel four months before the menstrual irregularity began, the probability is that it was sufficient to establish this morbid condition.

Lacking the proper data, we are at a loss for definite indications as to the most appropriate treatment. If we could be certain that the pelvic mischief began with an ascending endometritis, curetting and drainage should be resorted to at once. If, however, we were satisfied the uterus was only secondarily involved, we should let that alone and advise a laparotomy. Neither the trillium nor

* Continued from page 264.

the curette will be harmful, and they may be sufficient to clear up if they do not cure the case. Should they fail, however, it would be a question of trying operative measures of a more serious kind.

EXANTHEMATIC OVARITIS.—Wednesday, May 9.—*Case 22,044.* Miss —, æt 16, began to menstruate two years ago and until of late was always regular, but now the periods are delayed and scanty. She has always been nauseated and given to vomiting the first day of the flow, with pain in the left lumbar region and slight dyspnœa. The face, neck and arms are covered with the eruption of diffuse acne which is worse at each monthly period. This eruption is not hereditary, nor did it anticipate puberty, but came about the time that the menses became more scant and irregular.

One of the clever things that we have derived from Tait is the establishment of an important clinical relation between some obscure diseases of the ovaries and the acute exanthemata, as variola, scarlatina, etc. He has demonstrated that ovarian sclerosis not unfrequently originates in repelled eruptions of this sort, and when these diseases are prevailing especial attention should be paid to the health of young girls who are thus exposed.

Now the same is true of the possible relation between chronic skin affections and the internal generative organs. I have elsewhere reported several cases of membraneous dysmenorrhœa that were traceable to this cause, and which were cured by regarding it; and some of you can remember a patient from whom we took a pair of sclerotic ovaries in my clinic last winter in which the lesion was entailed upon a young woman after a desperate attack of scarlatina.*

It sometimes happens that a chronic skin affection like this will finally arrest or supercede the menstrual function. In this case the eruption is really vicarious of the flow just as it is in xenomenia and the purpura hæmorrhagica of the menopause (whether it is precipitated by the surgeon or not), or by any other kind of menstrual deviation. When it has this tendency I have sometimes found it to be associated with a form of glycosuria. The farther it goes in that direction the more likely is the eruption to be attended by papulæ and small boils, and even by carbuncles. Under such circumstances, and in such young subjects as this patient there is sometimes a rapid drift toward tuberculo-

sis; and when women have a similar condition at the climacteric they may have an inveterate pruritus of the vulva with a tendency toward carcinoma.

RETRO-UTERINE PROLAPSE OF AN OVARIAN FIBROID. REMOVAL. RECOVERY. Wednesday, May 16.—*Case 22,045.*—The hospital patient from whom this tumor was taken four days ago is forty-one years old and unmarried. She began to menstruate at fifteen; the periods were regular but very



FIGURE 11.

painful, and of late years the flow has been clotted and dark. For two years past she has had almost constant pain across and low down in the abdomen, and in the right iliac region, with constipation and a great deal of pressure upon the rectum. Digital examination detected a retro-uterine growth that was somewhat tender but quite immovable. A laparotomy was made May 12, and this tumor was found imbedded in the Douglas pouch. Its lower portion was very adherent; its pedicle was thin and membranous, but contained one good sized artery. For

this reason it was carefully ligated, a precaution that would not have been necessary if the fibroid had been uterine and its attachment so slender. It was the peculiar surface of this tumor, which you observe in the specimen, that led me to infer that it had an important vascular attachment; for these little hæmato-cysts, of which there are nearly forty, are never found except upon the surface of an ovarian tumor of some kind. (Fig. 11.) The right ovary was liberated from a bed of adhesions, but not being damaged was not removed.

Prolapse of the ovary in consequence of a strain, a misstep or fall, the concussion of a severe cough, tenesmus of the bowel or the bladder, where the patient has been predisposed to it by tight lacing, or ovarian congestion and inflammation, is more frequent than is generally supposed. I have called the attention of the class to several cases of the kind in my clinic. But ovarian fibroids are so rare, there being but 1 to 200 on the average in ovarian growths of various kinds, that prolapse of the organ from this particular cause is something which none of you have ever seen before, or will be likely to encounter very soon again. I am very glad to say that the patient is doing well in every way.

WEDNESDAY, May 23.—Convalescence is progressing without symptoms and, therefore, without medicine.

THE RADICAL OPERATION FOR ANAL FISTULÆ.—Wednesday, May 16, Prof. L. cited the following history of a private case operated upon in the hospital two days before: The patient was æt. forty-five, had one child twenty years ago, and a miscarriage at the third month five years ago. Three years since she had an operation for hæmorrhoids, and six months later a fistula was discovered. Before that, however, she had suffered much pain, swelling and discharge at the anus, which developed into an abscess. The fistula was treated locally and partially closed, but soon another one formed. This last one was then operated upon, and "the sphincter muscle cut," but the operation was not a success.

In a case of this kind I much prefer the plan of operation proposed by Emmet, which is to make a free incision down to the fistulous tract, and whether it is straight or bifurcate, cut out the pipe and close the wound with deep wire sutures. Usually there is no more need of cutting the sphincter ani than there is of slashing the buttocks

on either side in making a perineorrhaphy, as they used to do many years ago.

SEQUEL OF A SPONTANEOUS SYMPHYSEOTOMY.—Wednesday, May 23. An interesting case presented in a woman, æt. thirty-seven, mother of three children. Since the birth of her last child, two months ago, she has not been well, cannot stand but a short time, or lift her child without a feeling as if the pelvic bones were falling apart and slipping past each other, especially at the pubic articulation. Local examination showed that the pubic bones were still much farther apart than in the natural state. Excepting a moderate degree of uterine prolapse she was otherwise well.

Prof. L. said: As read, the clinical history of this case is incomplete. With such a record of one or more labors and their immediate sequelæ, such a train of peculiar symptoms, we should always inquire if the accouchement was especially tedious and severe, or instrumental, but, more than all, if the child was not an unusually large one. For under such circumstances it is not very unusual for nature to come to the relief of the woman by such a spontaneous separation of the pelvic bones as will add to the capacity of the superior strait and permit the child to pass through without injury.

(On inquiry the patient said that her second child weighed $11\frac{1}{2}$, and the last one $14\frac{1}{2}$ pounds.)

FAILURE OF THE ELECTRIC PUNCTURE TO CURE A CERVICAL FIBROID. REMOVAL BY ENUCLEATION.—Wednesday, May 23. *Case 22,052*, brought to the hospital by Dr. Geo. Edens, of Danville, Ill., has been subject to severe menorrhagia for three years past. Before coming under the care of Dr. E. she had been treated by electricity both topically and by puncture for the removal of a tumor at the os uteri, but without any result, either to lessen the size of the growth or the quantity of the flow. Local examination showed a fibroid as large as a lemon lying within the open os, its margin being attached all around, excepting at one point where the sound could pass into the uterus.

The operation consisted in enucleating the growth from its capsule, which extended quite within the uterus, and lightly packing the organ, especially the cervix, with a strip of iodoform gauze. Prof. L. said that within a week he had seen two other similar cases in which electricity had been used for months to dispose of such growths but without effect.

Clinical Reviews.

THE TRUTH ABOUT HOMŒOPATHY. BY DR. WM. E. HOLCOMBE, a posthumous manuscript. Also a Sketch of the Life of DR. HOLCOMBE. Bœricke & Tafel, Philadelphia, 1894.

The body of this bright little book is the last literary work of our distinguished friend and colleague. Its spirit and tone are characteristic of its author, and, as no more valid or valiant defense was ever before made of homœopathy, so it is probable that it will never need another. The text is the legacy of an honest, earnest, competent and experienced physician who, before quitting these shores, took the pains to place himself right on the record as to the law of scientific probity, and the practice of that healthful and wholesome freedom of opinion which is the handmaid of true medical progress. It brings the debate with Dr. Browning out of the mire and up to a high plane of thought and action, and leaves it in a kindlier and healthier atmosphere. We predict that the circulation of this little book will work such a revolution as to put an end to the publication of any more foolish and futile prize essays against homœopathy. If Congress would vote to send every old school doctor and every legislator a copy of it a good missionary work would certainly be accomplished, and this last will and testament of our lamented friend would not fail of becoming a still wider blessing to mankind.

DISEASES OF THE RECTUM AND ANUS, THEIR PATHOLOGY, DIAGNOSIS AND TREATMENT. BY CHAS. B. KELSEY, A. M., M. D., New York; Professor of Diseases of the Rectum at the New York Post-Graduate Medical School and Hospital; late Professor of Diseases of the Rectum at the University of Vermont, etc. Fourth Edition, Revised and Enlarged. With two Chromo-Lithographs and 162 Illustrations. Octavo, 496 pages, extra muslin, price, \$4.00. New York: William Wood & Company.

We cannot give a better idea of the practical character of this book as it appears in its fourth edition than to copy

what is said of the care that is requisite in making a diagnosis of stricture of the bowel:

In case disease actually exists high up in the bowel, the attempt to pass an instrument is full of danger. A patient may easily recover from a false passage made in the urethra, but such will seldom be the case with the rectum, for here when the instrument leaves the bowel it enters the peritoneum. To understand this danger it is only necessary to remember that the bowel is generally ulcerated both above and below the seat of the constriction, and is sometimes weakened to such an extent that it will allow a bougie to pass through it without the use of any appreciable force on the part of the surgeon. The bowel may also be lacerated without being directly perforated by the bougie, for the stricture may be pushed upward or dragged downward on the point of the instrument till the bowel gives way.

Supposing now, that a rectal bougie cannot be passed eight or ten inches up the bowel, is it safe on this account alone to make a diagnosis of stricture high up? I should hesitate long before doing so, and should make many careful attempts to pass the instrument at different times, resorting to ether if necessary, carefully exploring through the abdominal wall for induration, and watching for the usual signs of obstruction. There are one or two points worthy of remembrance in this connection. The first is that the obstruction due to a stricture will always be at the same point in the canal; and another is that when a bougie has once become engaged in a stricture it is firmly grasped, and the resistance to its withdrawal is equal to that encountered in introducing it farther. The feeling conveyed to the hand under these circumstances is diagnostic, and is like that which is felt when the effort is made to withdraw a sound from the grasp of a stricture in the urethra.

Scattered through the book we find the most satisfactory hints in evidence of the author's experience and sincerity, but lack of space forbids their citation. Every one who has to do with this class of diseases should have it within easy reach and not forget to remember its homely and wholesome advice. It is by far the best book of its kind.

T. S.

THE ESSENTIALS OF NERVOUS DISEASES AND INSANITY. BY JOHN C. SHAW, M. D. W. B. Saunders, Publisher, Philadelphia. 1894; pp. 200.

Oftener than otherwise there exists a particular place in the mother-heart for the new advent into the family circle, and which no other can so well fill. Saunders has brought forth another youngster into the student world, the Essentials of Nervous Diseases and Insanity, and they do say that the paternal ancestor, Dr. John C. Shaw, comes down street, "only touching the high places."

The author quite realizes the "lone lorn" redeeming feature of compends, viz.: "In this primer for advanced students the question of diagnosis has not been entered

into fully, as it is believed that a knowledge of these diseases must precede a clear appreciation of their differential points." To each subject is appended a bibliography or list of references which is no less commendable than the elimination of the "question feature."

We transcribe a paragraph that is quite representative of the method and style employed :

"CHOREA. ETIOLOGY. Heredity plays an important part in its production ; it affects chiefly children, girls more frequently than boys ; it may be due to anything which tends to lower the general vitality. There appears to exist a relationship between chorea and rheumatism. Fright, anxiety, overstrain at school, with confinement are exciting causes in those predisposed." O. L. S.

A MANUAL OF THERAPEUTICS. BY A. A. STEVENS, A. M., M. D., Lecturer on Terminology and Instructor in Physical Diagnosis in the University of Pa., etc., etc. Philadelphia; W. B. Saunders, 1894, pp. 435.

In an unusually frank preface we are told that "this manual has been prepared especially for students, with the hope that it may serve as an outline of modern therapeutics, to be filled in and extended by a systematic study of the larger works. For obvious reasons references have for the most part been omitted. Since a satisfactory classification based on physiological action or therapeutic application is at present scarcely possible, the drugs have been arranged in alphabetical order."

This statement with the following is very significant : "The knowledge of the action of drugs upon the human body is obtained in two ways; first, by clinical experiment; and secondly, by a comparative study of their actions on the lower animals." Manifestly, by omitting to study the effect of drugs upon healthy human beings as a test of their curative range it is, and will continue to be quite impossible to have "a satisfactory classification based on physiological action or their therapeutical application." And so the brief preface and the briefer opening paragraph inadvertently state the whole case, in so far as old school therapeutics are concerned. For this very unusual candor, as well as for much that follows, we commend this little book to our readers.

Skipping the coarser rubbish that concerns expectorants, escharotics, antispasmodics, etc., the action of drugs

on nutrition, on the blood, the respiratory and vaso-motor centres, the heart and its inhibitory and accelerator nerves, the brain, the spinal cord and the peripheral nerves is put in a very practical light. This portion of the book will be very useful, albeit there is too much condensation of the text, and a too ready endorsement of certain proprietary remedies that have done, and are still doing an immense amount of mischief.

Brief paragraphs are devoted to the different drugs of which the following are samples: "In toxic doses tartar emetic causes intense burning in the œsophagus and stomach, followed by persistent vomiting and purging of serous or 'rice-water' material, painful cramps, not only in the stomach, but in the muscles of the extremities, and all the symptoms of collapse—thready pulse, suppressed voice, shallow respiration, subnormal temperature, pinched features, cold sweats and scanty urine. The mind may be clear until the close, but frequently death is preceded by delirium, convulsions and coma.

"From the resemblance of antimony poisoning to Asiatic cholera and other choleraic diseases, care must be exercised in the diagnosis, which must rest on the history and the chemical examination of the discharges."

Of another remedy as a vaso-motor stimulant, we read: "Ergot is extremely useful in the treatment of *internal hæmorrhages*, as hæmaturia, hæmoptysis, and enterorrhagia from typhoid or other ulcers. On account of its influence on the blood vessels, it has been recommended in *acute meningitis* and *myelitis* and in the *splenic enlargements* of leucæmia and malaria, but in these affections it is generally useless. In *acute cerebral congestion* it may be given with advantage. In *diabetes insipidus*, which probably depends on a vaso-motor paresis of the renal vessels, it is often very beneficial, but in *diabetes mellitus* it is without effect. Many writers highly recommend it in *colliquative diarrhœa* and *dysentery*. It has been employed with good results in *exophthalmic goitre*."

An interesting chapter is devoted to Remedial Measures other than Drugs, such as antiseptics and disinfection, blood-letting, cold, heat, counter-irritation, electricity, massage, lavage and transfusion. These are briefly considered after the manner of Ringer. Applied Therapeutics is a department arranged as in Hughes' excellent Manual, but much less thoroughly. Incompatibility in prescriptions, a table of doses, and an index each of drugs and of diseases closes the very handy and useful little volume.

LECTURES ON AUTO-INTOXICATION IN DISEASE, OR SELF-POISONING OF THE INDIVIDUAL. By CH. BOUCHARD, Professor of Pathology and Therapeutics, member of the Academy of Medicine, Paris, etc. Translated by Thomas Oliver, M. A., M. D., F. R. C. P., etc., etc., Philadelphia: The F. A. Davis Co. 1894, pp. 302.

Whoever is infected with the craze concerning external asepsis which holds that the internal or autogenetic sources of mischief are of little or no consequence, should buy and read this excellent book, parts of which seem almost to have been inspired. Putrefactive processes in the intestinal canal and the development of physiological and pathological alkaloids play an important part in many diseased conditions until lately unknown or misunderstood. Five of these lectures of the most practical and interesting kind are devoted to gastro-intestinal septicæmia and antiseptis; ten to the toxicity of the urines and uræmia; three to cholera, and others to typhoid fever, jaundice and diabetes. Each is a gem and the collection is invaluable. The translation is very well done.

A COMPLETE REPERTORY OF THE TISSUE REMEDIES OF SCHÜSSLER. By S. F. SHANNON, M. D., of Denver, Colo. 1894. pp. 544.

There is no question that the Tissue Remedies have been steadily growing in the clinical estimation of our physicians. For their present popularity the works of Dr. O'Connor (1885), and Boericke and Dewey (1888) are responsible, and in this they did good service. But in certain quarters an unfair advantage was taken of Schüssler's idea, and crude chemical notions have threatened to choke them out of the field of legitimate medicine. Those who have employed them more or less empirically have felt the need of a chart by which they could be prescribed more accurately and satisfactorily. Such a guide is furnished by this Repertory, which is carefully arranged, complete in all its parts, and clearly and beautifully printed. The book is an excellent supplement to those already mentioned, and a glance at its contents will show that these remedies have a wider clinical scope than many of us have supposed. It certainly merits a place, not in the bookcase of the busy doctor, but on his office table, where he can and will turn to it for ready and careful reference. For the cures that will come of a proper affiliation of remedies through this process will not be empirical and accidental, but definite and satisfactory, and worthy of record even in the CLINIQUE.

Miscellaneous Items.

All hail to the Institute, our great national society, which has reached its first semi-centennial in peace and abundant prosperity! Our friends, new and old, will find the CLINIQUE a loyal factor in this jubilee, and the next, and in all that are to follow. And the "Old Hahnemann" also sends its warmest greetings from Chicago to Denver, the lakes to the mountains, on this glorious occasion.—The Clinical Society has taken a new start under the lead of its President elect, Dr. B. S. Arnulphy; ditto the Illinois State Homœopathic Medical Association, with our good friend, Dr. A. A. Whipple, of Quincy, for its chief officer.—Dr. Honberger's illustrated obstetrical report will appear in our July issue.—Our local removals include that of Dr. A. C. Halphide, to 3455 Cottage Grove Ave.; Dr. E. Therese Straub, to 922 N. Clark St.; Dr. Kate I. Graves, to 5663 Washington Ave.; and Dr. A. H. Wales, to "The Tudor," Ellis Ave. and Forty-third St.—The Transactions of the Homœopathic Medical Society of Pennsylvania for 1893 are received from the Secretary, Dr. E. R. Snader.—Everybody who goes to or from the Institute meeting, through Chicago, is invited to call upon the editor of the CLINIQUE, at 1823 Michigan Ave.—The microbe of measles is said to have shown some religious scruples of late, by attacking only the children of catholic families in a Swiss village, and in those of Jutroschin; the details of the latter sectarian epidemic being given by Dr. Gryglewicz, in the *Deutsch Med. Zeitung*.—For the Catalogue and Thirty-fifth Annual Announcement of the Hahnemann Hospital and College, address Dr. J. P. Cobb, Secretary, 3156 Indiana Ave., Chicago.

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Original Lectures.

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CANTHARIS VESICATORIA.

A LECTURE BY J. E. GILMAN, M. D., PROFESSOR OF MATERIA MEDICA AND THERAPEUTICS IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

This is an insect dried and a preparation of it either in tincture or trituration is used as a medicine. The common name is the Spanish fly, a name derived from the locality from which it was formerly produced. It is now found in all the southern and middle portions of Europe, and very abundantly in Italy, Sicily and the southern portions of Russia. From Russia come the largest and finest specimens. The larger flies are the more powerful in action and are the ones chosen for our use in medicine. The fly is about one-half inch in length, of a golden green color, glistening in the sunlight into changeable green and gold coloring. In May or June the insects swarm upon the trees and are collected in the very early morning when stiffened with the cold they move very sluggishly. Large cloths are spread on the ground underneath the trees and with poles, or by shaking the trees, the insects are beaten from the branches and fall to the ground. They are then collected and exposed on sieves to the odor of boiling hot vinegar, water or other liquid, or by immersing them in hot vinegar and water. They are then dried and packed in boxes lined with paper.

To prepare them for our use, insects that are perfect are taken, care being used that they are large and free from a parasitic moth that destroys the strength of the fly.

Pour five parts, by weight, of alcohol over them and let it remain eight days in a well stoppered bottle, in a dark place, shaking twice daily. The tincture is then filtered and has the drug power of $\frac{1}{10}$, and is a yellowish green liquid of a burning taste. The triturations are prepared from the powdered insect in the ordinary manner.

Cantharides is a drug possessing a history extending back into the realm of fantastic medicine. Hippocrates Dioscorides, different Arabian physicians, Celsus and others have written of the effect and uses of cantharides in relation to diseased conditions. It is a vesicant, an active irritant to any tissue or part upon which it is applied. If on the skin it produces a blister after a lapse of one or more hours. Its effect here is similar to a burn; there is redness, a large blister filled with serum, a feeling of numbness in the part, and afterward a burning, stinging pain such as would naturally appear after a severe burn. When it has been used in this manner externally its internal effects have been produced by the absorption of the irritant through the capillaries and the constitutional symptoms of strangury hæmaturia, thirst, colic, and bloody mucus at stool have made their appearance. The blister also, if it is the result of a long continued application of the plaster, may take on a poisonous action characterized by fever and nervous disturbances or may induce profuse suppuration, unhealthy granulations, or possibly gangrene

In the use of small doses of cantharis internally we have a sensation of warmth in the alimentary canal and respiratory organs with increased secretion, a greater inclination to urinate and a slight burning sensation. Increasing the dose, there is heat in throat, stomach, intestines and respiratory organs, burning sensation in the bladder, with straining to urinate and pain; the urine is bloody and there is pain in the loins with priapism. There is excitement of the nervous system, headache, delirium or convulsions. The skin is hot, the respiration quickened and the pulse frequent and hard. There is a general inflammation of the urinary passages and there are stools of bloody mucus.

In still larger doses, so as to excite the poisonous action of the drug, there is an acute inflammation of the whole alimentary canal. The throat is constricted, and even fluids are swallowed with great difficulty. There is violent pain, nausea, vomiting of bloody material and discharges per rectum of the substances like the lining of the intestines, with griping and great sensitiveness of the abdomen.

The symptoms of the inflammation of the urinary tract are increased so that the urine is voided drop by drop and is apparently of blood or bloody water. Delirium, convulsions, coldness and collapse, coma and death. Experiments on animals give very similar symptoms as related above. Hildefeld gave to a dog a drachm of the powdered cantharides mixed with water. An hour passed and the dog exhibited signs of debility. At the end of four hours he howled and moaned continuously, passed bloody urine and fæces, and at last died in about twenty hours. The intestinal canal was inflamed throughout, and in some places resembled a piece of scarlet cloth. Smaller doses were given to other dogs and produced frequent desire to urinate and irritation of the sexual organs. In doses of from thirty to sixty grains it was nearly always fatal to dogs.

The quantity of cantharides required to destroy human life cannot be accurately fixed. The smallest dose known to have the effect was 24 grains, but the patient was a pregnant female and it produced an abortion which may have had something to do with the result. An ounce of the tincture has also destroyed life from the inflammation produced, but life was not extinguished for about two weeks. One ounce of the ordinary tincture of the U. S. Pharmacopi is equal to $5\frac{1}{2}$ grains of the powder, but this is not of a stable strength, its power being due to the cantharidin held in solution and that is not always present in the same amounts. Cases of poisoning by cartharis are not very frequent. It has been given criminally as a means of inducing sexual excitement, but the dose sufficient to accomplish this is a dangerous one to life and by no means certain in producing the special effect aimed at. Any acute inflammation of the urinary tract is apt to cause an increase of sexual desire. This is one of the prominent symptoms of the early inflammatory stage of gonorrhœa and is also found in the inflamed stage catarrhal cystitis. A case reported by Taylor is as follows: A man swallowed 60 grains of the powder of cantharides in mistake for jalop. Some hours afterward he was found laboring under incessant vomiting, intense thirst, with burning pain in the mouth, throat and stomach, countenance anxious, tongue swollen and thickly coated, pulse 130, weak and tremulous. The matter vomited had a greenish color and a peculiarly offensive odor. There were frequent and urgent calls to micturate, always preceded by severe pain at the point of

the penis, and the passage of the urine was attended with severe scalding. The urine was turbid and slightly tinged with blood. There was a dull heavy pain in the lumbar region, increased by pressure and occasional priapism. Vomiting was promoted and a large quantity of a thick solution of gum arabic was administered at intervals. The patient rapidly recovered, due probably to the ejection of the greater part of the cantharis in the vomiting.

The antidotal treatment is to promote vomiting until the material is ejected by demulcent liquids, such as linseed tea, gum arabic or slippery elm, and if not sufficient to relieve emetics may be used or an injection of apomorphin. Oil is not admissible as it is has been found that this is a ready solvent of the active principle, and is therefore injurious. The fine green gold particles of the cantharis may be found in the discharges by careful examination as a proof of the cause of the disturbance in cases of poisoning, and even after a period of nine months have elapsed after death they have been found, says Orfile, in the body, showing that decomposition of the body does not affect them materially.

There are cases of disease so closely resembling the poisoning by cantharis as to compel the closest discrimination. Dr. Hasting in the *Medical Gazette*, Vol. 12, page 431, reports a case of "a young lady occupying the position of governess in a family, who was suddenly seized with vomiting, pain in the loins, thirst, strangury and considerable discharge of blood from the urethra. The generative organs were swollen and painful. She died in four days. There was suspicion of cantharis poisoning. There was found at the post-mortem that the stomach, kidneys and bladder were inflamed and the latter organ contained two ounces of blood. There was no trace of poison, and indeed it was pretty certain from the general evidence that none could have been taken or administered." The chief use or rather the most frequent use of cantharis is in inflammatory conditions of the urinary tract. Here we have an inflammation extending through the whole of the urinary apparatus, from the kidneys to the terminal urethral orifice. There is an acute nephritis so that the urine is secreted with difficulty, and is discharged into the inflamed ureters, burning and scalding as it passes down drop by drop, blood and urine mixed. There is pain in the kidneys as if cut with knives, with frequent urging but always emissions of only a few drops as if a red hot iron

passed along the urethra. And we have such symptoms as these strangury, urine passed in small quantities with pain in the back, micturition by drops with cutting pains, urine reddish or mixed with blood. The urethra is smaller and contracted, so there is a thin stream or even less. And we have the characteristic cutting, burning pain through the whole urethra with urging to urinate. Cutting, burning pain before, during and after micturition, so that it causes the individual to double up, severe burning at the end of the scanty micturition. The urine scalds and is passed drop by drop. As soon as there is any water in the bladder then comes the irritation and urging to urinate, and we have the symptom, irritation, so that he can bear scarcely more than a spoonful of urine in the bladder without urging to urinate. Pain with frequent urging and intolerable tenesmus. Tenesmus vesicæ after urinating. We have in these urinary symptoms a condition found from various causes.

There are some individuals who from some irritant cause have a great tendency to light up inflammatory action in the urinary tract. Every cold or exposure sends an inflammation and presents the above symptoms in a more or less aggravated type. We find the same thing in the inflammatory stage of gonorrhœa—so in that stage we have intense suffering, sexual excitement, chordee, constant distress in the bladder, bloody urine and intense pain in its passage through the infected urethra. The inflammation may be so severe as to even threaten gangrene. Priapism and nocturnal erections, with the contractions known as chordee, make the night a torture, and in this disease if the inflammation reaches the bladder or the prostate we have the constant desire to urinate with the excruciating pain which the urine gives as it scalds the inflamed urethra in passing over it.

The inflammation of the bladder, cystitis, caused by cantharis, is always of a strongly marked type and is associated with general fever chill and always the terrible distress in the neck of the bladder. There is spasmodic pain in the perineum along the urethra down over the testes which are retracted, intolerable burning pain in the bladder, cramping pain in the thighs, cutting pain through the abdomen, burning pain in the glans penis, the orifice of which is reddened. Micturition is difficult, only drop by drop, with a feeling as though melted lead were passing through the urethra, with a violent straining, which increases the pain—urine at first clear but afterward

turbid, bloody, or scanty, or only blood, painful erections of the penis, great restlessness and fever, thirst, but drinking or even the sight of water increases the pain. The great characteristic is the urine dribbles or passes in drops with burning, cutting pain, or frequent and almost continual desire to urinate ineffectually, or with cutting, burning pain, and passing a few drops only for a time, which are often mixed with blood. On the gastro-intestinal canal we have the next most important action of cantharis. It produces congestion, burning heat, inflammation and vesication of the gastro-intestinal canal, inflammation of the throat which feels as if on fire. Aphthous ulceration, or an exudation resembling diphtheria, with a constriction of the throat and an inability to coördinate the movements of the muscles, causing regurgitation of the drink, or if the liquids pass the throat the stomach rejects them and they are at once ejected. Water does not cool and does not taste good. There is intense pain in the stomach, with vomiting of a glairy mucus streaked with blood, severe abdominal pains, with great tenderness, intestinal inflammation, with burning heat, tympanitic distention of the abdomen and burning pains through the alimentary canal. The stools are at first mucous, then fibrinous and bloody, often very scanty, but excessively numerous and accompanied by great tenesmus. Sometimes the gastro-intestinal inflammation produces death by collapse, but if this is escaped we have the symptoms given above due to the discharge of the irritant into the kidneys and the inflammation of the urinary organs and passages. The diarrhœa characteristic of cantharis is a stool like the scrapings of the intestine, reddish mucus or bloody, flaky. During the stool there is extreme burning at the anus, intolerable burning tenesmus, with a chill, as if water were poured over one. The dysenteric symptoms as the large intestine receives the irritant give the acute thirst which water does not quench. The mouth, throat, lips, feel raw and burning. There is tendency to collapse and cold hands and feet. The stools consist of blood and mucus. Red, slimy stools, or white, tough mucus, like the scraping of the intestine, with streaks of blood.

Cantharis is of value in diseases when the inflammation is of a much less severe type than the instances noted and in those already cited it is to be prescribed in all stages of intensity, as we may have the lesser forms of the same inflammatory action in these as well as the greater ones.

Its employment is, however, in the more acute type of disease rarely in chronic affections except in the times of aggravation, when they approach the acute form. In the course of such violent action the nervous system is agitated sympathetically, inducing spasmodic action of and inflammation of the nerve centre. There is also a specific narcotic action which induces a congestion and inflammation of the brain, delirium, stupor, pupils dilated, coma, etc., and on the spinal cord, causing prostration and powerlessness, difficult deglutition, dread of liquids, convulsions, tetanus collapse and death. Paraplegia has been noticed in several cases, so we find use for this in cases of acute mania which have their origin in sexual derangements, or have a sexual type, and there is an amorous frenzy, an uncontrollable desire for sexual intercourse. Priapism or nymphomania, paroxysms of rage, crying and barking, even convulsions—in these cases there are always the urinary symptoms more or less severe attending.

The symptoms induced in one case of poisoning are so vividly given that they deserve a transcription here. "There were convulsions almost constantly, sometimes he tossed about in despair; sometimes he got up, rushed like a madman to another bed in the same room; bent the curtain rod like reeds; screamed; eight men could scarcely hold him; sometimes there was emprostotonos; sometimes opisthotonos; sometimes the mouth was open; sometimes there was trismus, with grinding of the teeth and running of frothy and at times blood-streaked saliva. The face was expressive of fright and despair. In the convulsions the hair bristled, the gaze fixed, the eyes sparkled then rolled frightfully. The pulse was full and slow. The abdominal muscles contracted when pressing on the umbilical region, that part of the abdomen seemed glued to the spine, especially the recti muscles, which were tightened like cord. Then the spasms became general and the head was thrown back. On attempting to make applications to the most painful part of the abdomen he broke away like a madman, frothing at the mouth more than ever. The eyes became fiercer, the constriction of the throat almost choked him. He howled like the barking of a dog. Then came general convulsions which ended in fainting and stupor. Renewal of these attacks followed pressure upon the painful places in the hypogastrium and at the sight of liquids, also there were violent spasms reproduced by touching the larynx.

We have in this indications for the use of cantharis in

hydrophobia cramp, as well as some of the acute mania conditions. In its action upon the skin cantharis is an active vesicant. Homœopathically, it is used as a remedial agent for the relief of burns, blisters, and as a remedy for vesicular eruptions with burning and itching.

Upon the hair bulbs it exerts a stimulating and tonic influence, locally applied and is the basis of all the prominent hair tonics. The tincture diluted is used for this purpose in the proportion of one to eight, the proportion varying more or less from that standard.

It has been used as a local application to abort inflammatory conditions of internal tissues, for example, a felon may be aborted by the use of a cantharis plaster over the sensitive point, retaining it in situ until the inflammation is external.

THE FUTURE OF THE AMERICAN INSTITUTE AND OF HOMŒOPATHY.

BY R. LUDLAM, M. D., CHICAGO *

It would be difficult to explain by what process of unnatural selection I was chosen as the prophet of this venerable and venerated institution. Fortunately, as the Arabs will have it, the list of the prophets is not yet closed. Whether what we read in its horoscope will be realized by those who shall come after us is a more serious question. If we may judge by what we know and by what my excellent colleagues have told us of this grand old National Society, there are, and there have been, no alarming signs of professional decomposition in its membership. Concerning the fascinating mystery of its future, therefore, the glorious record of the past and the ripe fruitage of the present afford grounds for hope, belief and enthusiasm.

One of the lessons of experience is that, with institutions as with individuals, the two problems of character and destiny by which we are confronted must be solved conditionally. If this Institute is to progress in ratio with its own history thus far, the alliance of its growing membership must be sincere and solid. We should not forget that prosperity is a menace to perpetuity; and that unless the

*Read at the Jubilee exercises connected with the Fiftieth Anniversary of the American Institute of Homœopathy, held in Denver, June 14, 1894. *Published by request.*

same or similar conditions which have already brought such splendid results continue to be applied on the same or similar lines, there will be disappointment and disaster. So that, while I must not commit the error of confounding the oracle with the prophet, nor assume a supernatural gift, I am forced to calculate and to judge of the future of our beloved society by the plainest rules of common sense and of human experience.

Having calmly reviewed the trials and triumphs of the past, I apprehend that we may now reach a reasonable probability as to the future. Taking the world as it is, and not as some of us would prefer to have it, everything depends upon what we do and what we avoid. With the changing times our task will become more difficult as the years roll on. Virchow to the contrary, notwithstanding, the history of medicine *is* one of epochs, or cycles, in which some particular theory, or practice, or specialty, has dominated the minds of medical men. These crises are not always ephemeral, like the freaks and fancies of the outlying world of quackery, but they stand for the emphatic struggle of earnest workers everywhere. They stamp their impress upon the modes of practice in each succeeding generation, act and react upon each other, and not only help to make history, but to evolve a better way of ministering to the ills of mankind.

At the present time the professional attention is almost wholly occupied with the growth and development of biology and bacteriology, aseptic and antiseptic surgery, and preventive medicine, to the exclusion of general and special therapeutics. These captivating studies have so engrossed the time and thought of progressive physicians, young and old, as to have lessened their interest in the closer relation of remedies to disease, beside creating an unfortunate distrust of their curative value. Sanitation as a prophylactic, surgical technique, and pre-operative and post-operative asepsis are regarded by many, in our own as well as in other schools, as practically covering the whole requirement of modern medicine.

The consequence is that, not only has clinical medicine come to a stand-still, in large part, as an essential branch of study and practice, but through a lack of faith in the efficacy of its resources and of its proper and thorough cultivation in some of our colleges and hospitals, the vicious habit of using patent and proprietary medicines has taken a very serious hold upon the profession. What with

the makers of microscopes, surgical instruments, and anti-septic appliances, as well as the scientific culture and study of microorganisms, on the one hand, and the claims of the vaunted specifics furnished by the druggists on the other, the family physician with his poor *medical* case is somewhere between Satan and the deep sea.

In such an emergency it is extremely difficult to decide upon the proper course to pursue, and a puzzle even for a prophet to determine what the outcome will be. However, it is very certain that, with all the obstacles that we have overcome, and the bitter opposition that we have survived, our school of medical practice has never before been placed in such a peculiar position. To keep step with the advancement of science, which is our bounden duty as earnest and honest physicians, and at the same time neither to forget nor to fail to cultivate the specialty of applied therapeutics after our own better way and method, is undoubtedly the proper line of action. But that line is not a mere mathematical one else it would have no breadth. We are in danger through those who run after everything that is new, no matter how absurd its claims, as well as through those whose minds are so fossilized that nothing new or fresh can possibly be admitted or acted upon by them.

No one disputes with more vigor and less reason than he who offers the old arguments against the collateral sciences as they were taught in Hahnemann's time, or even when this Institute was founded. All such contention is an obstacle to advancement and a matter of ancient history. The busy, earnest physician of our day cannot stop to discuss such questions, but some of our good friends are not quite ready to dismiss them.

If we are to keep abreast of modern thought and modern progress we must accept the situation, and, while we are developing our own curative resources, be very careful not to repel those who should be our recruits, and our stout and loyal subjects and successors.

I do not share the fears of those who fancy that the attractions of the branches of science which are allied to Medicine will decoy our best minds and damage the ultimate interests of a school that for a century has been almost exclusively devoted to therapeutics. In these matters there must be a tide with its ebb and flow, and if it sets out now, it will surely return. But if our conception of our own therapeutical preëminence is exaggerated, the reaction will be against us. This is what has destroyed

all the forms of quackery that have perished, and we owe our preservation to the adaptability of homœopathy to the varying stages of medical progress, as well as to its intrinsic worth and merit. It is a clear case of the survival of the fittest, and furnishes the best possible proof that homœopathy includes the germ of therapeutical immortality.

Every medical and surgical specialty that is worthy of a name and a record becomes useful and influential *by the force of its limitations*. And this is as true of homœopathy as it is of every other specialty. We have to deal with a time when the belief seems to be spreading that the newer branches which I have named are not only all-absorbing but all-sufficient; with a time in which we are told that our trusted indications and faithful remedies are not to be depended upon; with a time when the antiquated overdosing has either given place to expectancy or to the careless employment of so-called "specifics," with no other guaranty of their purity or of their efficacy than the say-so of the druggist and his far-fetched vouchers and sponsors; with a time in which some very intelligent people, and some of our most skillful surgeons too, are demanding that those who so quickly fly to the knife shall know more and think more earnestly of what they are about to do before maiming everybody, right and left, indiscriminately; and with a time when the medical mind is veering toward us, and beginning to interest itself in the claims of a better and a more rational system of therapeutics, of which hitherto it has been practically ignorant.

Does any one doubt that this is a turning point in the career of the Institute, and of the system of medicine which it represents? Shall we take the tide while it serves to make us familiar with all that is worth knowing of what is new and attractive, and be ripe and ready for the reaction? Or shall we oppose all progress simply because it is new, and because we are not shrewd enough and wise enough to see how it will help and not hinder our advancement?

Let those who are "in love with a microscope," and who are given to "flirting with pathological specimens," who think that the bacillus is the most interesting of all the beasts with which this world is infested, because its ways are dark and insidious, indulge their taste for the pleasure that it brings them, as well as for the profit that may accrue to others. Let them fill the interstices of

their laborious calling with all sorts of scientific inquiry, providing they do not go so far afield in the search of game and glory as to forget the interests of the sick and the afflicted. Let the evolution of all that is germane to medicine reach its highest degree of development, for, whatever it includes and whatever may come of it, the interests of the specialty that we represent will not suffer in consequence. None of these things can dispute or displace the rightful sphere of homœopathy.

We wind up the nineteenth century with rehearsing how its last half was spent in the interests of our beloved profession, and in foretelling what the next one has in store for us and for our successors. If our scientific attainments, critical thought, character and earnestness are equal to the occasion, the good that we have done is prophetic of greater good in the future. But these conditions are inexorable. Without the inspiration of downright earnestness this Institute could not have come into being and survived for so many years; nor can it have a historical continuity if the great moral victory that has been achieved fails to bring its suggestions as well as its opportunities.

We shall miss the spur of the ethical whip; the chafing of class legislation and professional Pharisaism; and all the kindly, charitable impulses that have come to us through the violation of the ninth commandment! But we must not be discouraged with the lack of these old-time incentives. Nor because the fences that separate the brethren are neither so high nor so strong as they were, should our faith be permitted to lapse into indifference. The expense of keeping those fences in repair, or even in existence, is none of our business any longer. And what a happy relief it is for ourselves, and for those who in the future are to look after the interests of this, as well as of all our societies.

I am not insensible to the eloquence of my colleagues, nor to the exhilaration of this moment, which mark the expansion and the substantial growth of a medical doctrine without an example in history. But I *am* anxious that we shall make the best of our excellent opportunities.

If we have selected our ancestors wisely, and no one will question it now, we must see to it that we are not hopelessly behind in the march of medical progress; must keep our best societies and our best soldiers at the head of the column; stop threshing the old straw of dead issues;

so train our clinical sagacity as not to use exceptions for examples ; be very careful not to get dizzy and spoil what we have done ; and not become intolerant toward those who *have* made it pretty hard and unpleasant to live in the world with them.

If the unripe higher education is a delusion and a snare, we should be certain that our educational institutions, our colleges and hospitals, are equipped as they should be, and must be, before we can hold our own and go forward. The spontaneous generation and segmentation of college professors within the last decade is a threatening evil of no small proportions. God forbid that the time should ever come when the membership of this Institute shall carry a larger proportion of those queer fellows than now !

The therapeutical reaction of which I have spoken can not reach its ultimate limit without the help of our writers, editorial and voluntary. We shall have no history until we have a record ; and whoever has charge of the making and moulding of our literature should be as carefully trained for it as if it were a distinct and separate profession. I am not quite clear that it would not be a good plan in the appointment of editors especially, to adopt the custom of certain religious bodies which, while they trust in Providence for a choice of candidates, make sure to elect whoever gets the largest number of votes.

The political economist is defined as one who can tell what will happen if something else happens. He hates the prophets because they are ethical and not scientific, and because "you can neither refute a prophet nor test him." But I am willing that our successors shall test our conditional prophecy, which is anything but doleful and discouraging. For half a century this Institute has followed mainly the lines traced by its founders. If we emulate their glorious example, with its inspired beginnings, sublime consistency, earnestness, fidelity, character, and loyalty, the story of its future will be all that the best friends of Homœopathy and of humanity could possibly desire.

What we want now, and shall always need, is liberty and solidarity; the liberty that accords to every faithful worker within our sphere the principle which limits our attention to our own professional concerns; and the solidarity which comes of united and persevering effort toward one common end.

I am thankful to have been a contemporary with the

most of those who organized this society and who have kept its wheels in motion from the beginning. And I am also thankful to see it grow and prosper so abundantly. For it is a power, and a growing power, in this land of liberty, a beacon light for the whole medical world.

SUGAR *versus* ERGOT.—Prof. U. Mosso and Luigu Pe-olettj at the conclusion of a memoir on the influence of sugar on the work of the muscles, says that we hope that it will be able to be used with advantage in therapeutics, to revive, for example, the pregnant uterus, tired out by effort, when expulsion of the foetus is necessary. A distinct allusion is here made to the possible ecboic action of sugar.

Prof. Bossi, of the Obstetrical and Gynæcological Clinic, of Genoa, Italy, reports the results he has obtained with the use of sugar as an oxytocic in a large number of cases, and concludes as follows:

First. In ten out of eleven cases a positive ecboic result was obtained from an ounce of sugar in eight ounces of water. This effect was observed on an average of a half hour after its administration, using one ounce every one or two hours.

Second. In some cases one dose was sufficient to induce expulsion of the foetus.

Third. If a second dose were given after two hours, the effect was most pronounced.

Fourth. In no cases were tetanic contractions observed, while on the contrary the contractions were regular, and no incarceration of the placenta was noticed.

From these favorable results, he feels justified in giving his experience to the profession. It is prompt in its action and unattended with the disadvantages that attend the use of ergot and its preparations.

It is non-poisonous and the dose may be increased and repeated at pleasure, without fear of doing harm either to mother or child. It seems to possess all the advantages of an ideal ecboic, without any disadvantages.

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

JUNE MEETING, 1894.

The regular monthly meeting of this Society was held in the Hahnemann Medical College, Saturday evening, June 30. In the absence of the President, Dr. Cornelia S. Stettler, Vice President, took the chair; and in lieu of the usual formal report from a clinical bureau, the following brief papers were presented and discussed :

XXIII. TORTICOLLIS OCULARIS.—By C. J. SWAN, M. D. I have to-night for your inspection and comment a rare case and one which I trust will prove interesting. I will not occupy your time with preliminary remarks, but will proceed at once to the history of the case, which is rather extensive, and, thanks to the patient himself, is unusually complete. He has kept the written diagnoses from every physician whom he has consulted, including myself. Mr. W. A. Meddaugh has very generously consented to come with me so that you may see the conditions as actually presented.

Case. He is a Canadian by birth, but is a naturalized American citizen. Home in Detroit, Mich.; 28 years of age; by occupation a marine engineer; unmarried; well nourished and muscles all in prime condition. No account of specific disease in his own or his family history; is not a drinker or user of tobacco and has no other vices.

In January, 1891, he first noticed the symptoms from which he now suffers. He picked up a letter intending to read it, and immediately had spasms of the left trapezius and right sterno cleido-mastoid, throwing the head to the left. After this any little effort would bring on the spasm, and these became more severe and frequent until the first of last September, when he was obliged to give up work.

In the spring of 1891 he went to the marine surgeon,

who found refractive error and advised glasses and a liniment applied to the muscles. An optician fitted, or rather misfitted, with + 1.5 D. sph. glasses which were to be used for near work only. The following winter he received electrical treatment. Faradic current along the spine. This was continued for two weeks.

In the summer of 1891, Dr. Todd, of Fairport, put a large and active sinopism on the base of the brain, which caused an ulcer that occupied over two weeks in healing. Internally he had iod. potash and sarsaparilla elixir. No improvement. Was then referred to Dr. Brown, of Cleveland, who prescribed the pure iod. of potash t. i. d. gtt. x. No improvement.

The next doctor to have the case was the marine surgeon stationed at Buffalo, who diagnosed it as chorea and confined himself to internal treatment.

In the summer of 1892 consulted Dr. M. S. Hosmer, of Ashland, Wis., who diagnosed the case as a rheumatic one, but prescribed massive doses of mercury and iod. potas.

The patient next imbibed seven bottles of Paine's celery compound and one bottle of Father Koenig's nerve cure. In the fall of '92 he consulted Dr. David Engles, neurologist of Detroit, who pronounced the trouble to be spasmodic torticollis, suggested galvanic baths, but made a bad prognosis and the opinion was verified by the result of treatment which was not good; took eighteen or twenty of the baths. In the spring of '93 he went to Dr. George W. Irvine, of Detroit, who prescribed bromide of zinc and sent him to Dr. Don M. Campbell for examination of eyes, with the following results:

O. D. V. = $\frac{2}{3}$ c 2.5 D. spr. 75 D. cyl. ax. 90.

O. S. V. = $\frac{2}{3}$ c 3.5 D. spr. 1.00 D. cyl. ax. 90

1° hypophoria.

2° exophoria.

and prescribed glasses which corrected about one-half the total error, and a prism base down in the left eye for correction of the hypophoria.

Previous to this Mr. Meddaugh had been suffering considerable pain at the occiput which the glasses relieved. (Patients with muscular asthenopia usually locate the pain in the occipital region.) Dr. Campbell thought that there was no connection between the ocular error and the spasm.

In July the spasms ceased, or nearly so, and were in abeyance until the 12th of August, when they came on severely for a month, after which there was another month's

intermission and final return on October 12, since which time the trouble has been continually in evidence.

The patient then went into the marine hospital, when hyosciamine gtt. x. t. i. d. and galvanic treatment was prescribed. Results: Negative.

He was next examined by Profs. Moyer and Bridge, of Rush Medical College. In their opinion the trouble was purely functional. Treatment: Inunction of bell. ointment—ether spray to spine and temporary brace to neck. No relief.

December 5, '93, Dr. John B. Hamilton, Ex-Surgeon General United States Marine, diagnosed the case as a specific one in spite of the denial of the patient. "Syphilitic gummy tumor." I am not informed whether it was supposed to be in the nerve trunk or central, in the floor of the fourth ventricle. He salivated the patient and treated him for six weeks without improvement.

February, '93, called upon Prof. Henry M. Lyman, of Chicago, who diagnosed the trouble as functional and prescribed bell. and suspension one week, followed by fluid extract conium gtt. xv. t. i. d. After a week increased a drop a day to thirty-three drops, with improvement. Dose then decreased in the same ratio, when patient retrograded. The conium then lost its effect in any sized dose. Next fluid extract ergot gtt. x. t. i. d. was prescribed with some temporary benefit, after which conium was again used, but without effect.

February 4. The dark-closet treatment as suggested by Dr. Hamilton was begun. The patient was placed in a dark closet three or four hours each day for two weeks, and while in the ward the eyes were kept bandaged and daily massage was used. During the time in the dark closet and while the eyes were bandaged there were no spasms.

February 28. Shades were taken off the eyes, when severe pains made themselves felt in the trapezius muscle, for which various liniments were applied.

May 21. Went to the Baptist Hospital, of Chicago, and on the 22d an operation was performed on his rectum. Hæmorrhoids were removed and a fistula repaired by Dr. J. J. Thompson, and the indicated homœopathic remedy given. This treatment was followed by considerable improvement in the general tone and appearance of the patient, and somewhat lessened frequency and severity of the spasms.

June 10, 1894. Dr. J. J. Thompson referred the patient to me for examination of the eyes.

I first took the history carefully in writing, and followed it by a careful and systematic physical examination, comparing my own findings with those of physicians who had previously had the case, and I will now endeavor to make clear my conclusions.

In the history we find many varying diagnoses, and we can doubtless think of many more that would fit the case as well, and vary even more widely. I will repeat the names by which this malady has been called, so that I may analyze them in order. Chorea, rheumatism, syphilis, spasmodic torticollis and torticollis ocularis. The last is my own designation for it, and my reasons for thus naming it I hope will be shown to be good and sufficient, before I close this paper. First of all I decided that this was not an organic disease, but a purely functional one. First, because the symptoms not alone did not progress, but have remained in abeyance for months at a time. Second, because if it were a lesion affecting the spinal accessory the nerve supplying the muscles in which we are interested either the nucleus or the main trunk, it surely would involve adjacent structures, viz., the vagus, pneumogastric, hypoglossus or glosso-pharyngeal. The localities and organs supplied by these nerves I found to be perfectly normal in function. Organic lesion was also excluded because the function of the muscle is perfect when the spasm is not present. There is no atrophy, no disuse and no electrical changes. In a word, there is no disturbance of motility or sensibility.

The reflexes, superficial and deep, over the entire body are normal. The fundus of the eye shows no changes. The condition and function of all the abdominal and thoracic viscera is absolutely normal. Syphilis is especially excluded because we find no bone changes, no muscle changes, no skin changes, no glandular changes and no mucous membrane changes. There is no history of primary lesion, and no response to antisyphilitic treatment.

The above positively eliminates all organic disease, including syphilis.

The next diagnosis we have to dispose of is rheumatism or gout—and we can do this very readily by observing that the trouble is not worse in bad weather; there is no pain in the muscle—there is no excess of urates in the secretions. There are no tophi or calcareous concretions or excretions about the body.

Chorea comes next under consideration. In this case the spasm is localized, and chorea of the head alone is extremely rare. The mental conditions are not such as would point to chorea. There is no mental uncertainty or weakness.

The only condition that it at all resembles is the so-called *maladie de tic* recently described by the French writers. In this disease, however, in addition to the convulsive movements in the muscles supplied by the spinal accessory nerve, there is infliction of personal injury upon the patient. He bites his lips, his tongue or his arms. These localized convulsions might also be due to hysteria or neurasthenia. But there are too many symptoms absent to warrant us in this diagnosis. There is no hysteropilepsy. The color sense and field of vision are both normal. No hysterogenic zones present, no tenderness along the spinal vertebræ, no points of anæsthesia and no mental changes. This rules out hysteria and brings us to the necessity of looking for a reflex cause for the disturbance.

There are several points of possible irritation that would occur to us, namely: phymosis, rectal disease, worms, gastric disturbance, empyema of the antrum of Highmore and traumatism. There are no indications of the presence of any of the above named disorders and it leaves us with one more point for examination. The eye is a fruitful source of nervous disorder, and in this case we have many indications that the trouble finds its origin here. I will review the phenomena observed by the various doctors who have seen the case and add some observations of my own.

While the patient is in a dark room, or has his eyes bandaged, or is walking in a dark street, or when he holds his eyes shut, there is no spasm. Again, when the spasm is present, if the eyes are turned to the right the spasm becomes more rigid, but if the eyes are turned upward and to the left the spasm is at once relaxed. The results of my examination of the refractive and muscular condition of the eyes were practically the same as those of Dr. Don M. Campbell, of Detroit. Both a high degree of compound hypermetropic astigmatism and heterophoria being present. I changed his glasses, giving him a correction for his total astig. and hyper. instead of about one-half, as Doctor Campbell had done. I also left off the prism which corrected the hypophoria. This was on the 10th of June. On the 12th the patient returned to my office in a deplorable condition. The spasms were terribly severe, and it was impossible for him to move without holding his head with both hands. I attributed this exacerbation to the removal of the prism, for the prism is like a crutch for a weak limb, if used constantly the limb becomes weaker and weaker. I therefore made a partial tenotomy of the left superior rectus and was so successful as to make an absolute correction of the muscular unbalance. The following day, June 13, the patient had regained the lost ground, and since then has been slowly improving from day to day. I may add that I have been unable to find any case similar to this reported in medical literature, but think, in view of the above, I am justified in giving it the name *torticollis ocularis*.

DISCUSSION: Dr. R. LUDLAM: Was there spasmodic involvement of any other muscle?

Dr. SWAN: I made a thorough examination but found nothing. There was some occipital pain but that disappeared upon correction of the refractive error. No, there is no history of traumatism in any form; neither is there any hereditary predisposition whatever.

XXIV. FRACTURE OF THE NECK OF THE RADIUS, BY DR. ORRIN L. SMITH. We report this case for three reasons: First, The occurrence of such an injury is denied by many.

Second, In any event the case presents rather an unusual grouping of the symptoms.

Third, We hope that it may bring a report of similar cases.

I am forced, and not entirely by exclusion either, to believe that Beatrice H., æt. 7, sustained a fracture of the neck of the radius, a condition of things denied by many good authorities and at best regarded as extremely rare; even the Mütter's collection boasting but one proof specimen.

Beatrice was pushed from a chair by her boy playmate and in falling her forearm became entangled in the chair back in such a manner that it was overturned and dragged down into her tumble. The mother arrived "during the bawl," but the child had managed to extricate the arm. Examination revealing no deformity and slight if any impairment of motion, she adjudged it but a bruise and accordingly, for two days, assiduously applied arnica, but becoming dissatisfied and worried I was called in to find considerable swelling about and below the elbow joint anteriorly, but no appreciable deformity. The relation of the olecranon and the condyles was undisturbed and flexion of the forearm could be accomplished voluntarily with but little discomfort, although rotation and extension were extremely painful. Was unable to detect either rotation of the head of the radius beneath the thumb or crepitus.

The forearm was flexed upon the arm and dressed with an anterior splint atop an interosseous splint. At the expiration of the third week provisional callus was quite discernible. I should say the case made an uninterrupted recovery in four and one-half weeks and that when I removed the dressings permanently, radial head rotation was plainly in evidence.

XXV. ECZEMA CURED BY VACCINATION. CHAS. H. EVANS, M. D.—This case illustrates the argument laid down in the *Organon* as to the curability of natural disease by the supervention of a later one possessing certain similarities of effect, and adds another example to the lengthening list of natural cures under these circumstances. No doubt this takes place oftener than we are aware, when diseases having a similar effect upon certain tissues or organs extinguish each other, but is obscured by the fact that relief was apparently obtained by the medication employed at the same time. Two or three cases have been related to me, in years past, by those who have experienced cure from a persistent disorder after a second one similar in some respect had attacked them. The subjoined instance, however, occurred under my own personal observation.

Case. Miss H., æt. twenty-two years, of inherited scrofulous constitution, had suffered during two or three years with subacute inflammation of the anterior cervical glands on both sides of the neck. In every instance these had gone on to suppuration. Upon each and every occasion, the inflamed gland and its surrounding connective tissue had been treated *secundem artem* with bistoury, subcutaneous injections of carbolic acid, and “regular” internal medication, but all to no avail. As each succeeding gland became involved, it passed through a sluggish course, unaffected by treatment until pus formed, which was evacuated by the knife, after which tardy healing took place.

At the same time, this young woman was a martyr to eczema, located principally on the hands and wrists. The upper layer of the skin was exfoliated and the fiery red secreting corium burned and itched to such a degree that at times she was nearly frantic. Antiscrofulitics in the hands of the dominant school had failed to bring relief during long periods of treatment. This was her medical history when she came to me for homœopathic guidance. I placed her upon *calcareæ iod. 3x trit.* in watery solution every four hours.

The inflamed gland in process of enlargement at that time did not fully suppurate, only a small amount of pus being formed and discharged, after which resolution took place. Quite a long period elapsed before another gland

was attacked, but the enlargement was not great and only a few drops of purulent matter were manifest. Another long interval passed before there was any recurrence, and this time the enlargement was very slight and suppuration did not take place. The cervical glands then became quiescent and have remained so ever since.

But the eczema persisted, although it became modified under the use of sulph., arsenicum, calc. carb. graphites, nitric ac. and other seemingly indicated remedies. Still it was not cured, and although it sometimes almost disappeared for a week at a time yet returned again and again. At this stage of affairs she visited the interior of this State for a short vacation, and while there was successfully vaccinated during a smallpox scare.

As might have been expected, the eczema became aggravated during the development of vaccination, but as the vaccine pustule declined, so did the eczema, until no trace was left, and there has been no return of the cutaneous disease up to the present time, a period numbering several months. Her general health is excellent.

Comment would seem unnecessary in the instance above narrated, but I cannot forbear emphasizing the lesson which it teaches. It is another example of the certainty that dynamic disease is not only curable by similarly acting forces, but that even when this may be accomplished by the unaided action of natural maladies it is due to the fact that nature herself is obliged to work in obedience to and in accordance with one of her own rules, viz., the law of similarity. Moreover, the case just cited is one more proof of the fact that in the production of artificial drug diseases for the treatment of similar natural disorders, we are but imitating the processes of the universal mother.

DISCUSSION: Dr. SWAN: Would you advise it as a therapeutic measure in every case?

Dr. EVANS: By no means. No more than you would advise a single remedy in the treatment of every case of eczema.

Dr. LUDLAM: Had she been vaccinated before, and were the menses regular?

Dr. EVANS: When she was a babe she was vaccin-

ated, but it did not take. Yes, the menses were quite regular.

Dr. MARGARET MCNIFF: How long did you give the calc. iod.?

Dr. EVANS: I gave it in solution, and only at the time of the attacks.

Dr. R. LUDLAM: The old principle of supercession illustrated in this report has many confirmations in clinical medicine. Vaccination for the cure of inveterate eruptions and for aborting severe attacks of whooping cough, pustulation by tartar emetic, moxa, setons, baunscheitism, blistering, and the inoculation of erysipelas to arrest the development of cancer are examples of this kind of practice. Whether cures effected by such means are to be considered as coming within the range of the law of similars is, I think, very doubtful. It would be hard to find any decided similarity between the vaccine disease and whooping cough; although it is certainly true that blistering has cured pleurisy because cantharis would have been the true homœopathic remedy for that lesion. That our remedies do overcome and supersede diseased conditions to which they are closely affiliated none of us can doubt; and I apprehend that it is in some such way that the second and more powerful disease supplants the first. If in the case of such chronic troubles as eczema, they can mutually extinguish each other, like the Kilkenny cats, so much the better, providing there is not too great a risk in the experiment. I recall a sorry experience from attempting to abort an attack of whooping cough many years ago which cured me of the disposition to try that expedient again. The child finally recovered, but it was not my fault.

Dr. EVANS: I can hardly agree with the statement that the case just reported is one of supercession, or has a resemblance to it. I freely admit the fact that whooping cough is made to cease by vaccinating the patient, but this is the suppression of a single symptom. The whooping cough disease is still present and exerts its influence upon the rest of the nervous system, perhaps all the more violent

for the repression of the pulmonary spasm. The instances mentioned by Dr. Ludlam are no doubt an illustration of this. It should also be remembered that whooping cough is a self-limiting disease, and the "whoop" needs only to be suspended until the rest of the disorder has run its course. This is not the case with eczema. Like Tennyson's brook, its tendency is to go on indefinitely, unless removed by some curative agent. Neither can it be said to have been suppressed in the case under consideration for there would be some manifestation elsewhere, and there is none.

Reports of volunteer cases being called for by the chair, Dr. Orrin L. Smith cited a case of furuncles following typhoid fever. He said :

I am reminded of a case which has occasioned me no little annoyance. The patient is a young man of nineteen years, whom I saw through a nasty siege of typhoid fever. He had a very good getting up save in the one particular, that "blind boils" would form on the margin of the eyelids, lips and on the end of the nose. They are of slow formation, finally a drop of pus appearing. They have been entirely uninfluenced by remedies, having in turn, as each seemed indicated, prescribed arnica, sulphur, silicea, pulsatilla, staphys. and mercurius iod. He asked if vaccination would not help matters, but that measure was promptly discouraged.

In the discussion that followed this verbal report Dr. S. was referred to an article entitled "Glycosuria in the case of furuncles and carbuncles," by Dr. R. Ludlam, Jr., contained in the CLINIQUE, 1890, Vol. XI., page 253.

XXVI. TWO CASES OF NOCTURNAL ENURESIS CURED BY CAUSTICUM 3. BY CORNELIA S. STETTLER, M. D.

Case 1, was that of a girl of ten years. She was in perfect health otherwise, but had been afflicted with the trouble from her infancy. It was a great source of annoyance to her mother, but she had come to look upon it as something that would have to be endured, since all efforts

at cure had been of no avail. This she told me in the most casual manner, for she was consulting me about another matter at the time. I asked her to let me prescribe and she willingly assented. I gave her causticum 3, to be taken four times each day, the last dose upon retiring at night. The first improvement noticed was that in the quantity of urine passed each night. Then there would be an omission for a night or two, and finally there was a cessation altogether. Two prescriptions of the drug sufficed for the ultimate cure; for now, after a lapse of three years, there has been no recurrence of the trouble.

Case 2, was that of a lad eight years of age. He likewise had been a great care to his mother because of this habit. She had sought relief from many sources and by various means. Improvement for a time would ensue; but he would soon relapse into the old condition. With all the assurance possible I again prescribed the causticum 3, for he was in perfect health in other respects. Although not so speedy in its effects; for we continued the remedy for two months or more, still the cure was effected finally and he has remained free from the trouble ever since.

I might cite other cases, but these two will suffice to illustrate the clinical value of causticum in some forms of nocturnal enuresis.

XXVII. PULMONARY TUBERCULOSIS OF GRIPPAL ORIGIN; SECONDARY PLEURISY; EXTENSIVE EFFUSION; CURE IN SIX WEEKS. By Dr. B. S. ARNULPHY.

Case. About six weeks ago Dr. Maguy, of Kensington, Ill., sent me for examination and treatment Mr. T. O'D., a patient of his. He came, accompanied by his brother, leaning on a cane, walking with great difficulty, and visibly faint and exhausted from the slight exertion incurred in going up the few steps leading to my office.

The patient is a man of twenty-six, tall, of lymphatico-sanguine temperament. He looked quite emaciated, with a hectic flush on the cheek. He had been in good health until three years ago, when he was prostrated with "la grippe," which he had in a severe pulmonary form, and from which he is conscious he never rallied fully. Some cough was left behind, and he had been slowly and steadily going down grade, with an ultimate loss of nearly forty pounds. (Quite a common tale of woe since "la grippe"

has acquired citizenship among us.) Finally, a few weeks ago he was taken sick again, with fever, pain in the side, an exacerbation of the old cough, and increasing difficulty in breathing. Some little blood had made its appearance in the expectoration. Abundant sweat at night. The family history is good. The man is a railroad clerk.

Proceeding to examination, one could not help being struck by a prominent symptom, viz., *the intense dyspnoea*, even after a rest of about twenty minutes. The respiration was 45, shallow and labored: pulse, 140, rapid, weak, compressible; the temperature, $102\frac{3}{4}^{\circ}$

A glance at his naked chest explained all. There was the left side of the thorax noticeably enlarged, practically motionless, while its fellow was doing all the labor. The lower two-thirds of the left thorax was occupied by a liquid effusion, as evidenced by a total lack of resonance, an absence of vocal fremitus on palpation, and a beautiful zone of bronchial breathing in the upper interscapular region above the line of dullness, just where the lung was crowded against the vertebral column. A slight but quite sufficient area of skodaic resonance could be detected below the left clavicle, so that, notwithstanding a marked displacement of the heart to the right, I felt that I could temporize and that immediate thoracentesis was not necessary.

This, by the way, is a pretty safe clinical rule, which I have had occasion to verify repeatedly. As long as the skodaic note—a kind of tympanitic resonance—is left under the clavicle, there is no urgency to tap the pleura.

Proceeding further, I discovered above and below the left clavicle small puffs of dry crepitation, mostly expiratory and intensified by cough, while the respiratory murmur bore the harsh, broncho-vesicular character that one would expect from the compressed condition of the lung.

These crepitant râles might have originated from an involvement of the apical pleura, or from the probable atelectatic state of corresponding portions of the summit, but the fact that they were modified by cough, and the further discovery of dry, crackling râles diffused among an area of sibilant râles at the very top of the axillary region, was sufficient evidence for me in favor of tubercular invasion of the lung tissue.

Over the opposite lung, whose harsh puerile breath-sounds plainly showed the vicarious strain put upon it, further confirmation of tuberculisation was found.

The whole infra-clavicular region exhibited a medley of dry and moist râles, some of bronchial origin; some of parenchymatous nature. Conspicuous among the latter was a well-defined crackling of medium size, but with sufficient moisture about it to indicate that the tissue at that point was beginning to crumble down. The percussion note over the affected spot showed a dullish tinge.

Therefore, this was the situation, pulmonary tuberculosis, probably of grippal origin, *attacking both apices*, the lesion of the right one being in a more advanced state, in fact on the borderland, between the first and second stage; a pleuritic effusion occupying two-thirds of the left pleura, with displacement of the heart, the result evidently of a secondary involvement.

The prognosis was decidedly bad. A double apical invasion is always serious, but the presence of such an extensive effusion, with all its purulent possibilities in the background, was well calculated to deepen the gloom hanging over it.

My prescription was tuberculin 8, and arsenicum 3. I did not feel that under the circumstances I could trust to tuberculin alone, and I chose arsenicum in preference to hepar sulph. recommended by Jousset in subacute forms of pleural effusion, because I have been taught by experience to dread the aggressiveness of sulphur, alone or in combination, in the course of active tuberculosis; also because arsenicum seems to me to affect the vitality of the serous surfaces in no small degree; besides, it had the advantage of fitting the hectic picture of the case more closely, including the dyspnœa.

I also resorted to an auxiliary mode of treatment which has during the past few years given me considerable satisfaction in the treatment of a variety of pulmonary affections: I mean the direct inhalation, nasal or oral, of superheated dry air laden with medicated vapor. I used the apparatus called "the triumph," which is of very simple construction but answered the purpose admirably. Many a case of unmanageable bronchorrhœa, of trying emphysematous bronchitis, and rebellious asthma, of profusely secreting tubercular cavity, have I seen yield to the steady application of this method. Of its philosophy and clinical importance I will speak more fully when reporting to this society the cases upon which I base my opinion of its workings.

One point only need I emphasize here, regarding its application to the treatment of pulmonary tuberculosis,

because it has a direct bearing upon the case in hand. Before I experimented with tuberculin in the treatment of consumption this apparatus was my main reliance. Since I found out that tuberculin is capable of inhibiting the development of tubercle, provided it be given early enough and persistently enough, incipient phthisis has lost almost all its terrors for me, as I feel confident that with the combined efforts of this remedy and the superheated air apparatus almost all cases of dawning consumption ought to be cured.

The present case is one in point, and it is characteristic enough to teach its own lesson. After six weeks of treatment, during which he took nothing but arsenicum and tuberculin in alternation, and the dry vapor of a solution of iodoform in oil of thyme (20 grains to 1 ounce) and lately that of a solution of guaiacol in oil of pine needles, the apparatus registering a temperature varying between 500° and 600° F. the patient is on the high road to recovery, in fact practically well, and will resume work as soon as the unsettled state of things in the railroad world will allow.

The effusion has steadily receded and the lung occupies now most of its former territory, save for a thick fibrous exudate which reveals itself by a loud friction sound, accompanied by many leather-like creakings; and the heart is at home again.

Over the left apex it is impossible now to detect the slightest crepitation, or in fact any adventitious râle whatever, the breathing being of a fair vesicular quality.

Over the right summit where destruction was so ominously impending nothing abnormal is left but a broncho-vesicular respiratory murmur, but devoid of any aggressive harshness. No adventitious râle either on coughing or deep breathing.

At the same time the general appearance of the patient has undergone a striking change. The hectic flush has given way to a ruddy glow suffused over the whole face; the cane is dispensed with and the patient walks a mile without fatigue or dyspnoea; 20 pounds have been gained, the appetite is voracious; the fever and the night sweats have disappeared, there is neither cough nor expectoration, save some frothy sputum in the morning; the tall bent frame of a few weeks ago is now erect, and the clear beam of the eyes speaks of a returning tide of life and hopefulness.

The question may be asked : what is it that did the work? My answer is: the "ensemble" of means brought to bear. Complex cases require complex medication. Arsenicum alone might have removed the effusion; it is doubtful whether it would have influenced the disintegrating apices to any extent; *tuberculin* alone would have benefited the whole condition of the patient; it would hardly have touched the effusion; the superheated air and medicated vapor treatment has manifestly helped both the above remedies, by means of its powerful antiseptic and stimulating action on the bronchial and air-cell surfaces. I repeat if complex cases require complex treatment, and we must never neglect to treat our cases "intus et extra" when we can do so with any chance of success.

I ought to state here while endeavoring to apply direct medication to diseased lungs, *especially when the apices* are to be reached, oral inhalation must be discarded, as I have been led to recognize the great superiority of nasal inhalation. A very simple contrivance, provided with a nose-piece allows the patient to inhale the vapor through the nose, thus giving the whole of the nasal surfaces the benefit of the medication. It is a well-known fact that the apices never fully expand in normal breathing unless one breathe through the nose. It fact there is no normal breathing except nasal breathing.

As a corollary to the above, I am enabled to give assurance that this method of nasal inhalation of superheated balsamic and antiseptic vapor will be found extremely helpful in the treatment of all forms of catarrh of the nasal, pharyngeal and laryngeal surfaces. I have tried it on myself with full success, and on scores of others.

Hospital Notes.

THE CHILDREN'S CLINIC.

SERVICE OF PROF JOS. P. COBB.

REPORTED BY H. J. PAYNE, CLERK OF THE CLINIC.

ENURESIS.—*Case 730.* Bennie, age thirteen and a half years, came to the clinic May 23. When six years of age had measles, and at twelve had whooping cough. Has since a baby been troubled with enuresis. Four years ago had la grippe and since then has been much worse; is always worse when he has a cold. Takes cold easily. He is employed at present lifting barrels for the Standard Oil Works; complains of pain in the lumbar region and between the shoulders; does not sleep well, is very restless at night, turning, tossing, and groaning in sleep; is very tired in the morning; appetite is good; bowels move regularly; stool normal; he has to urinate about every half hour during the day; when the desire comes it is very imperative and he cannot wait.

At present he is not troubled much at night, though he often is, and particularly when suffering with a cold. An examination of the urine showed an excess of bladder mucus and lithates; urine turbid and foul smelling.

You have heard the history of this case; the boy, small of his age, is doing heavy work, which continually strains him to his utmost strength. This strain in heavy lifting certainly must aggravate any unusual irritability of the bladder wall and simulates the strain put upon the bladder by a sudden expulsive cough. The history points to an aggravation following an attack of influenza, mentions that he takes cold easily, and that with a cold there is always an increased irritability of the bladder.

The examination of the urine reveals evidence of cystic catarrh and urine which is abnormally irritating. With this picture before us we shall prescribe causticum 6x.

June 2. He reported again at the clinic much improved.

Does not urinate so often; has no pain in the back. The remedy was continued in the twelfth potency.

June 6. He is much improved; does not urinate at night, and not so often during the day. The remedy was continued.

June 23. He reported again at the clinic much better in every way. Had stopped the work of lifting barrels. Urinates three or four times a day. The remedy was continued.

June 30. His mother reports that he is well.

CONSTIPATION—SCROFULOUS DIATHESIS.—*Case 716.* Albert Swanson, age thirteen months, was brought to the clinic May 2. Was troubled since birth with constipation alternating with diarrhœa. The mother had used soap injections during the periods of constipation; the stool was black, hard and dry; passed with pain. This condition lasted from three to four days, and was relieved by diarrhœa; at these times the stool was green or black, never yellow. He is restless at night; cries, jumps and starts in sleep; screams out as if frightened, then wakes. This waking occurs generally before midnight; always wakes about an hour after going to bed; he sweats a great deal at night.

Calc. phos. 3x was given four times daily. He was reported again May 9, improved, bowels moved regularly, not so cross, was restless at night; the remedy was continued.

Clinical Reviews.

AN ILLUSTRATED DICTIONARY OF MEDICINE, BIOLOGY AND ALLIED SCIENCES, INCLUDING THE PRONUNCIATION, ACCENTUATION, DERIVATION, AND DEFINITION OF THE TERMS USED IN MEDICINE, ANATOMY, SURGERY, OBSTETRICS, GYNÆCOLOGY, ETC., ETC., and the various sciences closely related to Medicine, Bacteriology, Microscopy, Botany, Zoology, etc., etc. By GEORGE M. GOULD, A. M., M. D., etc., etc. Based upon recent scientific literature. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street, 1894. pp. 1,633.

With such works as this within easy reach of the physician and student there is no longer any excuse for illiteracy. The objects of the book are to include many thousands of new words and terms in medicine; to give the best work of the older lexicographers; to include all the more commonly used terms of biology, because that science is the foundation of progressive medicine, and because no other English dictionary gives them; to make the work encyclopædic in character without exceeding a single volume; to illustrate it with the best cuts and the best orthography, are fully carried out. The text is clear, the page a delight to the eye, and the information given is exactly what is hoped for when the word, or table, or definition is sought. Such a book is really "a guide, philosopher and friend." The publishers as well as the author are deserving of great praise for its timely and careful production.

A TEXT-BOOK ON THE DISEASES OF WOMEN. BY HENRY J. GARRIGUES, A. M., M. D., Professor of Obstetrics in the New York Post Graduate Medical School and Hospital, etc., etc. Containing 310 engravings and colored plates. Philadelphia: W. B. Saunders, 925 Walnut Street, 1894. pp. 690. Price, cloth, \$4.00; sheep, \$5.00.

Some weeks of daily acquaintance with this book justifies the excellent opinion that has been formed of it by

others. It is written in so concise a style that it will be found comparatively easy to master by those who, besides gynæcology, have to learn the rudiments of all the other branches of medical science and art. The historical development of gynæcology is left out and only its present stage described. The text is not overburdened with proper names, which are only admitted when necessary in order to designate in a short way different methods of operating. Nor is it interspersed with histories of cases, which chiefly serve to advertise the author, and are without value to the beginner.

The book is divided into a general and special part, by which many repetitions are avoided, and which will undoubtedly particularly serve the ends of the beginner. All references to the author's own work and that of others have been relegated to notes printed in smaller type, so as not to intrude upon those whose sole aim it is to obtain an elementary knowledge. A large amount of original American work spread in journal articles and extending through a period of many years is here for the first time found in a condensed form.

Where many methods of treatment, especially operations, exists, not all are mentioned, but in order to preserve clearness and offer the best advice the author has made a choice and used his own judgment and experience as a guide. The methods of treatment recommended throughout the book are those followed in this country. This exposition of practical gynæcology is built on a solid anatomical and physiological basis, and anatomical divisions are strictly adhered to throughout the work.

The illustrations form a complete atlas for the study of the development and anatomy of the female genitals besides illustrating morbid conditions, instruments, apparatus, and operations wherever needed. The moderate price of this work will make it welcome to many students.

THE LONDON HOMŒOPATHIC HOSPITAL REPORTS. Edited by **DRS. GEORGE BURFORD, C. KNOX SHAW and BYRES MOIR.** Vol. III., London: London Homœopathic Hospital, December, 1893.

Among the sure lights of clinical research that for many years have come to us from beyond the sea in the form of hospital reports the annual volume from the London Homœopathic Hospital has already won a most honorable posi-

tion. We welcome its third and larger volume as worthy of the earnest friends and workers who have put its excellent contents into shape for us and for those who in the future will consult its very interesting pages. Its contents include an essay On the Study of the Symptomatology of the Cyclopedia of Drug Pathogenesis, by Dr. C. Harrison Blackley; Studies in the Materia Medica: Tabacum, by Dr. D. Dyce Brown; Syzygium Jambolanum, by Dr. R. E. Dudgeon; Incipient Senile Cataract: Its Etiology and Treatment, by C. Knox Shaw, M. R. C. S.; Mastoid Disease and its complications, by Dudley Wright, M. R. C. S.; Studies in Gynæcology: I. The Influence of Civilization on the Reproductive Life in Women, by Dr. George Burford; Slow Pulse (Brachycardia) with Epileptiform Convulsions, by Dr. Byres Moir; A Case of Typhoid Fever with Hyperpyrexia, treated in the acute stage by Hydrotherapy, by Washington Epps, M. R. C. S., etc., and five very practical papers entitled Contributions to the Treatment of Uterine Hæmorrhage, by Drs. Carfrae, Dyce Brown, Burford, Wm. Cash Reed and A. E. Hawkes, of the Liverpool Homœopathic Hospital.

From this interesting bill of fare we select a few appetizing extracts. In his paper on the *Syzygium* Dr. Dudgeon says:

"The chief case of diabetes for which I desired the remedy was that of a gentleman who had long resided in India, and who had presented symptoms of diabetes for several years, but had not benefited by any treatment employed. The case was not an ordinary one. I need not enter into a detailed account of his symptoms, suffice it to say he had concomitant signs of atrophy of the liver, and the amount of sugar in the urine was never great, though the quantity of urine passed was very considerable. The appetite was generally very great, and the motions were enormous, but of a very light buff color and spongy appearance. In this case the syzygium, though carefully and repeatedly tried, produced no perceptible effect on the quantity of sugar excreted, which, as I before said, was never very considerable.

"The next case was that of an old lady, who first came to me on account of intense pruritus vulvæ, which tormented her day and night. I found that she suffered besides from insatiable thirst and diuresis. I examined the urine and found its specific gravity 1,040, and it contained a large quantity of sugar. Careful dieting and phosphoric acid 1x. three times a day, had but little effect on the amount of sugar excreted or the quantity of urine passed, and the itching continued as intense as before. As I had quite lately received a supply of the remedy, I gave her syzygium, two drops of the tincture I had myself prepared, in alternation

with the phosphoric acid, each twice a day. I saw her four weeks later, and ascertained that the pruritus was considerably better, the thirst less, and the quantity of the urine passed diminished, though the specific gravity remained at 1,037, and it still showed a large amount of sugar. In this way she went on for twelve weeks, the symptoms considerably relieved, and the specific gravity of the urine fallen to 1,032. I then dropped the phosphoric acid, and gave her syzygium alone, two drops of the tincture three times a day. Under this medicine the irritation, thirst, and abnormal quantity of urine completely disappeared, and though the latter still contains a considerable quantity of sugar, the health of this old lady, now six years after commencing treatment, she being 78 years of age, is very good; but cataract having developed in both eyes she is not able to get about as much as she would like. The syzygium in this case did not eliminate all the sugar from the urine, but under its use the attendant discomforts of diabetes, the thirst, pruritus and diuresis entirely departed, and she is so well pleased with her condition that she considers herself cured, and is only concerned now about her failing sight.

"The best result I have obtained from syzygium was in the case of a gentleman, aged fifty-six, who consulted me for what he called 'prickly heat.' He had intolerable itching all over the upper part of the body and arms, which allowed him no rest at night. The skin when it itched was covered with small papules. He complained besides of intense thirst, and great flow of urine. I found its specific gravity 1,036, and it was very saccharine. He had been living for a week past entirely upon vegetable food with a view to allay the itching, but it had gone on increasing under the diet. I gave a small vial full of a weak tincture of syzygium, and directed him to take two drops every three hours. He visited me twelve days later, and informed me that he had taken the specific gravity of the urine every day. It was at first 1,045, but had now fallen to 1030. He visited me in another twelve days, and I found him quite well. The specific gravity of the urine was 1,025, there was no excessive quantity, and it was free from sugar. A year or two afterward he had an almost precisely similar attack, which yielded equally quick to syzygium. Now, two years after the last attack, he has not had any recurrence of the affection.

I have given syzygium in several other cases of diabetes without effect. But this year a lady, whom I had been treating for a serious attack of hæmatemesis, while recovering from the exhaustive effects of her loss of blood, complained of great itching all over, which kept her from sleeping. There was considerable thirst, and the urine was increased in quantity. On examining it I found a notable quantity of sugar, although the specific gravity was not very high—about 1,025. A few days of syzygium sufficed to eliminate all the sugar from the urine, and to remove entirely the troublesome pruritus. I made no alteration whatever in this patient's diet."

Dr. Knox Shaw's contribution on *Incipient Simple Cataract*, which is careful, elaborate and encouraging, closes as follows :

I would sum up the treatment that should be employed as follows :

1. Not to inform the patient of the condition of the lens.
2. To correct carefully any error of refraction, and if some of the impaired vision depends upon that error to order the spectacles to be used constantly, and if there is any sensitiveness to light to have them slightly tinted.
3. To prescribe internally and locally for any conjunctivitis or obvious accommodative symptoms.
4. To allow the patient full use of the eyes short of fatigue.

In conclusion, I would ask attention to the following propositions :

1. That simple cataract is not *per se* a senile change.
2. That the prime factor in its development is eye strain, due to over-exertion of the accommodation.
3. That its rate of development is slow, and that in many cases it may never reach maturity.
4. That mechanical means, such as spectacles, to remove the primary, and carefully selected medical treatment to remove the secondary effects of the eye strain, will delay the progress of simple cataract, and in some cases will for a time cause an improvement in the condition of the lens.

The book is well printed and the many illustrations are of an excellent kind. We congratulate everybody concerned in the issue of this excellent publication.

STORIES OF A COUNTRY DOCTOR. By WILLIS P. KING, M. D., etc., etc. Illustrated. New York: Bailey & Fairchild, 24 Park Place, 1894.

This little half-dollar book, in a soft-shell cover, is one of the jolliest and juiciest that we have read in many a day. It is filled with frontier experiences, bits of sentiment and pathos, stories and chronicles of the ups and downs of a doctor's life that are intensely suggestive, amusing and instructive. When our readers have run through the following brief extracts we advise them to buy the book as an antidote to the blues and an offset to the vexatious worries that nag the soul of a doctor whether he lives in the country or the town.

Does my professional reader remember his first case? I shall never forget mine. When on the way to see my first patient, I felt like I was

preparing to go up in a balloon. On entering the sick room I had a sensation as if I were walking on sand which was giving way under my feet; and when I felt his pulse (about which I am afraid I knew very little) and tried to look dignified and wise, the objects in the room grew double and danced around like puppets on a hand organ. But I prescribed. I got a half-pint bottle, partly filled it with water and put in something for each symptom I had noticed and some other things "just for luck." The mixture heaved and swelled a few times like the tide, turned all colors of the rainbow in succession, and then settled down to the consistency of soapsuds with a heavy sediment at the bottom; and the poor fellow lay there and took a teaspoonful of that stuff every three hours and actually got well. He believes yet that I cured him, but I know better.

Of sham suicides, of which most of our readers must have seen something, the following paragraph is worth remembering:

It is easy enough to detect these frauds, as a general thing. Any physician ought to know that a poison which is so deadly and instantaneous in its effects as to cause the patient to fall down immediately after swallowing it, should kill at once, and before he could possibly reach the patient. Again, a poison which affects the general system so suddenly and so seriously should put almost every muscle in the body in a state of semi-paralysis. In such a case the eyes would be open or partly open. In most cases the pupils should be affected—either dilated or contracted. The pulse should, as a rule, be weak and rapid. In many cases there should be vomiting or retching. It is also important to know whether the patient fell on a bed or a lounge, or on the floor or ground. Real suicides do not choose soft places on which to fall.

If the patient is pretending, he or she will almost surely shut the eyes very tight and when the physician attempts to open them for inspection, there will be voluntary muscular resistance.

Now, with close shut eyes, pulse at seventy or eighty, no dilatation of the pupils, the extremities warm and the addition of a motive for this kind of acting (if you can get at the motive) you may rely on it that, in nine cases out of ten, you will be safe in saying that the patient has taken nothing that will kill him. It may not always be best to say that the patient is pretending, and this more especially in the case of young girls. It is not necessary to tell the crowd anything, except that she will not die. But do not hesitate to tell her parents; and as soon as the girl will consent to talk, make her understand that you are not deceived. For she will respect you the more when she knows that you are not. It may not be out of place in such cases to deliver a kind, but firm lecture to the young woman regarding the wickedness and foolishness of her conduct. If done right it will do good.

Of quacks and quackery the following interesting stories are told:

In a small town where I once practiced there was an old fellow who was quite innocent in his way except for the murders he committed in trying to practice medicine. He had not the slightest idea of anatomy, physiology or pathology, and was just as innocent of any knowledge concerning the therapeutic value and action of drugs. He had a nose that had suffered from *rosacea* so long that it looked like an old, haggled and chewed up beet; one of his eyes was of the fried egg variety; but he always maintained an air of respectability by wearing a frayed plug hat.

He was always slipping in by the back door of the drug store and holding consultations with one of the clerks. This clerk really made out and filled most of the doctor's prescriptions for him after the doctor had detailed the symptoms in the case. This was, no doubt, better for the patient, for the clerk was sure not to recommend or use any dangerous drugs, while the doctor, if left to himself, might do so.

One of our physicians overheard the following conversation between a facetious drug clerk and this quack, while the clerk was helping him on one of his prescriptions: Clerk: "Doctor, I suppose you have performed a great many surgical operations in your time." Quack: "Oh, yes, a great many." Clerk: "Doctor, I have long since desired to find a surgeon who has performed a certain operation—an operation which has only been performed a few times, I believe." Quack: "What operation is it?" Clerk: "It is the operation of *abdominal digitalis*." Quack: "Oh, yes, I have done that operation twice; but the doctors in this town will not give me credit for it." Clerk: "There is another operation that I wish to ask about (and I have no doubt that you have performed it), and that is *aortic regurgitation*." Quack: "Yes, I have done that too, over at ——town. Oh! I tell you, it's an awful bloody operation."

After all my experiences with quacks, and, after a good deal of observation and devoting much thought to the consideration of the matter I feel constrained to say that the honest men in the medical profession would have destroyed him long ago, if the public and the press had permitted them to do so.

Miscellaneous Items.

The Board of Trustees announces that the new building of the Hahnemann Hospital, Chicago, (225 beds) is being rapidly furnished and equipped, and *will certainly be ready for occupancy by August 15*.—The Obstetrical department will report through Drs. Leavitt and Honberger at the next meeting of the Clinical Society, July 28.—Wayne, Neb., is in need of a good homœopathic physician.—Dr. O. S. Misick, Hah. '93 and Rush '94, will locate on the north side; Dr. E. C. Reed, formerly of Blue Island, is at 195 Powell Ave., city; Dr. J. F. Beaumont has removed from Minneapolis to 1206 Champlain Building, city; and Dr. R. C. Bain has become General Agent for the N. Y. Life Ins. Co.—Death has claimed two more of our friends, Prof. G. S. Walker, late of St. Louis, and Dr. W. A. Barker of this city.—We gladly extend the right hand of fellowship to the New Denver Homœopathic College.—The marriage of Dr. F. W. Gordon, of Sterling, Ill., June 12, and of Dr. Reginald Munson, of Washington, D. C., June 14, calls forth our hearty congratulations.—The Winter term in the "Old Hahnemann" opens September 11, at which time the formal dedication of the new hospital building will also take place.—We have very interesting letters from Dr. N. C. Kemp in Vienna.—Prof. Vilas is travelling in Europe.—The Hahnemann Hospital has had a splendid windfall *in cash*, of which more anon.—The Hospital Notes on Surgical Gynecology are crowded out of this issue, but they will keep; ditto other notices of new publications.—We regret to announce the accidental death of Mr. J. B. Bristol, an esteemed Junior of last year's class, while serving as deputy U. S. Marshall on the B. & O. Railway.—For the Thirty-fifth Annual Announcement and Catalogue of the Hahnemann Medical College and Hospital, address Dr. J. P. Cobb, 3156 Indiana Avenue, Chicago.

THE CLINIQUE.

VOL. XV.]

CHICAGO, AUGUST 15, 1894.

[No. 8.]

Original Lectures.

CONSUMPTION CURES.—A COMPARISON.

SYNOPSIS OF A CLINICAL LECTURE DELIVERED DURING THE SUMMER SEMESTER OF 1894, BY A. K. CRAWFORD, M. D., PROFESSOR OF THEORY AND PRACTICE OF MEDICINE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

It is during the summer months when relieved from the pressure of trying to teach, all at once, a few hundred ardent students in medicine that our overflowing clinics afford us the opportunity for occasional experiments in therapeutics. This is surely the proper place for the trial of things called *new*, and when discreetly carried on may prove advantageous to some portion of the profession whether the result is successful or not. A knowledge of the negative value of a form of treatment is positive for good in the mind of a physician when he can divert its trial in the next similar case.

The other day in discussing with a doctor in Duluth upon the use of bacillum in phthisis he asked me if I had seen any result from the use of it. The answer was at once in the affirmative. He then modified his query by asking if I had witnessed *good* results. Kipling would have said "that's another story," and I was constrained to say that in instances of advanced pulmonary phthisis in which this nosode was exhibited the effect was pronounced

shortening of the patient's days. So that now I do not tamper with it in cases far gone in the malady with their accompanying high temperature, very rapid pulse, hectic and sweats, emaciation, anæmia and debility. We know that its field for usefulness is in the early stages of infiltration, and having proven this let it rest there.

The experimental case to be cited is in the same field of research, viz., the treatment of consumption. There is no disease in the calendar which offers so good an excuse for the trial of new things, because no pathy under the sun is warranted in claiming even a moderate success in its cure. We pride ourselves upon our refinement of diagnosis, mapping out the diseased areas, and stating precisely which stage the disease has reached, vouching for the presence of cavities and of the condition of their walls. We likewise pride ourselves upon having saved a proportion of the lives of those so afflicted. But what doctor, living or dead, can claim to have saved more than one, while ten have gone under the sod before his eyes. We may not think we are altogether to blame for this vast mortality, because, first, we are not called when the disease is in its incipiency, and second, the patient's circumstances are such that all we could order done for their good cannot be carried out. Even admitting these cases are pardonable exceptions, look at the numberless cases that fall into our hands to treat just as soon as the patient and his friends are aware that there is any serious trouble—and what is the result? * * * *

Case 18,101. The lad came to our clinic last April. His age is twenty, but hardly appears that old. He is very fair in complexion, with light hair, beardless and pale. He walks slightly stooping and his voice is husky. Upon being stripped he exhibits swollen cervical glands which are painful to touch. The apex of the right lung is sunken and the respiratory movement is greatly impaired. The percussion note is markedly dull. The auscultatory signs are a tubular quality of breathing, increased in expiration, subcrepitation instead of a vesicular murmur and the speaking or coughing voice is loudly transmitted. Corres-

ponding with this there is vocal fremitus, and a sense of pungent heat conveyed to the fingers. He relates to us that his stomach is irritable, vomiting frequent, milk returns curdled, the bowels are abominably constipated, sometimes a week intervening between passages. He has nightly fever, and the racking cough disturbs his rest. He expectorates greenish mucus.

He was referred to the laryngological clinic for examination, and the following is Prof. C. Gurnee Fellows' report:

Typical pear-shaped hypertrophy of the arytenoids.

Thickened and curled epiglottis.

Thickened vocal bands.

General infiltration and superficial ulceration.

Dysphagia, and mechanical obstruction to voice production.

Unmistakable tuberculous laryngitis.

Here then is a case of tuberculosis of the cervical glands, larynx, and the right pulmonary apex progressively advancing and already in the stage of softening. My proposition in regard to its treatment was to watch it a few weeks to note the effect of our own choice of remedies, and as soon as convinced of its lack of response to them to place the patient under the "Amick chemical cure for consumption." This was all carried out honestly. He was first given my own preparation of beechwood creosote with hydriodic acid, then arsenic third, for the marked gastric symptoms. The creosote was again reverted to, followed by the arsenic as before, when both were laid aside and the Amick outfit supplied to the boy with full instructions how to use it.

Each time my first remedy was given him there was a slight improvement noticeable in his case. He said he felt a little stronger, and his face as well as the color of his lips showed a brighter hue. On the other hand under the arsenic he relapsed rapidly. It accomplished absolutely nothing in the way of allaying the irritability of his stomach or of lessening the fever and debility. Up to this time the lad came regularly to the clinic each week, and he felt somewhat encouraged because part of the time he gained slightly, and his throat and voice had improved under the

spray prescribed by Prof. C. G. Fellows. But after putting him upon the *Amick cure* we never saw him there again. Ten days of that treatment very nearly put him to rest—forever.

He took his "chemical injection medicine" for the bowels every other night like a man. He took his "chemical constitutional medicine," twenty drops of it, four times a day until he had no constitution left—only by-laws to live on. He took his four "chemical tablets" per diem regularly when a tablet in the graveyard was staring him in the face, and he pumped away every two hours at his "chemical inhaling medicine," with the will of a racer trying to break the record.

His sad mother came and gave the report to the interne, Dr. Clark, that her boy had grown steadily worse, too weak now to rise, drowsy most of the time; what appetite he had was gone; the throat had become more painful; the difficulty in deglutition had increased; the cough had become more aggravating, while the sputum, constipation, and broken rest were not in the least improved.

The only omission in this case that I can discover was in not having the patient take the dope prescribed after the very evident failure of the ten days' treatment. The modest pamphlet accompanying the drugs directs thus: "After using the treatment for ten days, if the appetite and digestion have not improved, it would indicate an impairment of the digestive organs and we would advise the following stomach tonic: Shaeffer's pepsin, hydrastic muriate, ferri phosphas, syrup lemon, elixir quiniæ, ferri et strych. Mix."

I am inclined to think that the administration of this was all that was requisite to complete the treatment. The undertaker would have done the rest.

In the same bashful pamphlet it reads: "occasionally persons are greatly benefited by the treatment for the first ten days or two weeks and then they fail to gain. In such cases the fault is generally with the patients. They feel so much better that they take an unusual amount of exercise

etc., etc., and the natural result is that they do not feel so well."

My poor patient holds a different opinion regarding the early improvement and the taking of exercise. He did not die.

It was my good fortune to be able to resuscitate him, and to know that he was able to be on his feet again. As soon as he had gained sufficient strength for the journey his family had him take the train to the home of some friends living out on the western plateau of Kansas.

The prognosis in his case is of course very unfavorable, but while he lives he will not suffer any more from the combination of bad drugs and a bad disease. The latter is sufficient for any ordinary individual alone.

And as for the "Amick chemical cure for consumption" it had better be relegated to the rear along with Bergeron's gasbags and Koch's lymph craze.

QUESTIONS NOW OF VITAL INTEREST TO THE PROFESSION.

1. *The average medical society; its true inwardness.*—Does it help or hinder progress?
2. *Proprietary medicines.*—Are they a help to the general practitioner in keeping patients otherwise claimed by the specialists?
3. *Microbes.*—Does their presence occasion any disease whatever? Are they present in every healthy organism? In this connection readers are referred to an article by G. M. Sternberg, Surgeon-General of the U. S. Army. He and many others who think for themselves declare the present microbic scare the most absurd delusion in medical history.

4. *Private hospitals.*—Can a doctor keep a hotel for patients without having his professional honor blunted by a hotel man's desire for many and long-staying guests?

Physicians of whatever school are asked to send in their opinion on these questions and their arguments pro or con at once. The best thought of the profession is wanted, whether from city or country, whether from specialists or general practitioners.—*Cincinnati Medical Journal.*

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D. RECORDING SECRETARY.

JULY MEETING, 1894.

The midsummer meeting, July 28, was a very full and interesting one. The first thing in order was the reading of the following Inaugural Address by the President:

XXVIII. THE OPENING OF THE NEW HAHNEMANN HOSPITAL OF CHICAGO. A PLEA FOR CLINICAL TEACHING AT THE BEDSIDE. BY B. S. ARNULPHY, M. D., PRESIDENT.

Ladies and gentlemen:—It is my pleasant duty, before anything else, to thank you all for the honor which you conferred upon me in selecting me as President of this Society for the ensuing year. If you meant this distinction as a reward for my undisguised attachment and unflinching fidelity to "Old Hahnemann" ever since I landed in Chicago, I can assure you that I appreciate it deeply.

All I can say, in return, is that I will try to justify your confidence in trying to discharge my duties earnestly and faithfully.

I can well remember the time when I first had the privilege to be present at one of your meetings. It was one sultry summer evening, some nine years ago, on the invitation of my excellent colleague, Dr. Ludlam. I watched the proceedings with great interest as clinical societies of our school are not common in the old country, or for that matter in any other, little dreaming, of course, that one day I would be called to the chair.

If I may be pardoned to dwell a moment more on this subject, I will say that what allured me to this country and detained me in it, was the free scope given to the development of our medical faith, and especially the facilities afforded in the teaching of its truths.

To me it was like breathing in a congenial, bracing atmosphere, for the first time since I graduated, and I suppose you can easily realize the fascination which seizes upon one, born on the other side of the Atlantic, where owing to ingrained prejudice below and intrenched authority above, the growth of Homœopathy is stunted and rachitic, when suddenly confronted by the depth and the breadth of its proportions in this free land.

I soon became identified with the good work of "Old Hahnemann" and every succeeding year has strengthened my bond of allegiance to the institution.

None more than myself has watched with eager interest the unfolding of our new college with its wealth of well-equipped laboratories and its staff of competent demonstrators.

But the latest achievement of "Old Hahnemann," the crowning glory of her useful career, and the pride of her thousands of alumni and friends, is *our New Hospital building*.

With its two hundred beds, distributed among cheerful wards, and its fifty private rooms, the floors and walls of which are strictly aseptic, entirely furnished anew, heated by steam, lighted with electricity, thoroughly ventilated, our hospital stands "facile princeps" at the head of any and all establishments of the kind. Add to these advantages that the inmates will never know any laundry or cooking odors in the premises, as these operations are confined to the highest floor of the building.

We have it on the authority of the Board of Trustees that the building will be completely equipped and ready for occupancy on August 15, only a fortnight hence. The question then will be, not how soon the wards will be filled with patients, but to how many we will be obliged to refuse admittance.

An institution of this kind in which every effort shall be made to increase to the utmost the comfort and promote the recovery of the inmates can only be eminently successful. The "Old Hahnemann" can now afford to heave a

sigh of satisfaction and exclaim: "*Exegi monumentum!*" It is the only kind of a monument, I am sure, with which our good old master, if he could have a voice in the matter, would express full and lasting sympathy. This sentiment was so tersely expressed by Dr. Ludlam at the time of the laying of the corner stone of the hospital, that I cannot refrain from quoting it in full:

"There are monuments and monuments, as there are missionaries and missionaries. We are rebuilding a monument to Hahnemann here in Chicago, and its corner stone has been laid this very hour. It is no new scheme, either, for this institution was the first of its kind to be named in his honor almost forty years ago. And the "Old Hahnemann" has not been a colossal figure to stand as a silent witness of his worth and of his achievements, but a busy, earnest school in which a host of pupils have been trained and taught, and from which almost two thousand graduates have already gone forth to carry the blessings of his ministry. With my Quaker proclivities I insist that this is the *very best kind of a monument*. For it is a monument with a heart in it, and a home and a bed for the sick and the suffering; an hotel, as the first hospitals were, where the weary traveler may find those who will nurse him and care for him, bind up his wounds, and set him on his way again."

Without being a Quaker myself, I may well assert that more enduring than bronze is the undying gratitude engraven in the hearts of the people, and this is what our hospital stands for, not as a dumb form, but a sturdy symbol of beneficent activity.

Now we may well ask ourselves: here we have this fine hospital, ready for work, waiting only for a signal to start the machinery of its intricate functions; what shall we do with it?

Are we going to follow the old routine? It strikes me that some new departure will have to be taken; a new policy inaugurated, if we would be consistent with the tide of prosperity and progress which carries the institution onward, if we would still be true to the proclaimed spirit of our Announcement.

New opportunities create new duties. Until now if

I am not mistaken, according to the Treasurer's accounts, it is the college that has upheld the old hospital. *From now on the new hospital should uphold the college.* And the process will be a more natural and a more praiseworthy one.

Our institution has always boasted that her policy was "to make no promise for college or hospital tuition, that is not literally and righteously kept." In the measure and within the limitations of our former possibilities, I believe that the faculty as a rule, have tried to do the best they could. But it is my unqualified opinion that, with the increased facilities at our disposal, the faculty ought to enlarge their sphere of usefulness in the hospital and ungrudgingly give our students the full benefit of this widening of horizon. What the students want, what they need, what they crave, is *clinical teaching*. They never can get too much of it. And clinical teaching, to be worthy of the name, *ought to be given at the bedside*. I refer you to the meaning of the very word "clinical." It comes from the Greek *klinè*, which means *bed*.

Now let us be honest. We have a splendid hospital. We promise our students the full advantages of the clinical material afforded by the hospital. We *must* give it to them. Not in words only, but in fact. Otherwise the faculty would incur the reproach contained in the Spanish proverb: "*Aviendo pregonado vino, vend vinagre,*" which means: "They advertise wine and sell vinegar."

My idea of clinical teaching in a hospital is this: To each ward should be appointed a "chief of service," with one or more assistants, as the case may be. It should be the duty of the "chief of service" to visit his ward every day, in the morning preferably; if he cannot do so every day, at least three times a week, and give his personal attention to all new cases brought into the ward.

It ought to be the privilege of the senior students to accompany the chief of service to the bedside of the patients at every visit. For the sake of convenience and to avoid crowding, the students will take their turn in classes of ten to fifteen. In the course of the visit, the

“chief” examines and diagnosticates all the new cases, and goes over the old ones giving a short synopsis of the most interesting cases, in the meantime instructing the students in the art of examination, and the methods of physical diagnosis.

Then he prescribes as to remedies and diet; both prescriptions having to be carried out by the interne or his assistant. The students ought to be entitled to an examination of the patients whenever the condition of the latter will allow.

All specimens of sputum, urine, blood, &c., as the case may arise, are secured on the spot, by the interne, or the clinical assistant, and referred to the laboratories where they belong, for examination; a report of the same being duly returned to the “chief.”

From time to time it should be the duty of the “chief” to give the students a general clinical lecture, reviewing the work done at the hospital and commenting upon it, with the help of analyzed specimens. Such work as this really deserves the name of “clinical teaching.”

The great schools of medicine in France, England, Germany, Austria, Russia, have all adopted that plan and thriven upon it. It has three great advantages. It benefits the students. I need not emphasize that point. It benefits the patients. They are surely better taken care of, their cases more thoroughly investigated, their ailments more promptly relieved, and they will not be slow in recognizing it.

It also benefits the teacher by bringing him closer to both the patients and the students, and because it develops his best powers.

Having recieved my own medical education under that system of clinical teaching, you will not be surprised that I am partial to it. It would be my delight to see it inaugurated in our new hospital, and the day it is in force will be a happy day for our institution. It will then take the lead as the clinical centre among similar institutions, and, as the example is sure to be followed, no higher recognition of its public usefulness can be conceived for it.

As far as I am personally concerned, and upon my own responsibility, I have determined to test the plan in the medical ward that has been allotted to my care.

In this way, at all events, a great anomaly—which is a great injustice—will be done away with. There will be no further occasion for students to complain that they have gone forth from the institution without having been afforded a chance to see a single case of acute disease, be it pneumonia, or pleurisy, or typhoid fever, or rheumatism, or what not.

I repeat it, what we need for the furtherance of the best interests of our college is a new, broad, liberal policy throughout the new hospital management; and the improvement I propose in the clinical teaching is only one step in the right direction. No member of the faculty has been approached by me with reference to the idea here advanced, and if I come out publicly with it before you, it is because I like open-handed, straightforward methods. Moreover, my purpose is to invite your fullest discussion of the subject, as it is one of vital importance, and nothing but good can come from such an interchange of opinions.

I do not feel that in giving vent to these utterances before you, I am straining a point at all, or overstepping the bounds of propriety. For, as members of a clinical society, mostly composed of former pupils and staunch friends of "Old Hahnemann," you are all surely interested in the furtherance of any idea calculated to improve our teaching methods in the hospital.

Is not this Society the child of the Hahnemann College and Hospital? Does it not derive the best material for its work from the monthly allowance of clinical food furnished by the hospital; and does it not enjoy to the fullest extent the fruition of the joint labors of the teaching staff of the latter?

And should the offspring remain indifferent to the doings and the destiny of its parent?

I think not, and hope you will approve of the bedside system I propose for our future clinical teaching as the only

one consistent with modern methods, and as promising to raise the standard of our school in the eyes of the profession at large and of our fellow-men.

If we would turn out a larger and better class of graduates, it is not a *revolution* in the teaching methods of our college that we need, but a *reform* in those of the new hospital.

Should the faculty conclude to carry out the plan here briefly and inadequately outlined, harmoniously and faithfully, it would not take two years to show the benches of the large college amphitheatre crowded to their utmost capacity, and our beloved institution fairly launched into an era of material prosperity and scientific efficiency such as it has never known before.

Far from me the idea of casting reflections upon, or trying to minimize in the least measure, the noble work that has been accomplished in the old hospital up to date. The work done there has been well and conscientiously done, and great results have been attained in spite of sometimes precarious resources and in the teeth of no mean difficulties.

This has always been a clinical school, even from the start; all we want is to sustain, nay to increase, its well-earned reputation.

This new hospital is but the natural, the logical outcome of more than thirty-five years of persistent, consistent work in the same line; the full blossoming, bursting forth in beauty and fragrance of a long evolution of silent growth, due to the painstaking efforts of a pleiad of men simply devoted to truth and duty.

My only wish in suggesting a reform is to preserve the freshness of the blossom, as the change appears to me as being the best calculated to foster the development and to stimulate the latent energies of the enterprise to its fullest proportions.

DISCUSSION: DR. LEAVITT: I have listened with pleasure to the excellent address of our newly installed President,

and feel like endorsing every thought and sentiment which it contains. We all feel justly proud of the fine hospital for which we have waited so long, the doors of which are about to be thrown open for the reception of the sick and injured among us who desire homœopathic treatment, and are thankful for any suggestions concerning the enlargement of its scope of usefulness and the most perfect utilization of all its facilities. Primarily it is an institution whose beneficent influences shall be extended to the afflicted of this community; but secondarily it is an institution whose usefulness shall be graciously extended to the development of well-trained physicians and surgeons, who in turn will go out to protect the health of the well, and to heal the illnesses of this and many other communities. I believe with Prof. Arnulphy that the new hospital opens the way to the perpetuation in all its roundness and fullness of the reputation of the Hahnemann Medical College of Chicago as the leading clinical school of our tenets in the country and the world. Bedside teaching is the requirement of the age, and, if we will but carry out the suggestions offered in the address of the evening, we shall find students journeying hitherward as they never have done before. Our advantages in this respect will be exceptional, inasmuch as we shall have a hospital under our own immediate control. The Cook County Hospital is a vast institution, but its patients are so hedged in by the authorities, and the appointment of its medical and surgical staff is so completely under the domination of the politician, that its clinical advantages to the medical student are reduced by comparison almost to the zero mark. And so it is with the other large public hospitals of the country. So patent has this fact become to the various colleges that they are fast reaching out after what we have now found—hospitals of their own, wherein they can educate their students according to the dictates of their own wisdom, and yet, I most emphatically add, without harm or injustice to the patients who may enjoy their benefits. Given this new hospital, conducted in accordance with Dr. Arnulphy's suggestions, we shall

soon have an institution wherein the afflicted will find the best care, the most skillful attention, the most humane treatment, and toward which the most refined and cultured, as well as the more intelligent from a lower social scale, will confidently turn in their hour of need. Let experimentation be relegated to public hospitals if you like, but here let us earnestly endeavor to successfully apply the most approved methods, with an eye to securing the best results, and neither patients in the hospital, nor students in the college will be wanting.

Dr. J. P. COBB : I am thoroughly in accord with the sentiment expressed in Prof. Arnulphy's paper. I believe that an opportunity now awaits us to put our school in a position far in advance of the standing she has already attained. A valuable lesson, however, can often be learned by taking a retrospective glance when contemplating our expectations. Few outside our immediate corps realize the disadvantages under which we have worked in the past. Our old hospital has been made to serve us well; with no endowment but the gratuitous services of the college staff, and with less than fifty beds at our disposal, there has never been a year when a wide range of surgical clinics has not been presented to the class; while the dispensary or out-patient clinics have been built up to and maintained at a level far in advance of those of any other homœopathic school of medicine.

By actual enumeration the patients presented to our classes in the twenty-five clinics and sub-clinics maintained by this faculty have during the last few years numbered over 1,000 per month. We draw our material for these dispensary clinics from all over Cook county and from adjoining States as well. The variety of cases presenting themselves is as widespread as the sources from which they come. Nowhere outside of a cosmopolitan city like Chicago would it be possible to build up such clinics as are here maintained, where all varieties of chronic diseases in all of their manifestations as developed in different nationalities are represented.

With the former hospital facilities and these out-clinics we have reached and held the enviable position as the leading clinical college of our school of medicine—a position which is conceded us even by our rivals. With our new hospital we have obtained the one thing that we needed, viz., the opportunity to present clinically all forms of acute diseases. That these facilities shall be used to their fullest extent for the advantage of the students is the determination of every member of the clinical staff.

Dr. E. M. BRUCE: The methods suggested by Prof. Arnulphy present to my mind two decided advantages, one to the patient and the other to the student. I believe one of the most beneficial effects upon a sick person is the knowledge that he is being carefully, methodically and persistently attended. The visit of the professor in charge with the students (if they have the proper mental attitude, and if they have not their place is not in a medical college) would, I am sure, be hailed as the event of the day.

The criticism I would make upon hospital practice as a usual thing is that the physician is apt to be lax in making a definite call upon each patient every day, just as he does in private practice. It may not be necessary but it is a great comfort to the patient.

The advantage to the earnest student can hardly be calculated. He would have the benefit of seeing the daily condition say of a case of typhoid fever, and would not, therefore, be so much at sea in the first days of his own practice.

He could take to the laboratories samples of urine for examination that would mean something. He would have all the data of the case, and could put some enthusiasm into the work.

To do good laboratory work in any science it is necessary that the subject be surrounded by some halo of importance.

Dr. R. LUDLAM also expressed his gratification with the President's timely address. For those of us who have waited so long for the new hospital building to materialize

it is a pleasure to see and to know that it is being furnished, and that in a few days more it will be equipped and in running order. We are all very happy over the prospect, and will celebrate the event, you may be sure, in a becoming manner.

The question that Dr. Arnulphy has raised is a serious one. For, while in the past we have been put upon our mettle to meet our obligations, clinical, moral and miscellaneous, with the true spirit of progressiveness we cannot disregard the claims that will come with the new quarters and the inevitable increase of patients and pupils. We must keep up the excellent system of out-clinic instruction, as well as the hospital work proper, that have given us such an enviable reputation in the past; and in addition be prepared to furnish such a bedside drill as was impossible under the old order of things, and with the comparatively few beds that were at our disposal.

There can be little doubt that the teaching corps which has done so well under the old dispensation, with all of its disadvantages, will do still better service under the new. The question is one of methods, and in this respect the plan suggested will, in my judgment, have to be modified somewhat.

It is true that we cannot have a large clinical hospital away from the great centres of population like Chicago or New York, because almost the only material that is available for clinical instruction is of foreign birth. For generations these people have been accustomed to life in the hospitals when they were ill, and to be handled by teacher and pupil in objective bedside instruction. They expect it and consequently make little or no objection to such a method as Dr. Arnulphy proposes. But not a few of our native patients, although becoming more reconciled to hospital privileges and safeguards than formerly, are still unwilling to be taken as subjects for a clinical lesson, either in the ward or in the amphitheatre; and therefore it is not altogether a question of what is best for the student, but whether such patients will consent to be utilized for the benefit of all concerned.

I have not a doubt that, in the teaching of certain branches especially, the best work can and will be done at the bedside. With kindness and care our hospital patients can often be made to feel that in some sort they are doing missionary work, when by a little self-denial on their own part, they are helping to educate our students to be better physicians and surgeons. But there are exceptions to this rule also.

This very meeting marks a revival of interest in clinical teaching. Thus far our sorry facilities have served a good purpose, but it was because of the inflexible persistence, the faith, hope and will of my colleagues as well as of our loyal alumni and friends everywhere. Now, however, we have a sublime capacity for increased usefulness, and the same old disposition to do what is set before us to the best of our ability.

Encouraging and complimentary remarks were also made by Drs. McCracken, Poppe and others.

Dr. ARNULPHY: I can only express deep gratification at the manner in which my suggestions have been received by this Society, and at the unmistakably favorable opinions that their presentation has elicited.

If the authorized voices we have just heard can be considered as a token of the sentiment of this meeting, I must take it that the ready endorsement which you have granted to the proposed change is fraught with a significance that cannot be overlooked. It shows very clearly that, though somewhat outlandish perhaps in its character, it has struck a sympathetic chord in your minds, and is not viewed in the light of an impracticable experiment.

I am fully aware that the conditions are different in this from what they are in the old country, with reference to hospital matters. Most of the large hospitals on the other side of the water, where clinical teaching is given on the plan mentioned, are supported by the respective governments; the patients admitted therein, though treated with the utmost kindness and consideration, are mostly of the class that we would here call "charity patients," and have to follow the regulations of the hospital as they find them.

It might be otherwise with the class of patients that have patronized our old hospital and will come to the new. Some may not relish at first the idea of being examined by the students.

But do not let us forget that these patients are as a rule a more intelligent class of people than those generally found as inmates of foreign hospitals. They pay their own board, in whole or in part; they have had the advantages of a better education; they have a better and more liberal understanding of the mutual duties between man and man upon which civilized society is founded. They understand that if the community is to be blessed with better physicians, greater advantages must be granted the medical students. I have no doubt that those people will soon understand our real motives in the matter, and that they will do their part nobly and willingly.

I repeat it, we have to deal with an intelligent class of people. They show their intelligence by coming to the Hahnemann Hospital for help—we must concede this point. Well, I reckon on their intelligence with a view to helping us in establishing this much-needed reform. The difficulty is simply a matter of education, which will easily be overcome.

I do not think that any pressure will have to be brought to bear upon them in order to get their compliance with the new order of things. They will soon find out that it is all to their advantage. Of course, much of the success will ultimately rest with the discretion and firmness of the "chief" in the management of his respective department.

While it might be optional for patients to be examined by the students or not, the "chief" will not be bound to give his personal care to the parties who choose to waive an examination. In my opinion, those cases will be rare, though I have seen some such stubborn people even in the foreign hospitals.

For more than five years I have seen clinical service in the Paris hospitals and elsewhere, and my constant experience has been that the morning visit of the chief was looked

forward to by the patients with undisguised feelings of pleasure. It was to those sufferers the happy moment of the day, the bright spot in their gloomy surroundings. I say gloomy, because twenty-five years ago hospitals were not what they are now.

In closing this discussion, I desire to thank the speakers; for I have derived great comfort from their remarks, and I feel more sanguine than ever and have great hopes that the faculty will soon see their way clear to the adoption of my pet scheme, and will put it to a loyal, practical test for the benefit of all who are or will be interested.

REPORT OF THE BUREAU OF OBSTETRICS.

BY DRS. LEAVITT AND HONBERGER.

XXIX. CASES FROM THE OBSTETRICAL CLINIC OF HAHNEMANN HOSPITAL, BY F. H. HONBERGER, M. D.—The following somewhat unusual cases are reported, not because they possess any especially new features, but simply in corroboration of what has been written in regard to what may be retained within the uterine cavity, and cause little or no disturbance to the maternal structures, especially when not exposed to atmospheric influences.

Case 1. Miss S., American, aged 20, primipara, menstruated last on July 15, 1893; entered the hospital May 3, 1894. Was confined on May 15, 303 days from date of her last menstrual period. Upon entering the hospital she reported that the membranes had ruptured with an escape of considerable fluid on the day previous. There being no further discharge, no pains or discomfort, my attention was not called to the case until labor came on about ten days later; labor then came on perfectly natural, was of only about three hours' duration and at no time were the contractions severe. The fœtus was delivered in the dorso-anterior position of cephalic presentation.

The child a male weighed eight and one-half pounds; was stillborn, had been dead for some time, the trunk and extremities were well rounded out and the nails projected beyond the tips of fingers and toes, showing that gestation must have been nearly complete before death. It was in a

somewhat macerated state, the epidermis being easily broken was partially removed during delivery. The cephalic extremity was the part in which the most marked changes had taken place. The entire head presented the appearance of a sac filled with fluid, the osseous development of the entire head was very deficient or else the part had undergone such a state of maceration that the cranial bones had not only become separated from one another but had become entirely broken down; a part of the

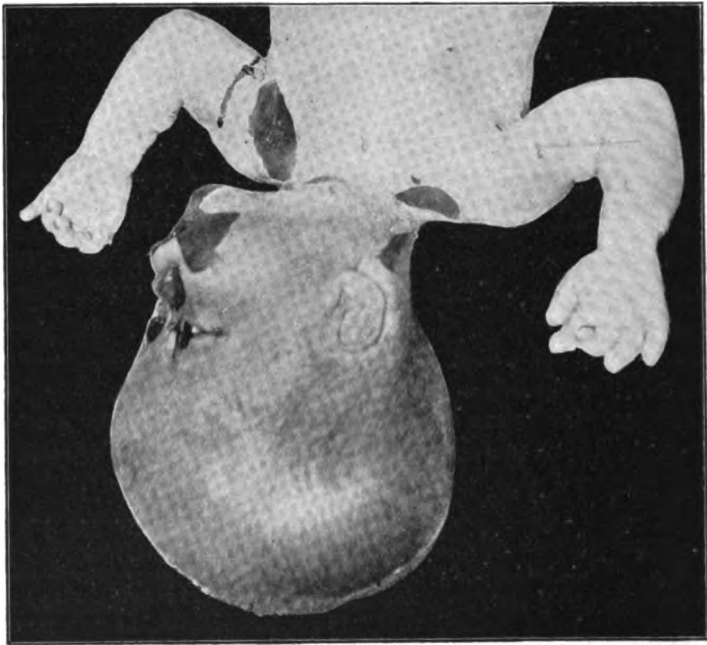


FIGURE 12.

occipital bone could be distinguished but very slight pressure caused it to fracture at the foramen magnum and left it floating in the sac with a number of small bony particles; there was no osseous structure about the eyes or nose and only a small portion of the superior maxillary could be felt. The inferior maxillary and lower portion of the temporal bones remained in position. The scalp was somewhat discolored as a result of putrefaction which probably began after rupture of the membranes. The accompanying photograph will give a fairly good idea of its appearance. (See Fig. 12.)

The cord was beginning to show signs of decomposition but the placenta was in an apparently healthy condition.

The mother reports that she had felt no foetal movement for five or six weeks previous to her coming into the hospital. She can recall no injury or shock of any kind and could gain no history of any specific disease. She felt perfectly well during entire period. Appetite remained good, has had no chilliness and no unusual symptoms except some little unusual weight in lower part of abdomen during last two weeks previous to confinement. She made a good recovery, temperature at no time rising above $101\frac{3}{4}$.

Case 2. Mrs. B., American, aged 30, primipara, menstruated last on August 18, 1893; was delivered May 24, '94, 297 days from date of last menstrual period. She presented a marked scrofulous diathesis, with a decided anterior curvature of the spine in the lower dorsal region, causing a marked shortening of the spinal column. The pelvis also came in for its share of deformity. There was a marked lateral flattening and somewhat increased depth of the pelvic cavity. The pubic arch was narrow and long. The greatest amount of pelvic contraction was in the right anterior region, which probably caused the head to rotate and enter the pelvis in the occipito-posterior position, which it did very slowly; labor began at 9 o'clock A. M. on May 23; the os was not fully dilated until 4:30 A. M. May 24. As the head did not readily enter the pelvic cavity the forceps were applied at the superior strait and delivery thus effected, considerable force being required to draw the head through the pelvic cavity, the most difficult point being at the bony outlet. The baby weighed six and a half pounds, was very poorly nourished, possessed of very little vitality and died on the third day.

Upon manipulating the uterus to remove the placenta it seemed unusually large and when the secundines were removed it was found that another foetus with unruptured sac and separate placenta had come away. The first placenta was apparently perfectly normal. The contents of the unbroken sac and placenta weighed three pounds, the foetus alone weighing one and three-eighth pounds. The amniotic fluid consisted of a dark yellowish liquid, emitting a peculiar but not very pungent odor and presented more the appearance of pus than of the liquor amnii. The cord about fourteen inches long was dark colored and in places had nearly sloughed off. The placenta six inches in diameter and three-eighths of an inch in thickness was in a

badly decomposed state. The uterine surface had sloughed off and was covered with a slimy, gelatinous substance, in fact the entire placenta was very friable—would almost drop to pieces in handling.

The development of the foetus would indicate that it had died at about the twenty-second to twenty-fourth week of gestation, and was in a bad state of decomposition. The integument was partially removed from maceration and would break from the slightest contact. The sac being unbroken protected the mother from its contents but the placenta must have caused more or less absorption from its surface. Yet the mother showed no symptoms of absorption. She had a good getting up and her temperature reached 102 for a few hours only. She left the hospital at the end of two weeks.

The only thing this patient complained of previous to confinement was a distressing cough and difficult breathing. She had a large abdominal development that caused a great deal of upward pressure, so that she could not breathe in a reclining posture during last two months. The cough came on as soon as conception took place; was severe and persistent, so much so that her physician advised her going to California for the winter, saying she would die of consumption if she remained here. She went to California but experienced no relief and returned in February. As soon as she was confined the cough began to improve and had almost entirely ceased when she left the hospital.

Her appetite remained good; temperature was normal previous to confinement and I could elicit no symptoms that would indicate the presence of any unusual condition within the uterine cavity.

DISCUSSION: DR. LEAVITT: This is an interesting report, but one not likely to elicit much discussion. The second case mentioned by Dr. Honberger was one wherein it is likely the foetuses began their existence simultaneously; but from some cause, probably placental, one foetus lost its vitality and the womb became its temporary tomb, while the other went on to complete development. This occasionally happens. Of course, after intra-uterine death degeneration sets in, but it is of an innocuous nature because sealed up within the foetal envelopes. Rupture

those membranes and admit atmospheric air, and chemical and bacteriological changes would be set up which, expulsion not immediately ensuing, might prove to be most destructive.

Post-mortem changes take place very rapidly when the child perishes in utero near the close of pregnancy. The skin deprived of its vital resistance begins at once to macerate and its epithelium to peel, while the brain rapidly pulpifies. The conditions described in the first case lead me to believe that death was not long antecedent to expulsion.

Dr. ARNULPHY: I have read of cases of abortion in which the placenta was retained for months, and there were no untoward symptoms. What is the explanation?

Dr. LEAVITT: There is a Providence that shapes our destinies, and this is one proof of it. In the cases mentioned by Dr. Arnulphy, atmospheric air unquestionably gains an entrance to the womb, disintegration often begins, and yet only rarely does a woman experience decidedly bad effects. Some women possess unusual powers of resistance, and no matter how slovenly their accoucheur and their nurse, they glide safely through the puerperium, while others develop septic symptoms from most occult sources. Why this is true we are unable to say.

Dr. LUDLAM would explain the immunity from septic infection where a portion of the placenta is retained for a long time, by the fact that its vascular connection, especially at the margin, is not cut off. While the utero-placental circulation is intact the vital-resistance remains; and this, with the natural drainage that carries off so much of the afterbirth as has decomposed, protects the woman against this source of puerperal infection.

Dr. LEAVITT: But to my mind this is not a solution of the problem, for we often remove putrid fragments of the secundines from women who do not present marked symptoms of infection. I have no doubt that in every case of miscarriage and labor, no matter how carefully conducted, there is left or deposited at some point in the genital tract,

sufficient morbid matter to set up pathological processes of a most pernicious kind. Yet the clinical experience of the prudent obstetrician is marred by few cases which are properly included under the concrete designation, "Puerperal Fever."

Dr. HONBERGER: As Dr. Ludlam remarks, I believe many cases of retained placenta do no damage because their nutrient supply is not severed. I was recently called to a case where the abortion occurred at the third month, the placenta not coming away. The woman was up and about most of the time for three months, and was troubled with but slight occasional hæmorrhages. She had no other discharge, and no odor. An examination showed that the placenta had separated from the uterus except at its circumference, where it was still firmly united. When broken loose it came away in an apparently healthy condition, which must have been due to its being perfectly nourished, as the os uteri was expanded sufficiently to admit one finger quite readily and air had ready access to the part.

In conclusion I have nothing in particular to offer, except that the second case was of great interest to me. Of course the mother was protected from the amniotic fluid and the fœtus by the unbroken sac; but the placenta being in the condition it was and the uterine tissues absorbing as readily as they do, it seems to me we would look for some rise in temperature, or other symptoms similar to what we get in the case of an abscess containing pus in any other part of the system.

Dr. CLARA YEOMANS cited a case in which there were two placentæ and only one fœtus, and asked an explanation of the anomaly. An old school physician of good repute and experience had treated the patient for an abortion and was positive that he had delivered the placenta after the fœtus came. Two weeks later Dr. Yeomans was called to relieve the woman's suffering, and to her surprise found what it was claimed must have been a second and a very large placenta where there had been only one fœtus.

Dr. LEAVITT: I should say that the real solution lies between these two truthful doctors. Seriously, however, there may have been in this case, a supplementary placenta, such as we occasionally find, which was torn from the main placenta and left behind. These *placenta succenturiatae*, however, are usually small, being made up of a single cotyledon.

XXX. TRENDELENBERG'S POSITION IN OBSTETRICAL PRACTICE. BY SHELDON LEAVITT, M. D.—Trendelenberg's position has proved to be one of the most important improvements in abdominal surgery, and I believe it is destined to become equally valuable in obstetric manipulation. It is but a rational application of a well-known natural law, that of gravitation, to the enforcement of conditions which have heretofore been imperfectly maintained at the expense of much effort. By means of it the field of intra-pelvic operation is easily cleared, the play of Jack-in-the-box with the intestines is rendered unnecessary, and every part is brought into view.

It consists essentially of the dorsal decubitus, and elevation of the pelvis to a degree which shall insure an inversion of gravity with respect to the long axis of the patient's body. To effect this purpose the body is usually made to rest upon a double incline, with the lower extremities bent over the apex.

To one who has experienced the difficulties attending coeliotomy with the patient in the horizontal decubitus, the advantages of the new position are manifest. Some time since it occurred to me that equally favorable effects might be obtained through the adoption of this position in certain midwifery cases. I am not aware that attention has before been called to the possible adaptation of the position to this department of practice, but my limited experience with it has served to assure me that it possesses decided advantages over the knee chest position, and thereby emphasizes the value to midwifery of the splendid surgical *technique* of recent years.

Anatomical Effect of the Position. Upon non-pregnant

women, inversion of the body causes the settling of all movable organs and growths within the peritoneal cavity toward the diaphragm, thus obviating the necessity during operative procedure for repeated manual elevation of these structures which have a pronounced tendency, even with the patient's body in a horizontal position, to gravitate into the pelvis. In order that we may get a clear idea of the effect upon the gravid uterus and its contents of inversion of the body, we should recall certain facts concerning the anatomical relations of the several organs and also of the fœtus in utero. Development of the pregnant uterus is mainly upward and downward, so that at the close of gestation the organ lies almost wholly within the abdominal cavity. But near the close of pregnancy there occurs a subsidence of the womb, the result of which is diminished pressure on the epigastrium, and usually a deeper dipping of the lower uterine segment, covering the presenting part, into the pelvic cavity. This movement is common, but not constant. Moreover we are to reflect that the fœtus at term, while not floating within the *liquor amnii*, as at an earlier period, is still, by virtue of the presence of the fluid, freely movable within the cavity. Now, when by changing the woman's position the attraction of gravitation is turned toward the diaphragm and away from the pelvis, both the fœtus in utero and the uterus itself will sag in the former direction, and hence press with diminished force at the pelvic brim, thereby making intrauterine manipulation a matter of far greater ease.

To What Cases is it Adapted Much has been said about the knee-chest and knee-elbow positions in connection with the necessary manipulation attendant upon the correction of malpresentation and malposition of the fœtus, prolapse of the funis, and other conditions necessitating intrauterine manœuvres; but recourse to them has made the practitioner painfully aware of their inconveniences and difficulties. A woman in the agonies of *distocia* can scarcely be prevailed upon to assume such a position, and one who has been tranquilized by an anæsthetic cannot well

be placed therein and held by the small number of nervous assistants usually at command. On the other hand, to operate in a case of difficult podalic or cephalic version, of face presentation, of prolapsed funis or of complex presentation, with the woman in a horizontal position is not an easy task. In truth, one must bring such matters to the crucial test of clinical experience in order fully to appreciate them.

We conclude, then, that in view of the operative difficulties besetting cases of the kind mentioned, it is but fair to assume that no earnest accoucheur will look with indifference upon any expedient which bids fair to foster the interests of his helpless patient and her unborn child.

Improvised Means for Securing the Position. Uncertainty as to the date of *accouchement*, and there latively small compensation given for obstetric service, dissuade the *accoucheur* from making preparation for labor with anything like the elaboration and precision which accompany a surgical operation, and hence the means for securing Trendelenberg's position requires improvisation. I have used an inverted chair, properly covered, upon which the patient is drawn until the hips are far above the level of the head. A folding sewing table, with the legs of one end only extended, would probably better serve our purpose. With the hips thus elevated, an assistant is required on each side to keep the patient's legs out of the operator's way, and to maintain the woman's balance. The position of the operator will be determined by the nature of the manipulation to be made. I have applied the forceps when the foetal head has been above the pelvic brim, from a position on the floor by the side of the bed, but would not recommend it for ease.

I take pleasure in bringing this matter to professional attention, inasmuch as I am convinced that the suggestions offered will prove of inestimable worth to the perplexed *accoucheur*.

DISCUSSION: The hour being late the discussion upon this very interesting paper was deferred to the next meeting.

VOLUNTEER PAPERS. XXXI.—SANTA BARBARA, CAL., AND ITS HOT SPRINGS. By Dr. BELLE L. REYNOLDS.—After reading the article in the June CLINIQUE on "The Hot Springs of South Dakota," I venture to present a few facts concerning one of the "Hot Springs" of Southern California.

Since the founding of the mission of Santa Barbara, by the renowned Father Junipero Serra, in 1786, these Hot Springs have been the Mecca for the afflicted of Southern California. First visited by the Indians, their location was subsequently made known to the pious monks who from time to time sought them, and sent the sufferers who came under their eye to drink and bathe in their healing waters.

The matchless climate alone of Santa Barbara would attract the invalid; for here not only is the eye enchanted by the grandeur of the views from the heights which surround the city on three sides, but the body is invigorated by the delicious air which is laden with the freshness of the ocean breeze and the spicy fragrance of ever-blooming flowers.

If he be a lover of nature he will also be attracted by the mountain range which protects the valley from the north. This Santa Yuez range is the dividing line between North and South California, and forms a very important factor in the climatology of this part of the State. Seen from a distance these mountains appear but a rocky forbidding barrier between this and another world, but as you approach their base, the cañons open up their beauties, and the eye is greeted by walls of velvety chapparal, oak and sycamore, and the ear cheered by the music of falling waters which come pouring down through steep storm-worn declivities, where only mosses and lichens cling and wild birds build their nests.

To the equestrian nothing can excel the delight of the mountain trails, creeping along the edge of a precipice or dipping down into the cool cañon, crossing with a bound the rocky bed of a rushing torrent, and mounting higher and higher until you stand on the dividing line 3,500 feet above the valley, where summer reigns on one side, and the snows of winter rest for months on the other. All this and more; for with sunny days and restful nights, with an average temperature of 68°, and sea-bathing which can be indulged in every day in the year, Santa Barbara becomes the most desirable, both as a summer and winter resort, of any city on the Pacific coast.

It may be difficult to convince those who have not visited the Pacific coast that *Southern* California can offer such a delightful *summer* climate, for a murky, stifling atmosphere is unknown. The air is light, pure and dry, and both bracing and invigorating. In looking over the records I find that in 1886 there were but twenty three days in which the mercury rose about 80°, the highest point being 85°, and but three days of that, one in January, February, and August; and for 1887, the average temperature of the summer months was 72°. Santa Barbara summers are unlike anything found elsewhere. Surely this "City of Roses" by the sea, has a glorious future as a summer as well as a winter resort.

These "Hot Springs" lie distant from the city about five miles to the east, at an elevation of 1,490 feet above the sea, and distant from the coast about three miles. They are reached by a picturesque, well kept road, which passes along the ocean beach, through the orange, lemon and olive groves, and by the beautiful homes of the favored residents of Montecito, the aristocratic suburb of Santa Barbara. The Springs are located at the head of a cañon in the Santa Yuez mountains, the water gushing from the crevices in a wall of rock, at a temperature ranging from 90° to 122½°. There are twenty hot springs and one cold, and the flow has not ceased since they were first discovered. The supply is bountiful, being sufficient for all bathing and household purposes, and the refuse, which forms a large stream, goes tumbling down the gorge in pools and cascades and is finally caught in reservoirs and used by the town of Montecito for purposes of irrigation.

Above the springs the rock-riven hills rise to the height of 3,000 feet, clothed in chapparal, with here and there the showy spikes of the tropical *Yucca* which shoots off its waxy bloom into the air and wastes its fragrance on the cloud-capped summits. From the hotel, which clings like a barnacle to the side of the gorge, one looks down the cañon, across the valley with its orange and lemon groves, over stretches of park dotted with the evergreen oak, out to the blue Pacific which rolls upon the silver sands and casts up the spray with its ceaseless song.

The fogs rarely reach this rift in the mountains, and the north wind cannot find entrance through the battlement of hills which rise on that side, tracks wind in and out of the precipitous sides of these towering cliffs until you find yourself 2,000 feet above the sea where the eye revels in

such scenes as only ocean, mountain and valley can give.

The hot sulphuretted springs are in the majority, but have been found to vary in their medicinal effects; one especially has been a boon to the dyspeptic. All have a favorable reputation in the treatment of rheumatism, gout, glandular and cutaneous and catarrhal affections, and also in genito-urinary diseases.

The "Arsenic Spring" has a temperature of $122\frac{1}{2}^{\circ}$. The tonic effect of this water has made it famous, and some most remarkable cases of wounds from bites of horses, also ulcers of the extremities have been cured both by external and internal application of the arsenic water.

There is a pool of ever-flowing sulphur water for bathing, with a temperature of 115° as it leaves the rock, and 102° in the pool, which has been of great benefit to the rheumatic invalid. There are also bath houses, and as the popularity of the resort increases additions are yearly made.

Camping parties pitch their tents on the mountain sides to drink the water and revel in the delights of nature and the delicious mountain air. A well-kept hotel supplied with all the delicacies of this semi-tropical climate makes life a pleasure to the *gourmet* and endurable to the invalid.

Disappointment in results oftentimes lies in the fact that patients go to these Springs without any line of treatment having been prescribed by a physician; but almost without exception, when properly and intelligently administered, the effect of these waters has been curative.

Some cures of Bright's disease are well authenticated by responsible physicians. One, a physician himself from Chicago, was sent out here as a last hope, and is now attending to a large practice, with no evidence of return of the disease. Muscular and inflammatory rheumatism so severe in one case as to necessitate swinging the sufferer in a hammock in the wagon in order to make the trip up the mountain was entirely cured after a few weeks of treatment.

When it is remembered that Santa Barbara is in the same latitude as Albuquerque, New Mexico; Tangier, Africa; and as the Island of Sicily (each of these having a worldwide reputation as a health resort), one cannot but be convinced of its health-giving climate.

Hospital Notes.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

REPORTED BY CORNELIA S. STETTLER, M. D.*

SARCOMATOUS DEGENERATION OF THE ENDOMETRIUM.—
Case 22,058. Wednesday, June 6, Mrs. —, æt. twenty-three, sent to the hospital by Dr. E. E. Rice, presented the following history: She has been married nine years and has a child now eight years old. She first began to menstruate at eleven, and with such a profuseness of the flow at each period as sometimes to send her to bed. She has had three small tumors, supposed to be fibroids, removed from the uterus within as many years; complains of sour stomach and a great deal of frontal headache. The hæmorrhage is almost constant and at times is copious and exhausting. She is pale and anæmic. The depth of the uterus is five inches.

There is a wide clinical difference between a cluster of fibroids that lie about the womb, or the abdominal cervix, beneath the peritoneum, and the occurrence of two or more within the cavity of the uterus. The former are almost never malignant, while the latter are, to say the least, of a very suspicious character. The former are almost never recurrent, or sarcomatous, but the latter are often so. Hence the significance of this case, and the importance of treating it properly.

If we knew the exact nature of the tumors that have already been taken our opinion of the nature of the case and of the necessary procedure might vary; for, if the growths were sarcomatous, the uterus should be removed before any further mischief has developed. As it is, however, not being able to find any fibroid, or any decided tumor, we have thought best to curette the uterus very thor-

*Continued from page 328.

oughly and see what that will reveal and accomplish by way of putting an end to the hæmorrhage.

Under these circumstances we often find a form of degeneration of the endometrium that develops an irregular, ragged surface with scattered polypoid concretions, and polypi such as this patient may have had removed a while ago. The chief characteristic of this sort of growth is that its surface has no capsule, that it is very friable, and very vascular, bleeding on the slightest contact, at the month and between the periods, and, in the interval giving rise to a fetid leucorrhœa. A thorough scraping of this surface down to the healthy tissue is the indicated remedy.

Operation. Under aseptic precautions the curette brought away the *debris* proper to this peculiar form of growth. The uterus was flushed and lightly packed with iodoform gauze. After the patient had been carried to her room, Prof. L. said that if there was a recurrence of the symptoms in a month or two, nothing but a vaginal hysterectomy would do the patient any permanent good.

ANÆSTHESIA IN WOMEN WITH BRONCHOCELE.—*Case 22,067.*

July 9, after the patient had been removed from the operating table to her room, Prof. L. said: That woman was sent here by my colleague, Prof. Crawford. As you observed, she has a bi-lobed bronchocele. You also noted that, by my instruction, Dr. Hendy administered ether instead of chloroform, which is an exception nowadays in my clinic. I want to remind you that almost any degree of thyroid enlargement, whether menstrual or maternal, or from any other cause, furnishes a contra-indication for the use of chloroform. For whatever theory we accept as to the origin of the symptoms in Grave's disease, we know from clinical sources that the heart, the respiration and the nervous centres are all more or less seriously involved. Under such circumstances, when the chloroform slackens the heart's action two dangers impend; either that organ may be paralyzed, or the fall of the blood pressure may be accompanied by fatal cardiac dilatation.

If in these cases we can exclude bronchial catarrh and

renal complications, as fortunately we almost always can, unless the bronchocele is a very bad one with decided pressure upon the air-way, sulphuric ether is a much safer anæsthetic than chloroform. But anæsthesia is a ticklish experiment at best, and whatever operation is made under these circumstances should be done as speedily as is compatible with safety lest there might be need to resort to tracheotomy. She came through it nicely, but if we had given her chloroform, or if I had stopped to say this much to you while she was still under the anæsthetic, the outcome might have been very different.

THE DEVIL'S OPIATE IN GYNECOLOGY.—July 16. Within the last ten days I have shown you three cases of uterine cancer in which the disease had reached such a stage of development as to preclude the possibility, or rather the propriety of a hysterectomy. In the first of these, *Case 22,069*, the patient was only thirty-one years of age. She had been married fourteen years, had had one child and one miscarriage. Menstruation began at fourteen and was regular until one year ago, when she fell from a step ladder, since which time it had been almost constant, and part of the time profuse. For the last five weeks there had been a great deal of pain in the uterus. There is no history of cancer in the family. She had had local treatment of the palliative sort for uterine "ulceration" during the year, but evidently there was no thought of cancer either by the patient or her physician until of her own accord she determined to have some special advice.

As you remember we curetted the womb very carefully and thoroughly, finding its vaginal cervix entirely eaten away and the organ itself a mere shell through the wall of which, without care, the instrument might easily have passed.

Case 22,070, æt. 40, had been married twenty-two years and had had five children, the youngest being seven years old. Until within the past year the periods had been quite regular, but of late the flow was frequent and so pro-

fuse as to cause "sinking spells." Three weeks before entering the hospital she was curetted at her home in a distant State. The diagnosis had been properly made out by her physician.

After due preparation it was hoped that we might be able to remove the uterus by a vaginal hysterectomy. The lesion had, however, not only destroyed the whole of the anterior lip of the cervix, and almost all of the posterior lip as well, but it had extended along the roof of the vagina behind the bladder as far as the urethra. All that could be done was to curette again and apply the proper local dressings.

Case 22,077, æt. 56, married thirty-two years, had had two miscarriages, but no child at term. Puberty was at fourteen with normal menstruation; and the climacteric at fifty-two, without symptoms. Until within two years past her general health had always been good. Then her strength failed and she began to have uterine hæmorrhages, which were sometimes copious and painful. Three months ago the diarrhœa to which she had been accustomed changed to constipation, and she has become extremely nervous and apprehensive. Of late the hæmorrhage has alternated with a very offensive leucorrhœal discharge. When this latter flow ceases there comes a pressing pain in the left ovarian region and she has chills and fever until the discharge begins again. (This offensive flow has now been absent for about two weeks.) Local examination showed complete destruction of the vaginal cervix and the uterine orifice filled with friable bleeding masses. The phagadenic ulceration had extended to the insertion of the vagina about the cervix, so that there was not the slightest margin of sound tissue between them. The uterus was anchored within the pelvis, and could not be brought down. This was the condition as revealed by a careful and critical examination under anæsthesia.

The last patient was brought to me by her physician about five months ago. He had made a proper diagnosis and realized that something radical was necessary to be done at once. We arranged for a vaginal hysterectomy for the next week. The lesion was limited, the vagina was not involved, the uterus would descend to the vulva, and the offensive leucorrhœa with the left-sided pelvic suffering and the suppurative fever had not begun. But for some

reason the operation was postponed, she fell into the hands of a so-called "Christian Scientist," and there remained until shortly before coming here again for an operation, when she was placed in the care of another excellent and conscientious physician who soon found that he could only palliate her sufferings, and who sent her forward with a proper understanding of the gravity of the case.

She too was curretted, for the present conditions would not justify me in making a radical operation. And what is worthy of note is, that while I was curretting the left side of the uterus, about its cornua, there came a sudden discharge of a teacupful of dirty yellow pus, which must have been retained within the corresponding Fallopian tube. This incidental fact furnishes a hint that, in occlusion of the inner extremity of the tube especially, we may sometimes establish an outlet for relief and for drainage by the use of the curette.

But the chief point that I wish to make for you in recalling these three unfortunate cases to your mind is that delay in their proper recognition and treatment is a kind of devil's opiate that often deludes the unwary and unsuspecting patient, deceives the doctor and does an infinite amount of mischief. This opiate is taken in various ways. Sometimes the poor woman persuades herself that her symptoms are transient and of no serious import. Or she defies them, and treats them with passive indifference, refusing to take counsel as to their cause or their significance. Sometimes both the doctor and his patient refer the suspicious symptoms to the "change of life," and insist that they will be self-limited. Or it may be that through over-confidence in the power of his remedies which, as the phrase is "ought to" cure everything, he permits the precious opportunity for surgical relief to pass by unimproved. Possibly he dislikes, or is ignorant of uterine pathology, and so fails to make an early diagnosis.

A prompt recognition of this disease especially is indispensable to its proper and effective treatment, otherwise the case may drift from bad to worse very rapidly. The

failure to learn and to realize how serious its initial symptoms are is the besetting sin of those who pin their faith to the "mind cure," or to the so-called "Christian Science" method. Beguiled by these moral hypnotics the victims of uterine cancer, as of other organic diseases, are cheated into believing that the lesion is fanciful, that it can be blinked, or blotted out by resolution, or faith, suggestion, or some supernatural agency. Meanwhile the local ravages extend, and the day of salvation for the poor patient is unprofitably and wickedly spent.

Wednesday, July 25. These three patients have passed the post-operative period in safety, and have left the hospital in the best possible condition under the circumstances. When the disease was so far advanced the true conservative course was to desist from a resort to more radical measures; but at the beginning, if it had been possible, our course would have been very different.

THE CHILDREN'S CLINIC.

SERVICE OF PROF. JOS. P. COBB, M. D.

REPORTED BY H. J. PAYNE, CLERK OF THE CLINIC.

WHOOPIING COUGH FOLLOWING UNRECOGNIZED SCARLATINA.
 —*Case 734.* Carl, æt. four years, came to the clinic June 2d with the following history: About five weeks ago a red rash appeared all over the body. The mother did not notice that he had any fever at that time, but she remembers that before the rash appeared he had been sick at his stomach and had vomited twice; this did not continue after the rash appeared and he did not seem sick at the time and nothing was done for him. In the second week after the eruption faded desquamation occurred and was quite extensive. Since that time he has not been well; has had fever off and on, and has been troubled with a cough; the cough is loose and rattling and he complains of its hurting his chest when he coughs. He is very thirsty all of the time; is very restless at night and coughs worse at night; is drowsy and sluggish during the daytime. His temperature to-day is 103, pulse 164 and full. He sweats a great deal about the head and neck when asleep. His bowels

are constipated and have been more or less so ever since he had the eruption. The urine was scanty for several days but otherwise not peculiar.

From the history we have no hesitation in deciding that this little patient had a mild attack of scarlatina; the rash in itself as it is described to us some five weeks after its appearance, is not in any sense pathognomonic; coupled with his previous good health, the occurrence of the nausea and vomiting and their subsidence after the eruption appeared is more than suggestive, and when we have in addition the occurrence of desquamation, which is general and follows from one to two weeks the subsidence of the rash, we may be very sure of our case. The occurrence of scantiness of the urine for a few days is confirmatory but nothing more, this is not unusual for short intervals in children who are out of sorts for any cause.

The cough sounds suspiciously like the early stages of whooping cough, though as yet it is only catarrhal in nature and not in the least paroxysmal. The fever is probably a part of the present catarrhal condition and not the result of any uneliminated scarlatinal poison. We will give him to-day, belladonna, four doses daily.

June 6. Carl reported that the fever began to decrease immediately after his first visit, and in two days his temperature was normal. The cough, however, is worse; is spasmodic; very little rattle of mucus; no vomiting; no mucus raised while coughing, but coughing hurts his chest. Appetite good and bowels normal. Naphthalin 3, four times daily.

June 16. Cough has changed in character, is loose and rattling; spells of coughing always terminate by vomiting a small amount of mucus; he wakes up, coughing, four or five times during the night. Tartar emetic 6, four times daily.

June 27. Cough is now at long intervals, and not severe. No vomiting; no pain on coughing; sleeps well; appetite good and bowels normal. The same remedy.

WHOOPING COUGH AND MAL-NUTRITION. DEATH.—*Case 758.* Gracie T., *æt.* five months, brought to the clinic July 7. This child was nursed until it was seven weeks

old; since that time it has been fed upon condensed milk of the sweetened variety. It was apparently a well, strong baby at birth, and while nursed appeared to do well. Since it has been fed artificially it has never been strong nor grown as it should, though it has not been sick until it was attacked with the whooping cough about four weeks ago. During the last four weeks it has run down very rapidly until now it is very frail and emaciated; it has frequent movements of the bowels, the stools being green or greenish yellow, thin, excoriating and offensive. The effort of coughing frequently causes the bowels to move. Vomiting frequently occurs.

The mother was advised to give in addition to the condensed milk a small amount of cream properly diluted. Under the influence of antimonium tartar. and naphthalin the cough improved, and in two weeks was entirely disposed of; but the baby failed to gain in strength. Digestion and assimilation continued very imperfect, and vomiting was of frequent occurrence; aphthæ appeared in the mouth and the child was listless and dull. Under the use of arsenicum and china at different times it improved some, but never made a good rally. July 28, it took cold and developed a slight attack of catarrhal bronchitis, and died July 30.

This illustrates a common experience with babies. Strong, healthy infants at birth are nursed for a while and thrive; for some reason, frequently insufficient, they are put upon artificial food and their decline begins. They may seem to thrive for a time, but they do not develop the strength which makes any resistance to disease. The first ailment, which in a nursling may be successfully combated, wilts them down. Once started, there seems to be no stopping the retrograde process, even though we may apparently control the specific disease which has initiated the trouble.

THE SCROFULOUS DIATHESIS.—*Case 684.* Grace Smead, age six years, was brought to the clinic February 3, 1894. Had measles and whooping cough when a baby. Two weeks ago had a sore throat and has just recovered from vaccina-

tion. Since Monday night (three days previously) has had pain in the right ear, coming on suddenly and so violently that she cannot sleep. After the intense pain there was some hæmorrhage. To-day there has been a slight mucopurulent discharge. Suffers loss of appetite, is sensitive to the cold, tonsils enlarged with an unhealthy looking throat. Was advised to wash the ear night and morning with a solution of boracic acid. There seemed to be some mechanical obstruction to nasal breathing and she was referred to the throat and nose clinic for examination. Belladonna 3, four times daily.

February 10. She returned from Prof. Fellow's clinic pronounced not well enough for an operation to remove the naso-pharyngeal adenoid which was present. There was still slight pain in right ear, sleeps well and appetite better.

March 24. She still complained of slight pain in the right ear. Appetite was better, was generally improved, a sty was appearing on the right eye. Pulsatilla 3, four times daily.

March 28. The child appeared at clinic. Had been well until two days previous when an eruption appeared on the posterior surface of right limb and thigh, stinging and burning. Eats well, sleeps well. The sty has entirely disappeared, to-day complains of slight pain in right ear. Apis 3 was given every three hours.

April 7. She was so much improved in every way that she was referred to throat and nose clinic. Kali iodide 3, four times daily.

Miscellaneous Items.

The Thirty-fifth Annual Winter Term in the "Old Hahnemann," will open September 11, with an Introductory lecture by Prof. E. M. Bruce.—The formal opening of the large new Hospital will follow with appropriate ceremonies.—Students, physicians, alumni and friends are cordially invited to be present, and to participate in this extraordinary event.—Dr. Emily L. Hill, who took the Trustees' prize in '94, has located in Rochester, N. Y., and Dr. Harriet M. Jackson, in Kansas City.—Drs. J. H. Thompson and H. G. Briggs, of Pittsburgh, have gone abroad for study and rest; while Profs. Crawford and Dunn are "off the coast of Maine" in a fishing smack.—We are pained to note the death of our genial friend of many years, Dr. Charles H. Lawson, of Wilmington, Del.—Dr. Alvin S. Butler died in this city August 5, æt. fifty-six.—Dr. Mary Osborn Hoyt has located at Keokuk, Iowa.—Attention is called to Dr. Arnulphy's Presidential Address before the Clinical Society at page 380, and also to Dr. Leavitt's paper on The Trendelenberg Position in Obstetrics, page 399.—Dr. Chas. H. Evans has removed his office and residence to 730 Warren Avenue, city.—Treatment by Electricity, or Electro-therapeutics, being a new system of treatment introduced in India, by Nondo Lal Ghose, L. M. S., etc., is a bright little book which comes to us from Calcutta.—The 15th Annual Report (1892), and the report on Medical Education and Medical Colleges (1894), of the Illinois State Board of Health, has just appeared in its usual form.—An excellent portrait of the late Dr. D. S. Smith has been presented by his family to the new Hospital.—A very practical lecture by Prof. Evans on *Calcareo carbonica* is unavoidably crowded out of the present issue.—The next meeting of the Clinical Society will occur on Saturday evening, August 25.

THE CLINIQUE.

VOL. XV.]

CHICAGO, SEPTEMBER 15, 1894.

[No. 9.]

Original Lectures.

THE CALCAREA SALTS.

A LECTURE DELIVERED IN THE HAHNEMANN MEDICAL COLLEGE OF CHICAGO, BY CHAS. H. EVANS, M. D., ADJUNCT PROFESSOR OF MATERIA MEDICA AND PROFESSOR OF THE INSTITUTES.

Lime, in some form or other, is the most universally distributed substance in nature, being present in the animal, vegetable and mineral worlds. In the form of carbonate of lime it constitutes the preponderating rocky mass of the earth, and magnesian limestone is the element contained in widely separated mountainous ranges. Carbonate of lime constitutes an ingredient of the water of springs, lakes, rivers and oceans. Zoöphytes secrete it from sea water and build up islands in this way by gradual accumulation; coral is nearly all carbonate of lime. Mollusks secrete it from fresh and salt water and construct their shells with it. Plants and trees and all other kinds of vegetation appropriate it to themselves from the soil in which they grow and store it up in all their parts. It is a constituent of animal tissues and fluids, both in the solid form and in solution or suspension. The bones are constructed of it for the main part, in the varieties of carbonate and phosphate. It also enters into the composition of horn, hoof, tusk and tooth and the exoskeleton of turtle, lobster, crab, armadillo and their congeners includes this same element. The flesh of herbivorous animals contains the carbonate in considerable amount, while the flesh of the carnivora is stored with the phosphate. Pearls are composed of carbonate of lime and will dissolve as readily

in acid and wine to-day as they did in former time for Cleopatra's whim. Native carbonate of lime in its purest form exists in Iceland spar and also in the crystalline rock known as Carrara marble, from which quarries it has been obtained for the sculptor's chisel in ancient and modern periods. It is a residue in animal tissue, especially pulmonary tissue, when caseous matter has become entirely absorbed, and is deposited in arterial walls during advanced life.

Medicine has used carbonate of lime from an early period when the rose colored bodies taken from the crab's stomach and called crab's eyes were administered for the same therapeutic purposes that traditional medicine employs lime to-day.

Lime is used as an antidote in poisoning with acids, especially the oxalic, sulphuric and muriatic. Lime-water, which is a simple saturated solution of lime, is used by the other school of medicine for the relief of gastro-enteric troubles, associated with faulty digestion, especially with vomiting and diarrhœa, attended with acidity. It is added to milk in the proportion of thirty to fifty per cent. When pseudo membranes are placed in a watery solution of slaked lime they undergo disintegration, and from this indication lime vapor has been used by inhalation for the purpose of softening croupous and diphtheritic exudations. Limewater mixed with an equal part of linseed or cottonseed oil constitutes what is known as carron oil, used for extensive burns during many years past.

Prepared chalk, the creta preparata of the U. S. P. is not a native carbonate, as chalk is but an aggregation of minute marine shells that have consolidated under pressure. It is, however, given by the old school for the general uses of lime. Chalk mixture is compounded of prepared chalk, acacia, sugar, cinnamon and water, and is in common use by the old school in the treatment of diarrhœa and summer complaint of infants.

Calcic sulphate, ground gypsum or plaster of Paris is used in surgery for making immovable dressings. The hypophosphite of lime has been extensively used in the treatment of scrofulous constitutions, and particularly in pulmonary consumption. Syrup of lime is simply a saccharated solution. Carbonate of lime is considered by the old school as antacid and astringent, and by the so-called physiological wing has been recommended to sup-

ply an assumed deficiency of lime in the human body, and administered in the forms of carbonate, phosphate and pulverized bones. According to their reasoning a deficiency of lime was the cause of imperfect osseous and dental development and this being supplied, healthy deposit would be secured; the beneficial effect of this, apparent in numerous cases seemed to justify such reasoning. But this is purely physical speculation; the fact is overlooked that the patient injects the lime in his food in the same amount as the rest of the family, and in the same proportion that every one else does who is in possession of fully developed bones and teeth. The fault does not lie in the mere lack of lime contained in the food, but rather in the fact that the amount assimilated from the food is insufficient. In other words the fault lies with the glandular and lymphatic systems which have become incapable of receiving and depositing it in normal quantity. At the same time it must be appreciated that the bony structures are not only affected, but that every other organ and tissue and cell in the body is in an unhealthy condition, due to the same faulty assimilation and elaboration—a systemic malassimilation and malnutrition. All the tissues are below normal both in function and structure. The indication for the relief of such cases lies in the administration of such substance as shall restore the normal activity of cells concerned in maintaining the physiological balance in each and every structure of the body at one and the same time. Such an agent is found in dynamized lime, according to its pathogenesis; not the only one, but a very important one.

In the homœopathic school, use is made of several salts of lime in the treatment of disease, all of which have been proven in greater or lesser degree. One of these is *calcarea acetica* or acetate of lime, prepared by breaking oyster shells with a wooden mallet, selecting the white internal pieces only, dissolving in boiling acetic acid and adding diluted alcohol, the resulting solution constituting the 1x dilution; a tincture does not exist. The proving is somewhat extensive. Clinically it is particularly useful in inflammation of mucous membranes attended with formation of pseudo membranes, especially in the respiratory and female genital organs. Comparison should be made in this respect with acetic acid.

Calcarea arsenica or arsenate of lime is a chemical product, existing in a white powder which is triturated

with sugar of milk 1 to 9 for the decimal scale, or 1-99 for the centesimal. It is useful in pulmonary tuberculosis and for profuse night sweats.

Calcareo caustica, or pure slaked lime, is obtained from Carrara marble subjected to heat in a covered crucible and immediately afterward made into a hydrate of lime, with water and alcohol. Another preparation is chlorinated lime, improperly called chloride of lime, made by exposing moistened slaked lime to the action of chlorine gas which it absorbs to the amount of thirty per cent. It is dissolved one part in nine, by weight, of distilled water to make the first decimal dilution.

Fluoride of lime, or fluor spar as it is called by geologists, is a mineral existing either in cubic or eight-sided crystals; the lower attenuations are made by trituration with sugar of milk 1 to 9. The provings have some resemblance to silicea. Clinically it is used in disease of the teeth and rivals rhus tox in the symptom of painful motion at first, relieved by continued walking. The hypophosphite of lime is prepared by a complex process and contains phosphorous in excess. Trituration prepares it for use. It accomplishes good results in suppurative bone diseases. Calcareo iodata, of the older pharmacopœias, and calcarea iodata, of the modern, is the iodide of lime made by the union of these two substances and contains some traces of the phosphorous used in its preparation. It is valuable in croup and fibroid tumors of the uterus. The lower attenuations are prepared by trituration with sugar of milk. Still another combination known in our pharmacy as calcarea muriatica, the true chloride of lime, or calcic chloride, is a white deliquescent salt, and when dissolved in the proportion of one part to nine of distilled water forms the 1x dil. The oxalate of lime, or calcarea oxalata exists in the fluid portion of many varieties of vegetation; in some of these it occurs in large proportions. It is also formed artificially by chemical action. Trituration prepares it for medical use. Another element and one which is also triturated for the lower attenuations, is calcarea sulphurica, known also as gypsum, and when ground to powder as plaster of Paris. Sometimes it occurs in crystalline form and is then known to mineralogy as selenite. It is also prepared artificially by chemists, as a white powder.

Calcareo phos, a mixture of basic and other phosphates in combination with lime, is obtained for use in our school

by adding dilute phosphoric acid to limewater as long as a white precipitate falls. This precipitate is triturated with sugar of milk. Its pathogenesis is a most important one and will be commented on later. The hepar of our pharmacopœia is calcarea, fused in a crucible with sulphur. Calcarea carbonica is a misnomer, it is carbonate indeed, but it is more. Properly it is calcarea ostrearum, signifying oyster lime. The carbonate has become united with the animal matter during the process of secretion. It is obtained by choosing large oyster shells, breaking them with a wooden mallet and selecting the snow white internal pieces for trituration with sugar of milk. The salts of lime that have just been enumerated possess in their pathogeneses many symptoms common to all of them; these are responses obtained from the action of the calcarea they contain, while the other special symptoms are due to the varied chemical combinations in which they exist.

Calcarea ostrearum, or carbonate as it is usually called, is one of the giants of homœopathic materia medica, and it is solely to this form of lime that your attention will now be directed.

When triturated and otherwise attenuated, it develops medicinal properties unknown in the crude substance, and becomes capable of inducing a state of defective and deficient nutrition. According to the pathology of Hahnemann, calcarea is an antipsoric. Whether his views in this respect are accepted or rejected it must be conceded that it induces, and is also curative, in that form of constitution known as the scrofulous and especially that variety termed leuco-phlegmatic. Infants and children present this condition oftener than young people or adults, although it is met with from time to time in the latter. The skin is soft and flabby and may easily be taken between the thumb and fingers, and what seems plumpness of figure and face is observed to be only a flabby softness of connective tissue and muscle. The hair is thin and fine in texture and so light in color that it has been likened to tow. The head perspires freely and together with the neck and chest is covered with thickly set drops of sweat during sleep, so that the pillow is thoroughly wetted, not only where the head lies, but for two or three inches beyond. The fontanelles remain widely open when they should be almost or entirely closed, and the calvarium is disproportionately large for the body. A variety of this is sometimes seen where the face constitutes a small triangle in comparison with the apparently enlarged dome of the skull.

Sometimes this enlargement of the upper half of the head is real, being due to an actual increase of fluid in the ventricles constituting what is known as chronic hydrocephalus. The teeth are slow in making their way through the gums, and soon crumble after their eruption. A tumid abdomen is constantly in evidence and so greatly convex does it become that it has been compared to a saucer or bowl turned bottom upward. Entire inability to walk or difficulty in learning to walk is another symptom of defective nutrition, and insufficiently developed muscles, and when this act has been accomplished, curvature of the spine often takes place. The cartilages of the ribs yield, the thorax projects forward and the lower portion of the sternum becomes tipped upward and advanced; disorders of digestion take place and an acid condition of the stomach and intestinal tract is developed; the discharges are acid and the person smells sour.

Lymphatic glands, thyroid, tonsilar, subcutaneous, bronchial, mesenteric and inguinal enlarge and become indurated. Defective assimilation and metabolism is the rule in every tissue of the body. This constitution of body is intimately connected with calcarea. The word therefore that may be used to describe the action of calcarea carb. is MAL-NUTRITION.

To enumerate all the organs and tissues upon which calcarea exerts its influence would only be listing every portion of the anatomy, but its especial effect is upon and through the glandular and lymphatic systems. There are young people who incline to grow very fat and this out of all proportion to their years, but whose tissues and muscles are soft and easily pinched up between the fingers. This is a continuation into later years of the leucophlegmatic constitution just described as occurring in infants and children, and such persons are likewise calcarea subjects. This condition of the lymphatic system is paralleled by graphites which also contains in its pathogenesis many symptoms possessed by calcarea. A marked symptom as expressed by adults consists in a coolness and clamminess of skin and this is especially experienced in the feet and lower legs, a sensation as if the stockings were damp and cold; it is also observed objectively in young children who present the leucophlegmatic constitution. This tendency of the skin to perspire continuously is one of the characteristics of calcarea. It should be remembered, however, that the opposite condition sometimes prevails, when the

skin is very dry and feels harsh and rough to the examining hand; at the same time the hair participates in this dryness so much so that it has a fuzzy appearance. This is readily apparent when it is borne in mind that hair is epidermic in structure. Enlargement of the thyroid gland is produced by drinking water strongly impregnated with calcaria. This is notably the case in the deep valleys of the Alps, and in Derbyshire, England. Spongia is a therapeutic rival to calcaria in this respect, for the cure of this lesion. Mucous membranes, wherever situated, are targets for calcaria and the inflammation produced by it in them is of a low character. The cells of this tissue undergo a slow alteration that results in a perversion of the normal secretions and later in an organic change in the membrane itself. Active inflammation is not a consequence of the action of calcaria; on the contrary it induces a sluggish condition in every tissue and every function of the body. Even in cases in which there is apparent activity it is at most only subacute and has either arisen out of the previous constitutional state or become engrafted upon it *de novo*. This will soon expend itself, whether occurring idiopathically or during the course of the various exanthemata, after which the sluggish calcaria state pursues its even course, preventing resolution from the intercurrent attack and allowing the most profound organic changes to take place.

Even where there has not been time for the latter to become established the failure in strength and function is steadily progressive until a fatal ending takes place. This is especially the case in infants and young children, in whom the vegetative system is most prominent and whose disorders threaten life from the assimilative side. It is in such depraved constitutional conditions that sulphur may be classed with calcaria, but the state induced by the former is very different from the latter. The sulphur individual has not the plump appearance of calcaria subjects, nor the fair, clear skin of the latter sometimes associated with pseudo-plethora; on the contrary the sulphur personage is apt to be spare in face and figure, or at any rate relaxed in tissue, and the skin is sallow instead of ivory white; the same flabbiness of texture is apparent under both sulphur and calcaria, and the same downward tendency and subacute or chronic alteration of structure is shared by them in common, but in their individuality they are quite distinct. The calcaria subject is sluggish

in function, activity and intellect ; the sulphur individual is just the reverse, for there is a nervous irritability and restlessness. Calcarea children are slow and dull, while the sulphur child is quick and nervous. The sulphur patient haunts the doctor's office and bothers the life out of him ; the calcarea patient stays at home and then the doctor is the one who makes the visit. There is another personage who resembles the make up of calcarea in general appearance and that is the bichromate of potassium representative, but the ailments are different in character and other structures are involved. Belladonna has a number of calcarea symptoms which are no doubt due to calcarea itself, for the deadly nightshade is always found native in rocky soil.

Nitric acid stands in close affinity with calcarea and follows that remedy when an intense debility has become engrafted upon the characteristic effects of the latter; is used as an intercurrent between all repetition of calcarea in adults, and the two have a mutual dynamic antidotal power over each other ; both are indicated in scrofulous and tubercular diseases. The individual differences of the *acid* are to be taken into consideration.

It has been recommended in rather a loose way that in constitutional deficiency sulphur should precede and calcarea follow; but discrimination should be made in their use, thus when sulphur has been prescribed on general indications and relief has not followed, and calcarea is then administered with success, the benefit is not due to the simple fact of succession, but because there has been a degree of sluggishness that has not been taken into consideration, and for which calcarea was the remedy from the first, according to its pathogenesis.

Another medicinal agent whose action approaches the one under consideration is silicea. It also attacks the vegetative system, and induces a perversion of cell growth in the same structures invaded by calcarea, and in consequence, has many identical symptoms; but every medicinal substance has an individuality of its own as much as two human beings who have characteristic personal differences notwithstanding their general resemblance; So it is that silicea is distinct in certain respects from calcarea, and varies in result when allowed to act upon the body. The resemblance is in the osseous and glandular systems, digestive and assimilative organs, ready transudations, general faulty nutrition and retarded growth; the differ-

ence being that while the calcarea subject is slow and leucophlegmatic, the silicea individual presents irritability and hyperæsthesia associated with exhaustion; calcarea is plump, but silicea is emaciated; calcarea secretions are bland, while silicea secretions are excoriating; calcarea is more exudative, silicea is more ulcerative.

Calcarea phosphorica is the closest relative that has yet been mentioned both in composition and pathogenesis, but the fact that there is a difference is shown by the record. While there is a marked resemblance, there are decided differences between them, mention of which will require more extended consideration than the limit will allow in this lecture, but will be presented later.

The typical individual who represents calcarea carb. is most apt to be undersized and slow in development, though this is not always the case. Indeed, the young person may be inordinately fat and gross, but the rule is as it has just been stated. The bodily constitution is scrofulous in character. The red globules of the blood are greatly diminished in proportion to the white ones and skin and connective tissues show the consequent lymphatic constitution; the color of the skin is very white, and together with the subcutaneous cellular tissue is soft in texture and plump with lymph. The epidermis is so thin and delicate that the course of the veins, particularly about the temples, is plainly seen. The hair of such a one is of a pale blonde appearance and has no body to it, often looking like the ravelings of rope or tow. The eyes are of a pale, watery blue color, sometimes having a fishy look, and the margins of the eyelids are pinkish or reddened. The face is full and round, flabby and expressionless, and feels soft and lacks elasticity. Eruptions form on the scalp and face, accumulating thick crusts of a greenish yellow color. The buccal mucous membranes are of a pale pink color. The normal secretions transude freely in all parts of the body and are discharged altered in character from every outlet; thus the head, face and neck are bathed in profuse perspiration, especially during sleep, in such quantity as to wet the pillow and is very sour in character, as indeed are all other secretions and excretions. In proof of this, profuse accumulation and discharge of mucus occurs in every organ where this tissue is present, and is usually thick, yellowish and offensive to the eye, and the menstrual flow is increased so greatly that the short intervals are more noticeable than the functional process, while the discharges

from the skin other than perspiratory, in many instances resemble those of a mucous membrane. The nose is often the source of a constant flow of altered mucus, which in many instances is the commencement of a lifelong nasal catarrh with ulceration, and the mouth furnishes an excess in the secretion of mucus and saliva. As before mentioned, chronic eruptions of low grade but considerable extent not infrequently appear on the face and scalp in all degrees of "rawness" and pustular hideousness. Enlarged glands arise along the anterior borders of the sterno-cleido mastoid muscles and in the posterior cervical region, the former chain frequently going on to suppuration. The tonsillar, axillary, mesenteric and inguinal glands also enlarge. The eyes are the seat of scrofulous inflammation, and the conjunctiva in common with mucous membranes elsewhere is bathed with mucus and pus, the inflammation sometimes involving the cornea and ulcers supervene. Even the leucoma that present themselves after corneal ulcers are healed are often amenable to calcarea, and where these were extensive in area and too deep to hope for restoration of sight, by its use I have in several instances induced sufficient absorption in area and thickness for the patient to readily distinguish between all degrees of light and darkness where none had been previously perceived. The ears are the seat of catarrhal inflammation, and discharge offensive pus. There is an acid condition of the mouth, and hypersecretion of acid in the stomach, vomited matters are exceedingly sour, and the alvine dejections have the same character. A prominent gastric, or more properly speaking a systemic one, is a repugnance to all fatty foods.

This is a symptom occurring in tubercular subjects, a diathesis which calcarea touches in numerous particulars. This is in marked contrast to the calcarea phos. personage who has an actual craving for fatty ailment, and to the silicea subject who desires fat and salt meat. A longing for eggs is a clinical symptom. Milk is vomited in hard lumps and is intensely sour, while the same kind of undigested casein is discharged from the bowels. There is a tendency to diarrhœa, acid stomach, and prolapsus recti, precursory symptoms of tuberculosis of the lungs.

Frequent and profuse menses are the rule under calcarea carb.; it recurs once in two weeks, or once in three weeks, is very free, and lasts much longer than the physiological period; in some instances any unusual excitement

is sufficient to cause its return. It may, however, be retarded in young girls who are slow in developing in consequence of the calcarea cachexia, or in whom there is a disposition toward tuberculosis, due to the same cause. A milky, burning leucorrhœa is present at all times. Upon the male sexual organs there is a state of erethism, in which impotence and desire are joined. It occurs after onanism or from sexual excess, and nightly emissions debilitate both body and mind. The respiratory apparatus from larynx to air cell receives a decided effect from calcarea carb.; catarrhal inflammation of the mucous lining with ulceration and destruction of tissue is very apparent. Stone cutters become the subjects of pulmonary phthisis more frequently than mechanical irritation can explain. The symptoms of hoarseness, cough, dyspnœa, expectoration and pain are too numerous to be reproduced here; the materia medica requires to be consulted for these. Many rheumatic pains occur in the pathogenesis of calcarea; these resemble rhus in the fact that they return or are made worse in damp or wet weather, and are felt most severely when first commencing to move, but are greatly relieved by continuous motion.

The calcarea personage is sometimes one who has lived in damp houses or damp localities. As a matter of causation or aggravation the calcarea subject has been doing work in water. Weariness and intense weakness is strongly developed; there is a constant complaint of weakness and this is especially so in making any extra effort like going up stairs, it seems as if it were impossible to reach the top, and becomes out of breath and faint from the exertion.

The nervous system participates in the general debility both from the constitutional cachexia induced by calcarea and by the exhaustion produced by onanism and long-continued sexual excess. Here it is related to cinchona, phosphorus and phosphoric acid. The *sabula serrulata* recently introduced does not enter this field; its sphere is shown to be very different. There is great mental depression and despondency, a hypochondriac state that causes the person to fear immediate want; although in good financial circumstances, the poorhouse is ever present to the mind. Another form is a fear of going insane and a belief that acquaintances already notice mental confusion, while the subject of nightly emissions fears that reason is departing. There is a dullness and slowness of compre-

hension and an inability to learn. Dullness of intellect, even to stupidity is noticeable in children owing to insufficient cerebral development, or to intraventricular pressure in that state bordering on the actual commencement of chronic hydrocephalus. This is especially noticeable in the extremest degree, in the cretin of Switzerland.

Hahnemann cautions against the repetition of calcarea carb. in adults unless an intercurrent like nitric acid has been administered, not in constant alternation but only at intervals; in children, however, it may be given frequently, and continued for long periods. All the tissue elements of the calcarea subject have an inherent tendency to soften, dissolve, and ulcerate, and this is especially true, in glandular, cutaneous, mucous structures. Wherever a breach of surface occurs whether externally or internally, it exists for an indefinite time and when healing takes place uninfluenced by medicine, or has been accomplished by external applications, it is at the expense of another locality, which, in turn, passes through the same experience. Even when traumatism has produced a wound, the edges degenerate and do not heal, and in some instances ulceration extends beyond the limit of the injury itself. This is also present under hepar and is no doubt due to the calcarea which it contains.

THE SURGICAL DISEASES OF WOMEN.

EXTRACTS FROM PROF. LUDLAM'S CLINIC IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO, SESSION 1894-95*.

REPORTED BY CORNELIA S. STETTLER, M. D.

THE HORIZONTAL POSTURE AND THE SITZ-BATH IN CERTAIN VESICAL DISORDERS.—*Case 22,079.* Mrs. —, æt. twenty-eight, was married at eighteen, had one child eight years ago, since which she has had a bearing down in the pelvis, with pain across the lower part of the abdomen. The menses are irregular, profuse and very painful for the first two days. The flow lasts eight days. For the ten years since her marriage, especially during the day, she has had frequent and painful urination; sleeps poorly and the appetite is capricious. She once had a small growth removed from the meatus. Local examination found the uterus

*Continued from page 410.

displaced forward against the bladder and downward, and the urethra extremely sensitive.

Periods of aggravation and relief for certain symptoms are sometimes very suggestive not only in a diagnostic, but also in a curative way. But you must translate them properly or they will mislead you. This woman has always had relief from her urinary symptoms at night, not because that time of day, so to speak, had of itself any special influence, but because, like the most of us, she has been in the habit of going to bed and lying down at night. So, it was the change of posture that came with the night and not the night itself that gave her comparative ease and comfort. If she had taken to her bed, or her couch for some hours every morning, or afternoon, the result would have been the same.

In a case like this if you can exclude a prolapse of the urethral mucous membrane, and the presence of the urethral caruncles, and neoplasms of all kinds, as we have just done by local examination, it is a fair clinical inference that the troublesome urination is due to the uterine displacement. For some unknown cause the urethra has been very sensitive, and the forward and downward pressure of the uterus whenever she was in the erect posture and in exercise, has nagged and worried the bladder into a more or less constant tenesmus.

Under these circumstances, more especially in hysterical subjects, there is sometimes a stammering of the urinary organs like that described by Sir James Paget some years ago.* This condition is more common with young girls of a neurotic temperament, and who are not as a class predisposed to any very serious uterine displacements. In married life, however, more especially after pregnancy and labor, these lesions of place in the uterus often give rise to more serious and lasting troubles with the bladder and the urethra.

Now, our patient's experience with relief from a change

*Stammering with other organs than those of speech." *British Medical Journal*, 1868, Vol. II., p. 48.

of posture, and the result of the local examination, are suggestive of the proper treatment. They do not send us to the *materia medica* in search of a remedy for symptoms that are better at night and worse in the day; but they remind us that the proper postural treatment may bring relief to her sufferings. They hint that, if we will have her lie upon her back with the hips slightly raised, the cause of the mischief will not only be removed, but such remedies as she may need for the remaining urinary trouble can be given with better hope of success. Such a postural treatment will cure the symptoms that are of mechanical origin, and the others should be amenable to internal remedies.

This kind of postural treatment is all the more efficient and useful in such cases as the one before us because it is next to impossible to fit any kind of pessary that will hold the uterus in place when it is tipped forward and prolapsed. Indeed, as a rule, while pessaries for anterior displacements are all right theoretically, they almost invariably fail when put to a practical test.

Beside instructing her to keep to the bed or couch, and to lie most of the time on her back, we will advise a warm sitz-bath to be taken every night on retiring. This bath should be as warm as can be comfortably borne by the patient, and should continue from ten minutes to half an hour. In order to make it more soothing and efficacious in these urinary affections the labiæ should be separated and the water allowed to fill the vagina during the bath. Sexual rest is essential to success in the treatment of these cases.

THE REMOTE EFFECTS OF POLK'S OPERATION IN LIBERATING THE ADHESIONS OF PLASTIC PERITONITIS.—Wednesday, August 29. Some of you may remember case 22,037, upon which I operated in my clinic April 23, four months ago. This is the patient. Her case was reported (page 264), she having suffered for twelve years from irregular, scanty and very painful menstruation. During nine years of married life she had never conceived; had become a wretched

invalid, and because of extreme pelvic and abdominal suffering and dyspareunia, had acquired the morphine habit. In consequence there was inveterate constipation, and the quantity of urine secreted was reduced one-half.

Abdominal section resulted in the separation of a mass of adhesions which included all of the pelvic organs and the neighboring intestines. These were bound together as a result of plastic peritonitis, with no signs of old or of recent suppuration, or of serous effusion. Under the circumstances the ovaries could not be identified without too great a risk to the life of the woman, and so were left behind. Flushing and the gauze drain with good nursing and care did the rest. She made a prompt recovery and since that time has been well in every way; menstruates more freely and regularly, with very little comparative pain; has no dyspareunia, has gained in flesh and is no longer addicted to morphine; the bowels are regular and the quantity of urine voided is sufficient; while as you see, the scar is firm and not tender. For a few days past, however, she has had a slight vesical trouble for which we will give her cantharis 3.

I am glad to show you this case again in proof that pelvic peritonitis may sometimes be plastic and non-suppurative, and that since it does not always arise from diseased appendages, it may occasionally be cured without removing them. Dr. Polk's proposition to break up such adhesions very carefully by sponge pressure, or by delicate manipulation of some sort, is generally regarded as too timid and conservative, but I am certain that this woman owes her life and present good health to it.

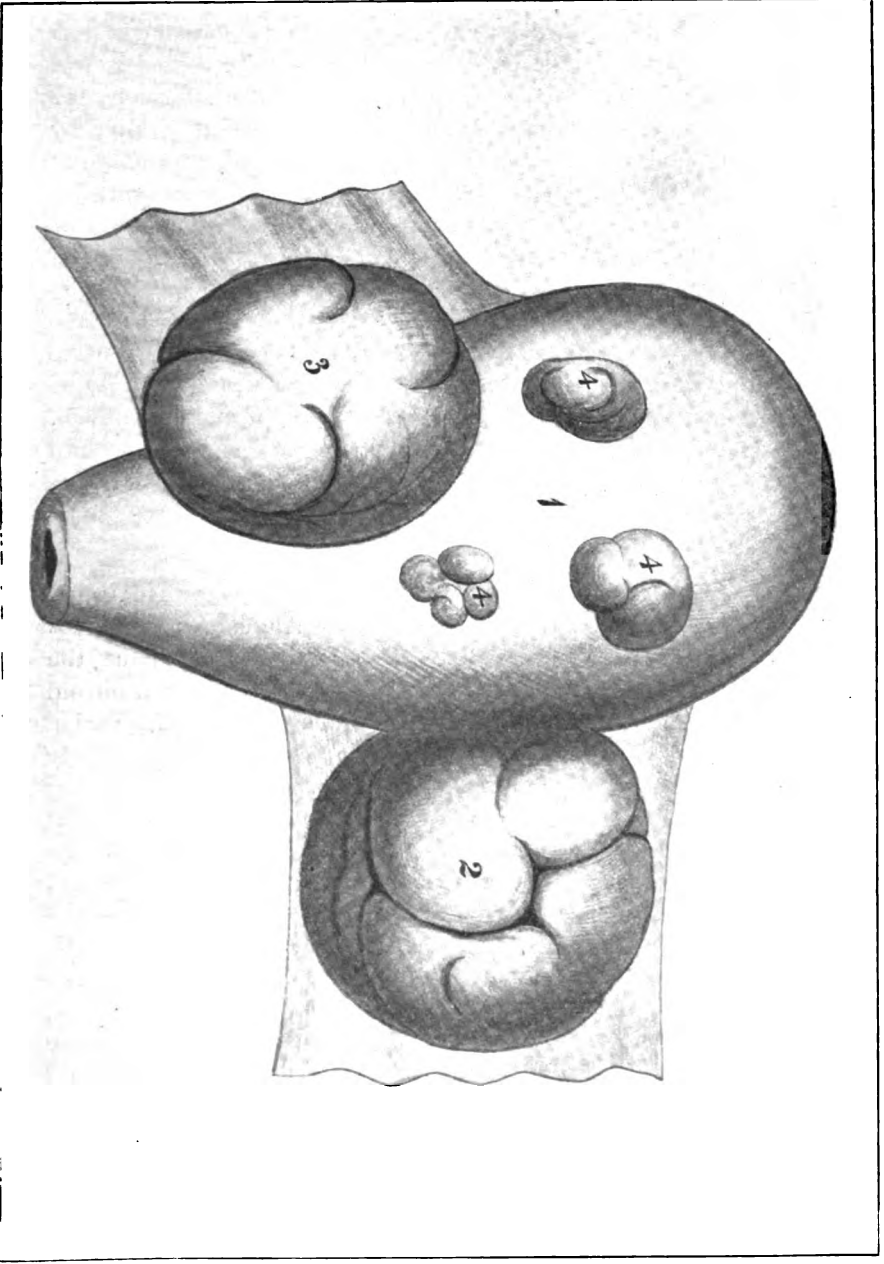
INTRA-LIGAMENTOUS FIBROIDS. ABDOMINAL HYSTERECTOMY. RECOVERY.—The proneness of uterine fibroids to grow from the anterior and posterior surfaces rather than from the sides of the uterus has often been brought to the notice of students in my clinic. I showed you three cases of the kind last week, and we have had two more of

them to-day. But here is a specimen that I removed from a private patient eight months ago. She was kindly sent to me by our good friend, Prof. Shears. If you will examine it you will find that beside a number of budding fibroids scattered here and there over the body of the uterus, there are two large lateral growths of the same kind low down by the side of that organ. The larger one was on the left side and was wholly imbedded in the broad ligament. The other was not so large, but it too was encapsuled in a similar way.

The case was a very rare one, and illustrates once more the folly of the do-nothing plan when applied indiscriminately to the treatment of uterine fibromata. For why should a tumor of this kind be permitted to grow and encroach upon the pelvic organs and finally to obliterate the rectum or the bladder, or both ?

Case. I remember going to Aurora, Ill., in 1877, at the request of the late Dr. Brigham, to suggest, if possible, some means of relief for a woman whose pelvis was filled with an impacted fibroid. It had gradually become more difficult to move the bowels and now for about two weeks she had had no stool. Meanwhile the abdomen had become enormously distended with gas, and the pain was so agonizing that opiates had no effect, while chloroform gave only temporary relief. It was one of the first cases in which I used Dieulafoy's aspirator, then a new instrument; but, after placing the outer end of the discharge tube in a basin of water, and securing the proper vacuum in the instrument, I plunged the trocar needle deep into the balloon-like, resonant abdomen, and directly the gas began to bubble on the surface of the water. The relief of the suffering was complete, and when I withdrew the needle its fenestrum contained a little fresh fecal matter, showing that it must have entered the bowel. No harm came of that, however, as my friend Dr. B. afterward used the same instrument ten or twelve times in the same way and with the same result, until the poor woman finally died of inanition and exhaustion. The tumor in that case mounted far enough above the superior strait of the pelvis to pinch the rectum and finally to close it entirely. It could not be moved in any direction.

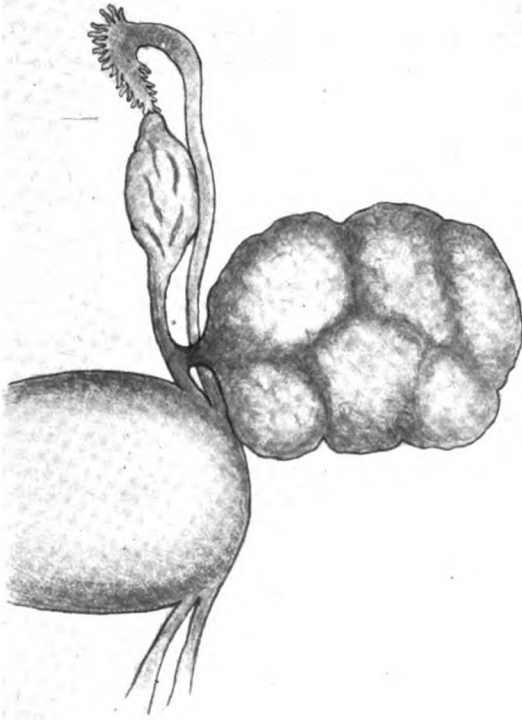
FIGURE 18. 1, THE UTERUS; 2 AND 3, INTRA-LIGAMENTOUS FIBROIDS; 4, BRIDGING FIBROIDS.



You will observe that the transverse diameter of this specimen (see Fig. 13) is the longest. Its breadth was across the pelvis. When I had exposed the uterus by the abdominal incision it was soon found to be impossible by any of the expedients that we usually employ to lift it out of the pelvis. Only one thing could be done, and that was to split the broad ligament and to enucleate the growth. Large as it was, I shelled it out, and then passing my hand behind and around the uterus, succeeded in detaching and liberating its fellow from its nest in the other broad ligament. Both these lateral fibroids were therefore enucleated, after which the whole mass could be raised to the incision and carefully and properly removed. Such an expedient with tumors of this size would not have been possible in a vaginal hysterectomy. Of my patient's convalescence and recovery we must speak at another time.

A FIBROUS TUMOR ATTACHED TO THE OVARIAN LIGAMENT. REMOVAL. RECOVERY.—Wednesday, August 29. *Apropos* of the possible location of fibroids upon and about the uterus, Prof. L. showed the class a specimen of a fibroid which he had taken from its attachment to the left ovarian ligament. (See Fig. 14.) The patient was a young lady of twenty-eight, who had suffered for years with symptoms of relapsing ovaritis and dysmenorrhœa, and with weight and bearing down in the left iliac region. Of late these latter symptoms had very much increased, and her general health was breaking down. Until a week before the operation no local examination had ever been made. The double touch easily recognized the presence of a tumor which, from its location at the left of the uterus, seemed to involve the corresponding ovary. A laparotomy disclosed this tumor, which was as big as my fist, and which was found to be attached by a very short pedicle to the left ovarian ligament, close to the horn of the uterus. There were no other growths, and the ovaries and tubes being healthy, we were satisfied with having captured this very rare specimen. It is now the fifteenth day, and the patient's convalescence has been uninterrupted.

FIGURE 14.—POSTERIOR VIEW OF THE UTERUS, TUMOR AND OVARIAN LIGAMENT.



Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

AUGUST MEETING, 1894.

The regular monthly meeting of the Clinical Society was held in the Hahnemann Medical College, on Saturday, August 25, at 8:30 P. M. Dr. E. M. Bruce was chosen President *pro tempore*, and the following papers were presented and discussed :

XXXII. A CASE OF PUERPERAL RHEUMATISM. By DR. MARY H. LANDRETH, OF CHICAGO.—*Case.* May 28, I was called to see Mrs. C., a blonde, aged 25 years. The family history showed the father's health to be fair, except a hacking cough, which he has always had. The mother's health is fairly good now, but she has had two cancers removed, one from the lower lip and the other involving the entire left breast. She has had fainting spells for the last twenty years, and before that had "hysterical fits." A sister younger than the patient has, during the last five years, had paralysis, "every joint dropping out of place;" also hysterical convulsions, often lasting three days at a time, with the body rigid and teeth set, caused by a retroflexed uterus. Before that her health had been good, but she was exceedingly melancholy.

I found that my patient had been suffering from more or less nausea ever since she became pregnant about seven months before, and that from the first week in January she had not been able to perform her usual household duties. She slept but little, the appetite was variable, and the bowels constipated. About the last week in April her symptoms changed somewhat, the nausea particularly, which now only troubled her after taking food. It would not be retained more than ten minutes, the patient declaring that "every morsel she ate was thrown up." About this time she began to have fainting spells if anything occurred to annoy or worry her. In these spells the body

became rigid, the hands and fingers tightly clenched, the jaws set, and there was a tremulous condition of the eyelids, but no change of color in the face, which was always very pale, with bright red spots on the cheeks. After these "spells" she was troubled with palpitation of the heart, which would pass off in half an hour or so, leaving her weak and prostrated. She had been under the care of an old school physician, who had given her large doses of morphia, cocaine and other drugs, the patient getting worse instead of better. The doctor then advised her to stay in bed and have the labor induced at once, as it was the only means of saving her life. To this, however, the patient strongly objected. Through a neighbor she was persuaded to try homœopathy. I found her in bed looking discouraged and distressed, and I tried to antidote the drugs and make her more comfortable. She had had fainting spells before, but only when pregnant; had had good health up to the time her oldest child was born, five years ago, at which time she got up on the fourth day and sat up and walked about the room every day till the tenth day—getting back into bed before her husband came home at night. On the tenth day she got up to stay, but after two or three days was compelled to go to bed and stayed there a month, suffering from prolapsus and retroflexion. After this she was well and strong, (except for a hacking cough which lasted three months) or until she became pregnant again, when she was troubled with the fainting spells occasionally. She got up from that confinement slowly, but was troubled with the hacking cough for nearly six months, after which she was very well indeed, working hard during the World's Fair.

On becoming pregnant again last October she suffered from nausea and fainting spells even more than in the two previous pregnancies. About the middle of June the nausea suddenly ceased, and from this time on she could eat and retain the food; and from the fact that the patient seemed to lose no flesh, and in spite of not retaining the food was in fair physical condition, I concluded that though she had not retained all the food, she certainly had retained a portion of it. She now got along nicely till July 13, when she began to have inflammatory rheumatism, involving all the joints, but more particularly the ankle joints, the fingers, wrists and left shoulder, which continued with but little relief from remedies or applications until after the birth of the baby, which occurred at 5 A. M. July 18.

About twenty-four hours after baby's birth the patient had an attack of violent, sharp pains in the region of the heart, cutting like knives as she expressed it, lasting a couple of hours, the nurse fearing she would die before I could get there. These violent pains happily yielded to hot applications and proper remedies, since which time she has been gradually improving, now having the use of all the limbs except the left arm, and that is getting stronger every day.

DISCUSSION: DR. R. LUDLAM was thankful for the report of this case not only because of its intrinsic merit, but also because in these days of asepsis and antisepsis many physicians are led to believe that the puerperal diseases are practically extinct. Although it is incessantly and exclusively occupied with clinical subjects, I can recall but one other instance in which for some years past any member of this society has furnished us with a puerperal case or paper.* Nor do our medical journals say but very little comparatively of these diseases at the present day.

Dr. Landreth's case is very interesting and suggestive, and no one doubts that it was treated intelligently as well as successfully. Not every doctor would have anticipated and averted the dangers that beset such an attack of puerperal rheumatism on the eve of delivery. The risk of præpartum sepsis as a complication of the articular lesion was very great, especially in such a subject; and septic rheumatism of this sort is a very dangerous disease. If such patients do finally recover from this affection it is the exception, and ankylosis of the joint (which is almost always one of the larger ones) is a pretty certain sequel of the attack.

The possible translation of the rheumatism from the joints to the uterus at a time when it might have wrought the most serious mischief to mother and child was another danger that threatened. For, although our obstetrical authors say very little nowadays of this form of metastasis, or of rheumatic metritis, no one of large and careful

*Heart Disease and Pregnancy. By Dr. B. S. Arnulphy. THE CLINIQUE, 1893, Vol. XIV., page 405.

experience doubts its occasional occurrence, and its serious character in a share of cases during gestation and parturition, as well as in the non-pregnant state. It seems probable, however, that Cazeau is right when he considers it more harmful in the early than in the later months of pregnancy.

But here was a woman who was strongly predisposed to cardiac trouble. The symptoms narrated make that plain enough. The tendency of rheumatism to cripple the heart, especially when that organ has undergone a change of structure and been overworked during gestation, is known to us all. That it frequently induces pericarditis, with or without peritonitis; and endocarditis, with or without ulceration and consequent embolism, should always be borne in mind. And that the puerperal form of these secondary cardiac affections is much more serious than the non-puerperal, because of the greater liability to septic and pyæmic complications, is equally certain and significant.

To have one's patient enter upon the strain of parturition under such disadvantages is extremely discouraging, especially if she is a primipara, and if the struggle to overcome the natural resistance of the parts through which the fœtus must pass will need to be severe and prolonged. It was perhaps a fortunate circumstance that Dr. Landreth's patient was not in labor for the first time, and that she already knew from experience what she would have to endure. Otherwise a severe mental shock might have been added to the other symptoms, and possibly an instrumental delivery might have been necessary.

If the doctor will kindly give us the history of the labor, its course and progress, and something of the remedies that were prescribed, it will add very much to the interest of the report. For there is little doubt that the continued use of drugs, and especially of morphia, with its tendency to diminish the urinary excretion; and of revulsives to repel and drive the rheumatic inflammation from the joints to the uterus, or to the heart, would have compli-

cated matters very seriously, and probably have destroyed the life of both the mother and the child.

Dr. LANDRETH: On my arrival in the evening of July 17, the os uteri was fully dilated, so much so that, although she had had no severe pains, and was not in active labor, I did not dare leave her lest she might be delivered rapidly in my absence. So I waited all night and the child was born at 5 A. M., the actual expulsive stage not having lasted an hour. I was prepared to apply the forceps, but the labor was so rapid and so natural that I did not need them. There was no trouble afterward, excepting the attack of angina pectoris already reported, and there was no lacteal secretion. From the time that I first took the case there was no albuminuria or other renal disorder. She is now out again and getting stronger, but still has a hacking cough which greatly annoys and wearies her. The remedies of most service in the case were *nux vomica* ʒ as an antidote for the drugs she had taken, and for the gastric disturbance; *spigelia* and *cactus* for the cardiac pain and oppression; *rhus tox.* and *macrotin* for the rheumatism; and *digitalis* to slacken and steady the heart's action. These were, of course, given separately and as they were required from time to time.

XXXIII. THE RELATION BETWEEN CERTAIN OCULAR TROUBLES AND DYSMENORRHŒA. Translated by DR. R. LUDLAM, JR.*—Dr. Gallemaerts, of Brussels, calls our attention to the relationship which exists between ocular and menstrual disorders. Two young women suffering from entirely different ocular affections first drew his attention to this subject.

*Those of our readers who are interested in the study of these oculo-genital disorders will find the following papers and discussions thereon in Volume XIV. of the CLINIQUE: The Physiological and Morbid Relations existing between the Uterus and the Eye, page 314; Utero-Ocular Therapeutics, p. 286; Amaurosis complicating Hæmorrhagic Endometritis, p. 300; Total Blindness during the Lying-in, p. 302; and The Ocular Phenomena of Hysteria, p. 460.—EDITOR.

Case 1. A young woman, æt. nineteen years, consulted him in February last on account of a haziness before the left eye which had existed for eight days, and was accompanied by headache. The visual field was normal; there was a speck in the right cornea and myopia; and hypermetropic astigmatism in the left eye. The vitreous body was transparent, and without opacity. The left papillus was more red than the right one, and had a cloudy, dim outline, masked by a milky appearance which extended to the retina, especially the lower portion. Along the vessels there were whitish plaques due to the same serous infiltration. He, therefore, had to deal with a case of neuro-retinitis, and the cause must be found. To his great surprise the patient said that her menstruation was regular, and attributed her complaint to the extraction of a tooth a fortnight before. This might have been possible had not the tooth been taken from the opposite side. Dr. G. insisted upon his diagnosis of neuro-papillitis, due to menstrual disorders, and prescribed pills of podophyllin, a blister behind the ear, a leech to the ala nasi, and foot-baths.

Some days later she acknowledged that for several years she had suffered from menstrual troubles, especially from dysmenorrhœa.

Case 2. The other patient was aged twenty-three years. About the right cornea there was a very marked venous injection; the iris was irregularly dilated; the vitreous body was murky and full of opacities. The papillus was red and injected; there was no trace of syphilis. Menstruation was always very painful and the flow very scanty. A diagnosis of irido-choroiditis was made, and dysmenorrhœa was the assigned cause.

The ocular trouble in this case was more serious than in the first one; was more profound, more extensive, and will leave more visible effects. This young woman had already had an attack of neuro-papillitis from the same cause, which, thanks to energetic treatment, had disappeared. It therefore was a relapse, with adhesion of the iris to the crystalline lens and the choroid, and the white plaques which indicated the development of atrophy.

Concerning these two cases, Dr. Philippeau, the editor, remarks: We may attribute the ocular affection to the menstrual disorders, for nothing else disclosed in the examination could give rise to the ocular symptoms.

The only incidental disorders were found to be situated in the genital organs, and both these women suffered from dysmenorrhœa. At the same time local treatment was begun, and efforts were made to obtain a normal menstrual flow so as to make a permanent cure and to prevent a relapse.

The report of these two cases prompts me to speak of ocular troubles in their relation to menstruation. The discharge of the menstrual flow brings about certain changes varying in their intensity in the different organs of the body. In the healthy state, when the periods assume a regular course, the troubles which follow can be placed in three groups: (1) vaso-motor disturbances; (2) cerebral disorders; and (3) spinal troubles. Each organ and every part of the body may feel these changes, which are usually slight in character. The eye participates in these modifications, which are inappreciable when menstruation is normal, but which may assume a thousand forms when that function is diverted.

The state of visual acuteness and the condition of the visual field during the menstrual period have been studied by Finkelstein. This author found that the central vision does not change, but that there is a narrowing of the visual field which commences two or three days previous to the flow, reaches its height the third or fourth day after the flow has appeared, and disappears about the seventh or eighth day. This narrowing is more pronounced when accompanied by pain in the head, palpitation, nervous excitement, and especially when the flow is excessive. It exists not only for the white, but also for green, red, yellow and blue rays. In twenty per cent of cases the sensibility for green is changed. Peripheral vision is therefore altered, while the central vision remains intact. Summing it up, in normal menstruation the ocular troubles are slight, and serious eye affections are rare. However, your attention should be drawn to the presence of styes on the lids of certain women who are regular, and the reappearance of keratitis with each menstrual return.

In pathological states the alterations in the visual field are much more decided, and vary with the nature of the affection by which the patient is attacked. When the flow of blood is slight and accompanied by severe pain the narrowing of the visual field becomes very apparent. The same thing happens at the proper menstrual epoch when there is an absence of the flow. When the flow is profuse the visual field becomes still more decidedly narrowed. The observations of Finkelstein are therefore verified when the periods are normal, as well as when they are either scanty or too copious.

Passing from the examination of the visual field to certain ocular affections we find them related to amenorrhœa on the one hand, and to dysmenorrhœa on the other. A complete absence of the menstrual flux is exceedingly rare, and the eye troubles which it provokes are still more rare. Mooren, however, reports an interesting case of this kind. A country woman, æt. twenty-eight, had suffered since the age of fifteen from an interstitial keratitis, which was characterized by decided exacerbations that occurred every four weeks. Her courses did not appear, and emmenagogues produced only the slightest flow of blood, which flow, however, had the effect to cause a slight but temporary remission in the corneal trouble.

We might include the various forms of vicarious menstruation among those which produce troubles with the eyes as well as with other organs. Just as epistaxis, gastrorrhagia and hæmorrhoidal flux may depend upon a deviation of the catamenia, so hæmorrhage may occur in the eye at the menstrual molimen. It is possible that through a rupture of the vessels of the conjunctiva the blood may be mixed with the secretion of the lachrymal glands.

Dysmenorrhœa is much more frequent than amenorrhœa, and is characterized by either a slight or a very copious flow. It may depend upon various causes; it often results from general disease or from an affection of some part of the genital apparatus, and sometimes it may arise from a combination of these two causes. Ovarian con-

gestion, ovaritis, periovaritis, the different forms of metritis, uterine displacements and malformations, as well as endometritis, may possibly occasion it. Being a common complaint it is quite susceptible of proof that dysmenorrhœa is often complicated with eye affections.

The clinical relation between uterine and ocular disorders was recognized by the earlier authors who wrote of menstrual ophthalmia and menstrual amaurosis without any very definite idea of their classification. Some of them even held that menstrual amaurosis should be regarded as glaucomatous, while the term menstrual ophthalmia was reserved for diseases of the lids and of the conjunctiva.

The dysmenorrhœa of young girls is often ovarian, arising from defective maturation of the ovule, the resistance of the stroma to the rupture of its follicle, or from alterations of a similar kind of which we are still ignorant. In some cases the dysmenorrhœa depends upon a general condition, such as chlorosis, and this general weakness shows itself by defective contractility of the ocular muscles, inducing such anomalies of accommodation as diplopia, and strabismus. In other cases the nutrition of the eye will be attacked, whence we may have a serous iritis, or irido-choroiditis.

Whenever the dysmenorrhœa and the ocular affection are both dependent upon the general condition of the patient the treatment must be constitutional. If the result is favorable the eye trouble improves rapidly, and the relapsing symptoms, if there are any, may be treated locally.

The dysmenorrhœa that is due to disease of the genital organs may give rise either to functional troubles or to serious disorders of the circulation in the eyes. Among the former is the affection which has been variously styled as neurasthenic asthenopia, retinal hyperæsthesia, and optic hyperæsthesia. Its symptoms are fatigue of vision after labor, sometimes photophobia, pains in the eyelids and epiphora. Later on the hyperæsthesia is changed to anæsthesia; it causes a concentric narrowing of the visual field and finally a diminution in the acuteness of the central vision.

The color perception is usually altered. There may be a reflex amblyopia having its origin in a diseased uterus. So also in uterine displacements there is a drawing and abnormal pressure upon the nerves which act in a reflex way upon the eyes to cause retinal hyperæsthesia. This complication often occurs in anteflexion and prolapsus of the womb; and it has frequently been noted that the reposition of that organ will relieve and cure a reflex amblyopia. Metritis with increased size of the uterus may give rise to the same eye trouble; and so also with those peri-uterine deposits that involve the cellular tissue and the nervous filaments about the uterus. Cervical stenosis, and ulceration of the neck of the womb may occasion an ocular hyperæsthesia, and the fact remains that when these abnormal uterine conditions are relieved the optical lesion is rapidly modified and perhaps entirely cured.

In case of chronic inflammation of the uterus, however, with retraction of the organ and a constant pressure upon the nerves, there may arise what has been described by Förster and Freund under the name of hysterical kopipia. These patients complain especially of photophobia and periocular pains, with a sensation of a burning and of biting in the lids or the globe, as well as of foreign bodies in the eye. At the menstrual period there is frequently a sudden relapse and increase of the symptoms without other apparent cause. At the same time the pains may extend to the back, and sometimes the hyperæsthesia reaches the auditory and the olfactory nerves. On examination of the eyes, however, there is no alteration and the central vision is intact. In such cases it is almost certain that on a careful examination of the internal pelvic organs we shall find a chronic parametritis with atrophy. This is especially apt to be the case in subjects of from twenty to forty years of age.

Besides these functional eye troubles dysmenorrhœa may occasion various organic lesions of the eye, such as choroiditis, iritis, irido choroiditis, capillary hæmorrhage, hyperæmia of the retina and of the optic papillæ, neuro-

retinitis and retro-bulbar neuritis. All these affections may have their root in dysmenorrhœa, and may improve or disappear when the monthly flow has become normal. It is difficult to explain the reason of this fact, and it is usually referred to reflex action. It is possible, however, that it may depend in part at least upon the non-elimination by the monthly flow of certain organic products that tend to impair the vision and to injure the eye.—*Gazette de Gynécologie*, 1 Aout, 1894.

THE TOPICAL USE OF COLLODION.—At the July meeting of the Belgian Homœopathic Association Dr. Gaudy cited several very interesting cases in which he had employed the oleaginous collodion locally with remarkable success:

1. In *typhlitis and perityphlitis*. In a case where a relapse followed improvement by the internal use of mercurius, bryonia and belladonna, he painted over the entire right side of the abdomen from the linea alba to the crest of the ilium and upward to within two finger-breadths of the false ribs. In twenty-four hours there was a complete arrest of the disease, and the internal treatment being resumed a cure followed. In another case he resorted to the same treatment with the same result. A woman was seized with typhlitis and came very near dying. The collodion was applied and the relief of her suffering was almost immediate. She recovered in four days. In the case of a child with congestion of the liver complicating typhlitis there was vomiting, colorless stools and extreme sensibility of the cœcum. The collodion was applied and in four days it too was well again.

2. In *metritis and metro-peritonitis* during the lying-in. In one case of this kind there was intestinal obstruction, an imperceptible pulse, cold skin with a sticky sweat, cyanosis, a cadaverous look and fœcal vomiting. The collodion was applied over the entire abdomen and she got well.

3. In *tabes mesenterica*, Dr. Dewees reported excellent results from the same topical application in this affection among children.—*Revue Homœopathique Belge*.

Hospital Notes.

THE CLINIC ON DISEASES OF THE SKIN.

SERVICE OF PROF. HALBERT.

KELOID-ACNE.—*Case 1.* Charles M., age thirty, experienced at the age of puberty an unusual form or *acne vulgaris faciei* which persisted, in a mild form, for two or three years. Then after treatment the face was much relieved and for the past few years his back and shoulders have been literally covered with this indurated keloid form. Reddish, tubercular nodes had become incorporated into the skin until much of the surrounding tissue was hypertrophied and sclerotic. Cicatricial scars were intermingled with large and unnatural comedones until the whole surface revealed to palpation a peculiar papular feeling.

External and internal agencies had heretofore given no relief whatever. The local treatment had certainly been overdone, and from what we could learn, the same was true of the internal medication. His general health was fairly good with the exception of an occasional lymphangitis.

The patient offered such a good opportunity for experiment with the internal remedy alone that we decided to give that method a trial. After directing him to wash the parts well every day with soap and water, he was given Hydrocotyle 3 every hour for a week, every two hours for the second week, and four times daily for several weeks after. There is at present every evidence of improvement for many of the indurated spots have disappeared, and no new ones have formed. This is the greatest encouragement he has had so far.

Here is proof that excessive local treatment for any form of acne is a mistake. The disease is purely a neurosis incident to puberty, and hygienic treatments and internal medication in a mild form, should take precedence of heroic efforts to relieve the local expression of the disease.

ERYTHEMA. INTERTRIGO.—*Case 2.* Mr. J. a very large and fleshy man of exceedingly good habits and with no history of specific trouble came to the clinic for relief for this long standing and obstinate condition. The case had been prescribed for under nearly every conceivable diagnosis, the majority of the clinicians claiming it was due to syphilis. During a fishing expedition, some years ago, he thought he had been poisoned while in bathing, and since that time he has been exceedingly troubled with this persistent local inflammation. His unusual flesh had been a constant irritant and being obliged to work for his living he had almost despaired of recovery.

In the folds of his right groin and extending back between the nates an immense phlegmonous surface was visible. So long had it existed that fissures and ulcerations, and excessive secretions of sweat and pus had complicated what might have been a short enduring, and simple sore. A rash, like measles, extended over the surrounding healthy skin. Extreme local itching and general aching pains made him exceedingly restless. These symptoms were always worse after midnight and during wet or cold weather.

With these indications he was given rhus tox 30 four times daily for a week. He was directed to use a local wash of warm water and lanoline soap, being careful to wipe the parts to perfect dryness. He was then to use a dusting powder of aristol, and wear an abdominal supporter to relieve any chafing. In four weeks he was entirely well.

This experience furnished a good lesson in the simpler skin affections, which too often, as in this case, are perplexing. The truly indicated homœopathic remedy was probably called for in the very beginning and might then have sufficed. The local care removed the constant irritation and helped a filthy pus secreting surface resolve itself into healthy tissue.

ECZEMA FACIEI.—*Case 3.* Miss Maude H., age sixteen, has had this form of eczema for five or six years continuously. It appeared when she was two years old, but was supposedly cured, or at least suppressed by strong astringent applications. For several years after that her general health was very delicate until the reappearance of the eruption when she rapidly grew stronger.

The disease was perfectly symmetrical involving the

temporal region of each side and extending down upon both cheeks to an exactly corresponding point. While it was vesicular and superficial at first it had now become a large erythematous blemish without much exudation. The tissue was very much indurated even beyond the line of eruption. Fissures, larger than are generally seen upon the face, were quite numerous, causing thereby much bleeding and excessive itching. The latter was so bothersome that the frequent scratching had made the eruption resemble erysipelas. Besides this the patient complained of a deeply seated and constant pain in the facial region which indicated periosteal involvement. There were other symptoms, rheumatic in character, which were always worse at night, all of which pointed clearly to inherited syphilis or scrofula.

On account of this history Mezereum 3 was given four times daily for two months. The potency was occasionally raised for a time, yet but little benefit was obtained from the attenuations. Locally the parts were washed every morning with aristol soap, after which a little olive oil was applied. Every evening she applied a 5 per cent solution of europhen.

In one month there were encouraging signs of improvement. The induration, itching and bleeding had disappeared. At the end of the second month she was discharged as cured, although she reports every two weeks for the sake of our watching the result.

Mezereum is indicated here because of the history of scrofula and syphilis, and also on account of the periosteal involvement. While there was no vesicular or pustular tendency during the latter stages it did appear at first, and hence the remedy is still useful. Europhen overcame the deep inflammatory indurated condition.

CHROMOPHYTOSIS, OR PITYRIASIS VERSICOLOR—*Case 4.* Mrs. S., age forty, had been troubled with what the "doctors called liver spots" ever since a severe attack of fever some three or four years ago. She had always been a hard working woman and suffered much with a "torpid liver" for which she had taken, from time to time the routine cathartics for temporary relief. These spots began as isolated brownish yellow patches in the upper sternal region. In the beginning they were not large but many of them, becoming confluent, covered now the entire portion

of the right breast and extended down the side in intermittent spots, as far as the thigh. Starting at the same point on the left breast they extended upward to the clavicular and cervical regions, being more pronounced on the covered part of the body.

These diffused patches were perceptibly elevated and in some places they were decidedly scaly. Under the axilla and between the shoulders the mottled and scaly condition gave a peculiar variegated semblance. Itching was quite a prominent symptom and the surrounding healthy skin had a lardaceous expression. In addition to this there were many signs of dropsical tendency and varicosity of the veins of the lower limbs. The urine, she said, had a "strong odor" and the stools were very light in color.

Taking into consideration the history of a previous fever, the perversion of the liver's function, and the other allied symptoms the case was treated from a systemic standpoint. *Carduus marianus* was chosen as the remedy. Five drops of the tincture were prescribed four times daily for a few days. Then the 3, 6 and 30 potencies were given respectively for two weeks at a time. Carlsbad salts were given before breakfast twice a week. Locally a solution of hyposulphite of sodium (10 parts to 100 parts of water) was applied to relieve the itching.

The experience of this case teaches that the most pronounced eruptions may be due to a physiological perversion as well as a local lesion. In this example the condition of the liver was of far greater consequence than the appearance of the integument.

PEMPHIGUS. *Case 5.* Arthur G., age eight months, was brought to the clinic by his mother who had been scared into the belief that her child had variola. He was covered from head to foot with oval and spherical bullæ averaging about the size of a pea. Preceding the eruption he had a high fever with excessive coryzal symptoms. Some of the bullæ contained a fluid resembling blood, but the majority were filled with serum. There was no peripheral inflammatory areola, and the only local congestive sign was observed previous to the formation of the bullæ and was limited to the area corresponding to the base of each. There was no resemblance to papular or pustular formation. There was every reason to believe,

from the information gathered, that it was epidemical as other children in the same family and vicinity were afflicted with similar eruptions.

It was therefore diagnosed as an acute form of pemphigus which is indeed a rarity. An interesting feature of the case was the fact that the child had suffered with a previous attack of meningitis. From this we explained the severity of the case inasmuch as the true lesion of pemphigus is supposed to be in the cord, especially near the trophic centers. The toxic cause no doubt came from the contagion, but the meningeal irritation supported its development through trophic insufficiency.

Tartar emetic 3 was given four times daily for a week. The second week showed some improvement and the 30 x potency was then given for three weeks longer. The only local application used was a 5 per cent cerate of eucalyptus to relieve the burning and irritation. The recovery was complete.

SCABIES—*two cases.* *Case 6.* Lewis B., age four years. For several weeks the child was bothered with an inordinate itching of the fingers which very soon manifested a local form of interdigital scabies. It was purely vesicular in character inasmuch as the acari, being limited in their invasion, had only produced a slight dermatitis. The child had been exposed to a typical case of the "itch," and hence the confirmation of our diagnosis. Sulphur 3 was given for a week with no improvement. The potency was then regularly raised but gave no better results. Sulphur cerate (23-13) was then prescribed as an inunction night and morning. Careful directions were also given to precede this application by a thorough washing with soap and water. In three weeks the case was cured.

Case 7. Michael M., age thirty-six. This patient presented himself to the clinic with all the evidences of a filthy history. He was possessed with every corporeal possibility for the encouragement of parasitic development. Nearly every part of his body had some traces of the "itch mite," and by his continuous scratching it had progressed from the most pronounced confluent pustular form to the resemblance, in some places, of an eczematous eruption. The furrows, marked by all the products of the acari, were evident under a strong light. The itching had become almost unbearable.

The directions were to take a thorough "scrubbing"

with ichthyol soap and to literally keep himself smeared with a 10 per cent cerate of ichthyol. In a few weeks he was entirely relieved of this loathsome disease.

From these two characteristic cases we learn: *First*, that scabies is not a disease amenable to internal medication. It is purely local in its effect, and every effort must be toward the destruction of the *acarus scabiei*. When this is done the indicated remedy may be properly used for the resulting dermatitis of whatever form.

Secondly, it is perceived that the interdigital form has a tendency to limit itself, and is almost always typically vesicular.

ICHTHYOSIS. *Case.*—Rudolph S., age fourteen, a boy possessing every appearance of robust physical health, came to us for relief from a "terrible skin disease" as he termed it, after having tested all the other dermatological clinics of the city. He was of Polish nationality and in addition to this unfortunate disease he presented all the evidences of unnecessary epidermal accretions of terra firma. His face bore the expression of chagrin as if he had been too long the object of scorn and in every way his plight was pitiful to behold.

As long as he could remember this eruption had infested him, though from his father we learned that it was not congenital. The claim was made that he was once cured for a year's time, but that the disease returned as the result of a fearful fright. No other member of the large family had any traces of it and the parentage for generations back had been equally exempt. Scaly patches, worse in places, covered the entire body, the face, head and palms alone excepted. The elbows, knees, and dorsa of the hands were the most involved; and in these parts were found the real resemblance of this type of eruption. Here the excrescences were acuminated, showing the papillary projections and the epidermis was hypertrophied and cracked. In other places pentagonal scales, with raised margins, interspersed the extensive "fish skin" appearance. The peculiar dryness and roughness were easily recognized by palpation. On the extensor surfaces, under the arms and on the dorsa of the hands instead of true exfoliation the large scales had formed excrescences which looked like the cracked bark of a tree.

The dry and wrinkled skin, with its bran-like and scaly eruption, presented such a perfect picture of Arsenicum symptoms that he was given that remedy in the third potency with directions to take it as often as every hour for a week. The next week he was to continue it every two hours. The third week he was given the 6 potency every three hours. The fourth week he received the 30 potency four times daily. The fifth week the 200 potency was given, and which he is still taking.

Locally he was directed to wash the whole body once daily with a strong alcoholic solution of green soap and to follow this ablution with a thorough application of tumenol oil cerate (ten per cent). To insure the perfect fulfillment of this order one of the students was delegated to keep an oversight of the case.

At this writing there are signs of improvement far in excess of our expectation. The back and limbs are entirely free of eruption and the hands and extensor surfaces are rapidly being relieved. The change in every way is remarkable and there is every reason to hope for a cure. The relieved skin presents a healthier appearance and natural perspiration—not observed before for years—has relieved the integument of its excessive burning and itching.

We may learn from this case that ichthyosis, if not congenital, is certainly amenable to remedies, and that arsenicum is still the most useful remedy (in graduating potencies) for those dry forms of eruption and proliferation of the stratum coreum. Secondly, we learn that tumenol oil has proved its wonderful power in arresting the inflammatory invasion about the papillary layer. Without this I do not believe the internal remedy could have alone overcome the rapidly increasing cutaneous hypertrophy.

The third conclusion is to the effect that cleanliness must be preserved by an astringent soap such as was used above. The combination of these adjuvants can alone secure the desired result.

THREE CASES OF PSORIASIS.—*Psoriasis punctata*.—Case 9. Miss M., a beautiful young lady, nineteen years of age, had suffered with this disease for six years. It appeared about the time of the first menstruation and involved in the beginning simply the extensor surfaces of the limbs and arms.

It was of the simplest variety but it soon covered the scalp, face and eventually the entire body. There would often be some remission of the eruption but new crops would rapidly supplement the older ones. Specialists, quacks and water cures galore had all failed to give more than temporary relief. The last "professor of healing power" had used the curette only to leave his reputation in the form of cicatricial scars which deface the integument more than the original disease.

When she was intrusted to my care she was placed under the most exacting diet and hygienic regulation. Her general health was considered in every sense and she was obliged to forego all society pleasure and to retire every night at nine o'clock. Arsenicum iodide 3 and 6 were given consecutively six times daily for two weeks at a time. Then the 30 and 200 were given each four times daily for two months at a time. In addition to this she was instructed to take a cold sponge bath every morning and evening. Immediately following this the whole body was washed with lanoline soap and afterward anointed with a five per cent cerate of tumenol oil.

It is now one year since the beginning of this systematic treatment and for the last five months there has not been the first indication of the eruption. The patient has improved decidedly in health and life has now for her some features of happiness. The last potency of the remedy is only used once daily and the local application only occasionally.

PSORIASIS ANNULATA.—Case 10. George S., age twenty-eight. A strong and hard working carpenter, presented a typical case of the annular form of this disease which had afflicted him for four years. These round spots were located on the extensor aspect of the limbs and arms and a greater portion of the back. He too, had tried many physicians without the slightest help. Connected with this there was the slightest history of specific involvement and for that reason he was given mercurius bin-iodide in the regular gradations of potency, starting with 3 and continuing it for several weeks. In addition to this he was directed to pursue the same local process, as in previous case, a ten per cent cerate of tumenol oil being used. After four months' treatment the centres of many of the eruptive rings began to clear up. At the present time many more have shown the same signs of improvement while several

others have disappeared entirely. In all other treatment for the past four years, there had been no improvement whatever. Taking everything into consideration a cure is hoped for and expected.

PSORIASIS DIFFUSA.—*Case II.* Mr. R., a man of thirty or more years, revealed, upon examination, a most rare case of this form of psoriasis. From his neck to the buttocks behind and encircling one-half of the chest in front there was with few interruptions, one solid mass of confluent eruptive rings. These in the beginning were annular for a short duration, but soon the identity of each individual ring was lost in the extensive confluence. The scaling was often so excessive that he seemed almost to be shedding plates of integument. There was also unnatural itching, and he had many cachectic symptoms simulating consumption. A tubercular history existed in the family.

Creolin tablets 3 were given four times daily and he was also advised to take a tablespoonful of cod liver oil after each meal. Locally he was given the alcoholic solution of green soap and a 10 per cent cerate of alumnol.

Three months later the erythema became paler and less scales were formed on the right side from the axilla downward. In four months healthy integument had appeared in spots. On this the fifth month there are decided signs of improvement. The patient is seemingly better in many other respects, and the greatest hopes of an ultimate cure are entertained.

From these three cases we may learn: *First*, that the most hopeless cases of psoriasis, though for a long time pronounced incurable, are certainly within the pale of possible cures. This can be done alone by the homœopathic *similium*, in its gradations of potency, and by the proper astringent local adjuvant. *Second*, that the dietetic and hygienic considerations are as important as the indicated remedy. *Third*, that the application of tumenol oil and alumnol cerates are the most beneficial local aids as yet introduced. The former has given me the most satisfactory results. Having received a sample one year ago through the kindness of the importers, I have given it a thorough trial in private practice and in my clinic I must confess that my satisfaction has only equaled my sur-

prise at its wonderful results. I can, therefore, heartily recommend its use in these and other cases which seem almost hopeless.

Tumenol is found in the distillate of a bituminous mineral from the Messel mine in Germany. The parent substances were found in the unsaturated hydrocarbons of the mineral oils. By further separations the oil and the powder are obtained. From either of these we make our cerates, the oil being more preferable in my experience. It has been in use by Prof. Neisser, of Breslau, for two or more years, his preparations being in the form of solutions and ointments. Let it be said to the credit of the dermatological clinic of our Hahnemann College that these successful experiments are the first introduced to this part of the country.

Alummol I have not as yet had so large an experience with and refer to it in this case only for its exceptional results.

SYPHILODERMA PUSTULOSUM.—*Case 12.* Mrs. M., age forty-five, came to the city for treatment for a far different disease. She had hardly arrived before she was seized with rigors premonitory of a severe fever which followed the next morning. The fever was very persistent and for some time delirium and coma indicated a fatal termination. After a few days, however, the temperature began to fall and the dangerous symptoms disappeared. As she approached recovery a papular eruption appeared on the face, forehead and the greater portion of the body. This so suddenly became vesicular that grave fears of variola were entertained. The next change was to the pustular formation which was excessive and attended with a very bad odor. The sloughing was so rapid in places, especially near the vagina and the *alæ nasi*, that it was necessary to keep them constantly packed with iodoform gauze. Very soon papillary growths were seen in the eye and the ulcerative process severely involved the fauces.

The diagnosis was now quite clear, especially after the husband had privately admitted having had syphilis several years ago. The patient had always been ignorant of her condition and therefore, in all probability had con-

tracted a local chancre which had given this secondary eruption.

The inflamed parts were kept cleaned with boracic acid solution and internally, potassium iodide (saturate solution) was given in fifteen drop doses after each meal. The second week she received ten drop doses and the third week she received the 3x potency of the same which was continued for some time. Nothing else was done except to preserve perfect cleanliness at the suppuration points. In a month the patient had fully recovered from the suppurative fever; the sloughing had ceased, the throat and eye were cured and the eruption showed positive signs of disappearing. The second month the eruption had entirely gone and she was able to go home and continue treatment by mail. With this recovery her previously supposed disease absconded.

The interest in this case is centered in the fact that potassium iodide is the remedy par excellence for pustular syphilide. Furthermore it can be used homœopathically after giving the saturate solution for awhile. Therein lies the secret of success in our school. The excessive dosing of the drug not only retards the cure but develops cutaneous complications simulating the syphilitic eruption. The use of the internal remedies in these cases is all that is called for. Cauterization is uncalled for and irritating. The only cases in which it should be employed is when the specific virus involves a mucous membrane in the form of a chancre; then it should be used early and thoroughly.

THE CHILDREN'S CLINIC.

SERVICE OF PROF. JOS. P. COBB, M. D.

REPORTED BY H. J. PAYNE, CLERK OF THE CLINIC.

CATARRHAL INFLAMMATION OF THE LARYNX AND BRONCHIAL TUBES, WITH CATARRHAL DIARRHŒA.—*Case 613.* Robert B., æt. fifteen months, came to the clinic July 19, '93. The family history is good; previous to this illness he has never been sick. For a week now he has been ailing; has had a fever; is thirsty and restless at night. Has a loose, rattling cough. The bowels move seven or eight times a day; the stools are watery in consistency, and their color

varies from white to yellow and green; the movements are mostly during the daytime, but the fever is worse at night. The child is teething, is fretful, cries especially during evacuations of the bowels, has no appetite and has been losing flesh.

You notice in the replies given to our questions that the mother ascribes all of the child's symptoms to the fact that it is teething. This is a popular theory so deeply imbedded in the minds of the laity that it will take a good many years yet to eradicate it. During dentition a child is apt to be more fretful and restless because of the irritation caused by the erupting teeth, and this puts them in a condition where they are more liable to contract any disease; in a condition where they do not offer their usual resistance to outside invasion; but there is always an exciting cause for the catarrhal inflammations so frequent during this period, whether it is located in the respiratory or alimentary tract.

The profession help to keep this fallacy alive by accepting the parent's diagnosis as the easiest route by which to satisfy their minds and by neglecting to impress it upon their minds that they have been careless; have exposed the child in some manner, or have given it improper food. We will give this child arsenicum four times daily, and the mother specific directions concerning its care and feeding.

August 7. The child has been kept upon the same remedy and has reported improvement. To-day we learn that he is having about three stools daily, yellow or greenish, small in amount, preceded by cramping pains in the abdomen, and the appetite is poor. Colocynth four times daily. He reported later and was discharged cured.

THE SYPHILITIC DIATHESIS.—*Case 749.* Georgie L., æt. four months, was brought to the clinic June 23, 1894. The mother reports that she contracted syphilis from her husband at the time of her marriage, and gives us a history of her experience which confirms her report. She was treated for several months and pronounced cured by her physician. Fourteen months after her marriage she gave birth to a seven months' baby which lived six weeks.

Twenty-six months after her marriage this baby was born; he seemed perfectly well at birth, but when two months old a rash appeared first in the face, spreading over the neck and shoulders. When brought to the clinic the legs, buttocks, and genitals were covered. The testicles were inflamed and swollen. Merc. iod. was given internally and eucalyptol cerate was advised as a local application.

This case illustrates several points which I have frequently referred to in our discussions of syphilis.

1. It is not safe to promise a parent immunity for their offspring until they have been systematically treated for at least two years, and even then we should be guarded in our promises.

2. Women who have contracted syphilis are prone to miscarry, or have feeble, premature children; this is especially true of the first children begotten after the infection, but this predisposition may be outgrown.

3. A child born to a syphilitic parent may at birth appear to be perfectly healthy, and not until it is several months old show any evidence of a syphilitic inheritance. These evidences are apt, however, to appear prior to the fifth month of its age.

A marked improvement was noticed each week until August 18, when the rash had entirely disappeared; the bowels moved regularly, the appetite was good, slept well, and was cutting four teeth.

August 29. The mother said that her milk was not nourishing enough, and that she had been feeding the baby anything it wanted to eat. For this reason the baby was cross at night and its stool was green and watery.

Merc. iodide 3 was continued and chamomilla 6 was also given one dose at night. In addition the mother was given instruction concerning feeding the patient.

INDIGESTION. *Case 751.* Bernard C., age seven years, brought to the clinic June 23; is one of eight children. For two weeks he has not been feeling well; has no appetite; is drowsy and languid in the day, is tired and drowsy in the morning. He does not sleep well, grinds his teeth in his sleep, cries out in sleep, wakes up

frightened and screams. He is thirsty and drinks much water; has lost flesh; coughs some, especially at night. On examination we find his tongue coated, the abdomen tender to firm pressure, the temperature 100° , with a throbbing of the carotids. Belladonna 3 every two hours.

June 27 he reports not so drowsy through the day, sleeps better at night, the bowels move regularly; has no appetite, but when he eats does not properly chew his food; is cross and peevish. Yesterday he vomited several times between 5 and 8 P. M. A slight rise of temperature is noticed every day; it now registers $99\frac{1}{2}^{\circ}$. Nux vomica 3 was given every hour.

June 30. Is much better; the bowels are not regular, however, and there is still a slight rise in temperature. The remedy was continued. His mother afterward reported that he was well.

As usual the mother informed us that the child was suffering with "worms," and would not be convinced that such was not the case until we sent her home to look for them, telling her if they were present our medicine would bring them away. Of course she found none, but she did watch the child better, and paid more attention to what he had to eat, and when he ate it, and was willing to own that she was mistaken.

MALNUTRITION.—*Case 768.* Agnes W., æt 10 months, was brought to the clinic July 21. She was in an apathetic condition and weak and listless; coughed occasionally and has been sick for one month. Is restless and cross day and night, has no appetite, the tongue is coated, the mouth dry, and she is very thirsty. The bowels move several times a day; she strains and cries during the movements, but feels relieved afterward, and sometimes sleeps. Stool watery, green or yellow. Has no teeth. Phosphorus 6 was given four times daily.

August 22 was reported again at the clinic. Child has been improving steadily until now. Is beginning to cut teeth and seems to be getting into her old habits. Calc. phos. 3 was given four times daily, and improvement was reported the next week.

CONSTIPATION.—*Case 783.* Edwina G., æt. 5 years, was brought to clinic August 11. The family history is good. This child had measles when three years old. For three

years has been troubled with constipation. Three days will sometimes pass without a movement. The bowels are then moved by castor oil. She has pain before the movements, and frequent painful desire for stool without effect. The stool is dark and hard at first, then yellow and softer. When it is very hard streaks of blood are noticed upon it. Upon examination the anus was found to be very much inflamed. Sulphur 6 was given four times daily, and calendula cerate applied externally to the inflamed parts.

August 25 the child was reported very much better. Has no more trouble with the constipation, but has a hacking cough, for which phos. 6 was given four times daily.

SUDDEN DEATH FROM BICYCLE RIDING.—At the meeting of the Paris Academy of Medicine September 4, Dr. L-H. Petit related three cases of sudden death from this cause. The first was that of a man of 65, who had been practicing upon this vehicle for a month and who died by falling into the arms of a friend on dismounting from his machine.

The second case was that of a physician, æt. 48, who, having grown too fleshy after convalescing from typhoid fever, had resolved to combat the tendency by this kind of exercise. He had never complained of heart trouble, but after considerable exercise of this kind he was suddenly seized with breathlessness and such a severe pain in the cardiac region as forced him to get off his machine and to sit down upon a bench where he died in a few minutes.

The third party was a clubman who died upon his bicycle in the streets of Paris. He also had been seized with heart trouble and was aged about forty years. From which striking facts Dr. P. concludes that cardiac diseases furnish a decided contra-indication against the use of the bicycle, and so also does old age. The indulgence of this species of pleasure should therefore be prohibited to both these classes.

Opening Exercises.

*OF THE HAHNEMANN MEDICAL COLLEGE AND
HOSPITAL, OF CHICAGO, SESSION 1894-'95.*

The thirty-fifth annual winter session of this flourishing school opened at 8:30 P. M., of Tuesday, September 11. Prayer was offered by the Rev. Dr. Carlos Martyn, of the Sixth Presbyterian Church. Prof. H. V. Halbert was master of ceremonies and the music was furnished by the Imperial Quartette. The audience comprised a large class of students, visiting physicians, alumni from everywhere and friends of the institution generally, all of whom were very enthusiastic. After the formal programme came the inspection of the college building and the opening of the new and splendid hospital adjoining. With all of its ups and downs the "Old Hahnemann" has never had such a send-off before. Following is

THE INTRODUCTORY LECTURE.

By PROF. E. M. BRUCE, M. D.

It is very pleasant to see so many familiar faces among you and welcome the return of our upper-class men and women, and to extend the right hand of fellowship to those of you who are here for the first time.

This is a red-letter night in the history of our institution. The dream has been realized. I believe I can appreciate the feelings of those who have watched and tended the growth of the Hahnemann Medical College and Hospital of Chicago from its humble beginning to its now noble proportions upon this its thirty-fifth annual opening. The new college building is equipped with everything that is necessary for the several departments to do successful teaching. Our new hospital, which is of no mean dimensions, and supplied with everything that the experience of men or the intuition of women could suggest is open. This

hospital, the greatest monument yet builded to the memory of Samuel Hahnemann, is something of which we are sincerely proud. There will be another occasion upon which we may enlarge more particularly on this subject, and when abler tongues than mine will tell its story.

If the shades of Smith, Small, Hall and Laning can look down on us from the beyond surely they will think a new kalpa has begun, and rejoice with us. The few ideas I have to present are somewhat disjointed and I must crave the audience to supply the ligaments.

The personal history of the Art of Medicine is very interesting and exceeding varied. The faith and unfaith in which we are held by our victims is likewise so. Occasionally the art is lauded almost to fulsomeness, and again is impaled on the trenchant wit of a Molière. Hundreds of years ago Agathias in his unfaith wrote :

"A thriving doctor sent his son to school
To gain some knowledge should he prove no fool;
But took him soon away with little warning,
On finding out the lesson he was learning—
How great Pelides wrath in Homer's rhyme,
Sent many souls to Hades ere their time.
No need for this my boy should hither come;
That lesson he can better learn at home—
For I myself, now, I make bold to say,
Send many souls to Hades ere their day,
Nor er'e find want of grammar stop my way."

On the other hand a story which is going the rounds now is an example of extreme faith. A gentleman was mortally injured. The doctor and wife were doing all in human power to bring back consciousness. The case seemed hopeless. The doctor listened for the heart beat, but could not hear it, and said: "It is no use, madame, he is dead." Just then the man opened his eyes and murmured faintly: "Not quite, doctor," whereupon the wife quickly said: "Hush! hush! John, the doctor knows best." I trust all of you may be able to inspire such confidence.

The choice of a life work, whether it be medicine, law, engineering or what not is a serious question to decide; and

the pros and cons should be most carefully considered. Emerson has said that each individual has some special adaptability to do some one thing. It may be in bad taste, and perhaps the result of limited and faulty observation, but I differ somewhat from the great thinker.

It is granted of course that there are those who have special gifts and who are going to reach certain goals, over whatever the obstacles, impelled by the inherent force of their genius. But the majority of us one talent people, who are subject to all the one talent temptations can under like conditions do one thing about as well as another. The elements which make success do not differ much among different professions. The question of the personal agreeableness of toil becomes a thing of paramount importance. But granted the question settled and that one is to be a physician ; then comes the selection of a place in which to secure the best training for the life of a medical man or woman.

The functions of a medical college are undergoing constant change which the optimistic ones call progress.

Did you ever stop to think how much care is necessary on the part of a college faculty, to meet these changes and prepare a satisfactory course of study? The physician of to-day has no easy task before him. To be an expert in anatomy will not be taken as an excuse for ignorance of physiology, and to be well up in both of these serves not for a faulty knowledge of chemistry or hygien or bacteriology or materia medica. Then add to this all the "ins and outs" of theory and practice and surgery. Verily, the task of a faculty to arrange studies so that the student is not discouraged at the start and so that the curriculum has not a hypertrophy on the one side and an atrophy on the other has a heroic task.

Working as we are under graded systems, each year's work should form a part of a complete rounded whole. It is absolutely necessary that a goodly amount of clinical or objective teaching be done, in order that a student may be able to recognize a given disease when he sees it, and to add something concrete to the work.

Metallurgists use a term, limit of elasticity, by which is meant the stress a piece of metal will bear and return to its original condition. A bar of iron may be subjected to a stress a little below its elastic limit an infinite number of times, but once pass its limit, then the bar takes a permanent set and never returns to its former condition. So it is with the human mind. It can work each day up to its elastic limit, but force it beyond this and the permanent set comes, and the capacity for doing work goes.

It is the duty of a *medical* faculty any way to set the pace of its curriculum, not for those of unusual brilliancy but for the average. This I believe is one of the most difficult things to do correctly. Medical men do not differ materially from those in other walks of life, and geniuses are rare. In spite of the fact that there is so much to learn, the rate should be made for the average. The teaching should proceed along a broad free highway, taking care not to implant prejudices for the principles.

Other things being equal the course of study should be finished at the college in which it is begun.

There are usually several ways of reaching the same end. But to cut one year out of one course, and a second out of another, breaks the continuity and does not make a complete whole.

Mr. Lincoln's advice was: "Never swap horses while fording a stream."

The same idea holds good in the matter of text-books. Select on the various subjects some one standard author. Become thoroughly familiar with him. After you have finished your course enlarge your reading upon the broadest lines within your reach. But while in college I am convinced that heterogeneous reading is fatal to thorough scholarship.

To those of you who are thinking of taking up a specialty—a word of caution. The earnest, honest, and skilled specialist is of no mushroom growth. A specialist some one says: "Is a man who knows something about everything, and everything about something." This comes

only with years of hard work and opportunities for large observation.

We teach in this college the practice of medicine according to the homœopathic theory. This does not mean that nothing but the homœopathic methods are ever mentioned.

Your teachers will probably from time to time detail to you some of the modes of treatment of other creeds of medicine.

Do not, I pray you, ever think that a medical education lies in knowing only one point of view, and that all a homœopathic doctor needs to know is *materia medica*, important even as that is.

The homœopathist who would throw bacteriology out of the curriculum displays an ignorance and blindness that is lamentable. Koch and Pasteur are doing more to prove the correctness of Hahnemann's hypothesis than the homœopathists are doing.

We hear a great deal these days of Comparative Zoology, Comparative Philology, and even Comparative Religion.

Why not a chair of Comparative Medicine? provided you could find an incumbent who was large enough to mentally to fill it.

To-morrow morning, ladies and gentlemen, you will begin your year's work.

I trust it will be one of profit and pleasure to you, and that you may find this faculty an inspiring one.

To the faculty I would call to mind a stanza from the pen of one of Ohio's teachers:

"Action is not always gain,
Crystals form when left at rest,
What the teachers leave undone,
Haply may be done the best."

The following address was then presented by PROF. T. GRISWOLD COMSTOCK, of St. Louis:

Officers of the Hahnemann Hospital and Professors of the Hahnemann Medical College of Chicago : It is a great pleasure that I am so fortunate as to be present at the formal opening of your new hospital. I well remember your first hospital opened in 1870, and when passing through your city I availed myself of the privilege to be present at your clinics. This beautiful building is a great contrast to the original one. The opening of this new house is to me tinged with a little sadness, because I recognize only a single one of the old corps of professors, Dr. Ludlam. The others such as Drs. Smith, Small, Beebe, Shipman, Hall, Laning and others have passed away. If they could have been spared to witness the completion and dedication of this new building it would have been a great satisfaction and joy to their hearts. As long as "Old Hahnemann" shall exist their memory will remain precious.

The Hahnemann Medical College of Chicago has now been in existence for more than one-third of a century, and its diploma is an honor and passport for its graduates wherever they may go. This new hospital equipped and furnished in accordance with the most recent advances in surgery will be especially gratifying to the alumni of the college all over the world. To the untiring and indefatigable efforts of the trustees and faculty of the college is this triumph due. Although I am a resident of a rival city, St. Louis, which has also a homœopathic college, and a children's hospital of which we are proud, still I feel no little interest and personal pride in being present with you this evening, and I rejoice with you because you now have both a college and a model hospital where students can be thoroughly trained by didactic instruction, analytical and laboratory work, supplemented by medical and surgical clinics in a modern hospital. The idea once was that a hospital was only a place exclusively for the poor and friendless sick. We are now much better instructed and realize that it is a place where not only the poor can be treated, but where the wealthy (who are seriously ill) can be best treated and cared for, and even better than at their own palatial homes.

In an address that I made as President of the Alumni Association of the Hahnemann Medical College, of Philadelphia, at their Annual Commencement in 1892, while

complimenting the professors of the college because they were early in the field in the adoption of a three years' course of study and three courses of lectures, I then predicted that within another decade, the best medical colleges of our country would require five years of study.

But two years have now passed since the delivery of that address and already the American Institute of Homœopathy at its session in Denver in June last, adopted a resolution governing all homœopathic medical colleges, which requires their students to study four years and take four courses of lectures instead of three. I am pleased to know that this College has at once fallen into line with the requirements of the Institute.

I will now make another prediction, that within eight years, in accordance with the rapid advance of American institutions, the term of medical pupilage will be five years of study, thereby following the example of medical universities in Europe.

It should be the point of the profession in America (and professors in medical schools should be foremost in insisting upon it), that the standard of medical education should be raised, and that in the future candidates for the degree of Doctor of Medicine should be as thoroughly educated as they are in Europe.

In our advance in medical education we have already set Europe an example. I refer to post-graduate instruction, and in this the Hahnemann College is already abreast with the times, as she has such an annual course for graduated doctors.

In all Europe there is but one place where a post-graduate school has been established, that is in London, and it is far inferior to what we have in this country. They have been, however, at last forced to adopt the new American innovation in medical instruction.

In post-graduate instruction a hospital is essential where clinical lectures and surgical operations may be made. This is a great work and was first introduced in America. It is in imitation of what has been so successfully done at Chautauqua where the benefits of a college course can be given to physicians who twenty-five years ago did not enjoy the benefits of the great advances made in medical science such as is given by colleges at this date.

With the clinical instruction which you can now furnish at this new hospital organized and built,

“To minister delights to man,
To comfort man—to whisper hope.”

you are in a position to give a thorough medical education, abreast with everything that is great in this, your wonderful city of Chicago.

“Let us then be up and doing,
With a heart for any fate;
Still achieving, still pursuing,
Learn to labor and to wait.”

After a bright and very clever speech on behalf of the Alumni by Dr. O. W. Carlson, of Milwaukee, a brief address by Prof. H. B. Fellows, Dean of the Faculty, and official announcements by Prof. Cobb, the Secretary, the audience adjourned to inspect the new hospital.

The greatest possible interest centered in this part of the programme. The halls and private rooms were soon filled with eager and admiring visitors, and the scene was beautiful and enjoyable to the last degree. Everything, even to the kitchen outfit on the top floor of the seven story structure, was inspected and warmly commended. The arrangement and comfort of the rooms and the wards; the lighting of the building with the beautiful gas and electric fittings; the furniture and appliances of the operating and sub-clinic rooms, elicited the most hearty approval and appreciation. Neither old nor young among us have ever before received such cordial congratulations, for never before in the history of the institution has there been such an occasion for them as was presented by the opening of this new and commodious hospital.

And so the thirty-fifth annual session of the “Old Hahnemann” was fittingly opened and its new clinical hospital inaugurated in the presence and by the aid of a host of friends, physicians, alumni and students. *Vive la clinique!*

THE NEW HAHNEMANN HOSPITAL.

The following items will interest our readers, and should be a matter of record in connection with the recent opening of the new Hospital building.

At the August meeting of the Board of Trustees the following letter was presented by Prof. Shears :

To the Board of Trustees of the Hahnemann Medical College and Hospital of Chicago :

GENTLEMEN: I beg leave to present my resignation as superintendent of the Hahnemann Hospital, the same to take effect September 1, 1894, or at such prior time as may be most convenient to the members of the Board; and in so doing I desire to express my recognition of the uniform courtesy with which, as superintendent, I have been treated during the eleven years in which I have occupied the position. In presenting my resignation, however, it is not my intention that the interest which I have heretofore taken in the hospital shall be lessened in any degree. The growth of the Hospital has made it impossible for me to give to it the attention which it demands, and I have therefore determined that my efforts must be concentrated more upon my own department, the surgical department, which, in the new hospital, will be prepared to take care of as many patients as could be taken care of in all the departments of the old hospital combined.

When I entered the institution, in 1883, as superintendent, its receipts from pay patients for the year previous were \$2,395.38; its expenses, \$5,498.56. During the last year its receipts from pay patients were \$7,119.61; its expenses, deducting \$712.50 credited to the new hospital, were \$1,150.48. Comparing the receipts and expenditures of the first year with the last year of my administration, we find the percentage of increase of receipts to be 197%, and that of increase of expenses to be 92%, which I consider a very creditable showing.

When I entered the office we had only one regular nurse, depending upon students who received their pay in college tickets, or upon private nurses hired by the physicians in charge for the remainder of the work. During the past year we have had ten regular nurses in constant attendance, beside extra ones for an overflow of special cases.

Then we had two resident physicians; now we have four. Then we had six clinics weekly, made six thousand prescriptions yearly, and furnished the medicine free. Now we have thirteen clinics per week and make twenty thousand prescriptions each year.

The clerical work of the position is constantly increasing. During the past year over four thousand letters have been written in answer to patients, physicians, and applications for nurses' positions. In the ordering of supplies and kindred topics, a large portion of the time of my assistant has been occupied in this and similar work.

My recompense has been the pleasure which I have had in the prosperity of the institution and in the hope that I was doing something toward a larger and finer institution, which, I am pleased to say, is now ready for occupancy, and to the management of which the whole time of an experienced man is certainly demanded.

(Signed) G. F. SHEARS.

Mr. Higinbotham moved, and it was seconded by Mr. Phelps, that the resignation be accepted, that the report of the superintendent be made a part of the record, and that the Board hereby sincerely thanks Dr. Shears for the long and efficient service rendered by him as superintendent of the Hahnemann Hospital of Chicago. The resolution was adopted unanimously.

THE NEW SUPERINTENDENT.—The election of John C. Burt, Ph. C., to the general charge of the hospital came in season for the exercise of his powers in the organization and equipment of the new building. And the result has already proved the wisdom of the choice on the part of the Board of Trustees when they selected him for the place. Mr. Burt has previously had fourteen years' experience in the Illinois State Hospital, first as Supervisor and afterward as Business Manager; an institution with 2,200 beds for patients, and an army of 300 employes, with an average of \$240,000 per annum for ordinary expenses.

THE SCOPE OF THE NEW HOSPITAL.—It is proper to remind our medical friends that with the new and enlarged quarters we are prepared to receive the greatest possible variety of cases and to care for them properly. Under the old narrow arrangement there was not room except for surgical and emergency cases; but now there is, and every department of clinical work is fully equipped and ready for the reception of patients. The scale of prices has been adjusted to suit the times and the needs of those who apply, and it will not be the fault of the hospital staff or of the management if all who come hither are not treated skilfully, kindly and successfully. Correspondence should be addressed to the Hahnemann Hospital, 2816 Groveland Ave., Chicago.

Miscellaneous Items.

The thirty-fifth winter term opened on the 11th inst. with a rousing class and a royal house-warming in the new College and Hospital buildings.—Our worthy namesake, the *St. Louis Clinique*, has come under the editorial charge of Prof. Lanphear, formerly of Kansas City.—Two of our boys, Drs. C. R. Mayer and Gayle Aiken, have been appointed by the Governor of Louisiana on the Board of Medical Examiners.—Dr. Mary H. Landreth has removed to 3307 Cottage Grove Avenue, and Dr. H. R. Böttcher to 70 State Street, city; Dr. Alice M. Goss to 632 Sutter Street, San Francisco; Dr. Francis Peake from Walton, N. Y., to Champaign, Ill., and Dr. Louisa A. Sager has located at N. Baltimore, O.—The N. I. and S. M. Homœopathic Medical Association meets in Elkhart, Ind., September 27.—We sincerely regret the death of our old friend, Dr. Banton, of Waterloo, Iowa, July 27, æt. 66, as well as that of the excellent and beloved wife of our esteemed colleague, Prof. J. C. Sanders, of Cleveland.—Dr. Louis A. Shultz was married September 3 to Miss Annie L. Smith.—Dr. and Mrs. G. Hardy Clark, of Humboldt, Iowa, have gone to Europe for a year's study.—Prof. Vilas and Watry returned safely from Europe in season for the winter campaign.—The current issue of the *Pulse* contains an excellent portrait and sketch of the indefatigable Prof. Cobb, and withal is the best number of that spicy periodical that has yet appeared.—At the "opening" of the Session Bro. Carlson, of Milwaukee, took the prize for the best off-hand speech, as he always does when he consents to be heard from.—Properly enough, Prof. Shears put the first patient into the wards of the new hospital, a man upon whom he had operated before the class for a huge encephaloid tumor of the left femur.—The *Calcutta Journal of Medicine* is a very welcome addition to our list of exchanges.—Prof. Vilas has presented 70 volumes, many of them rare and valuable works on his specialty, to the college library.

THE CLINIQUE.

Vol. XV.]

CHICAGO, OCTOBER 15, 1894.

[No. 10.

Original Lectures.

ON EXTRA-UTERINE PREGNANCY.

A CLINICAL LECTURE DELIVERED SEPTEMBER 27, 1894, BY R. LUDLAM, M. D., PROF. OF SURGICAL GYNÆCOLOGY IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

According to promise I propose to devote this hour to the clinical study of extra-uterine pregnancy. My remarks will be based not only upon the two cases of the kind upon which I operated successfully last week, but upon my former experience as well.

Of the many remarkable results that are due to the recent development of surgical gynæcology none are more striking and useful than those which concern the pathology and treatment of this extraordinary lesion, as well as of its bloody congener, pelvic hæmatocele. Indeed it was only when these twin subjects were taken up and carefully studied by the gynæcologist that the old errors and confusion of the obstetrician concerning them began to be corrected and dissipated. Naturally enough there is not a recent book on gynæcology which deserves the name that does not treat of this very interesting subject.

The terms extra-uterine pregnancy, extra-uterine gestation, and extra-uterine fœtation are usually applied to the forms of conception and of fœtal development that may take place in women outside of the uterus. But not being defi-

nite, they are not suited to the language of modern gynæcology, and I have no doubt that, like the terms peri- and parametritis, they will soon fall into disuse.

Such anomalies of location are ectopic, or out of place, and are in a sense accidental. But even that word does not afford a complete definition ; and since they may concern the uterus as well as its adnexa, I venture to propose a new and more specific title. I submit that to call this form of pregnancy *utero-appendicular* would better accord with our present knowledge of its pathology, as well as with the surgery of those appendages.

Without discussing the question as to where normal fecundation occurs it is enough to say that in extra-uterine pregnancy the fertilized ovum lodges somewhere in the Fallopian tube, or possibly at the surface of the ovary. There it forms unnatural attachments, and the gestation sac begins to develop. If it remains within the tube, there will be a gradual expansion thereof until at the end of from ten to fourteen weeks, through the evolution and pressure of the growing embryo, it will burst and discharge its contents. The point of rupture varies. If the sac is in the pavilion at the outer end of the oviduct, it may be emptied directly into the peritoneal cavity (tubal abortion); if at the inner end of it, interstitial pregnancy, into the uterus ; but if at its middle portion (which is many times the more frequent), it will find the point of cleavage and drop the embryo between the layers of the broad ligament.

This *primary* rupture is the first and principal crisis in the clinical history of extra-uterine pregnancy. It is critical because the escape of the embryo involves the rupture of vessels which may result in collapse and a rapidly fatal hæmorrhage. If the blood accumulates and the woman survives, she will have an hæmatocele with its incidental peritonitis and possible suppuration and abscess. The gelatinous embryo may be broken down by the suppurative process, and then absorbed ; or if its attachment with the maternal circulation is not cut off, it may continue to grow, and so live on until term. Even if the placenta has been de-

tached it may possibly be transplanted and take root again. Lodged within the broad ligament an adventitious sac, or ectocyst is formed, and this may continue to grow and to expand until it fills the abdomen and the child is fully developed. Sometimes, however, this ligamentous sac bursts later on and discharges its contents directly into the abdomen. Such an accident, which is extremely rare, constitutes a *secondary* rupture, and results in what has been called "abdominal" pregnancy. The primary rupture at the tubo-ovarian outlet and the secondary rupture of the intraligamentous cyst are the only possible sources of this form of extra-uterine gestation. The differential diagnosis of the several varieties of extra-uterine pregnancy from each other is impossible before the first rupture has taken place.

The first of the two cases under consideration was sent to the Hahnemann Hospital by Dr. Cornelia S. Stettler, and was shown in my clinic on Wednesday, September 12. The following is the patient's clinical history as furnished by her physician :

Extra-Uterine Pregnancy at the Third Month. Operation. Recovery.—Case 23,015. Mrs. B., æt. thirty-seven, is the mother of three children, the youngest being seven years of age. She has not been strong nor in her usual health since the birth of the last child. Menstruation was regular until three months ago when she was taken with menorrhagia, which she ascribed to an excess of hard household cleaning. The flow was almost constant and at times excessive, the proper period being lost in the irregular return of it ; but it was painless and without clots or shreds. She was given trillin 1, for the excessive discharge and china arsenicum 3, in the interval, with such good effect that the flow stopped for a fortnight and she gained in general strength and vigor. Ten days ago she had the first pain, which came on as she was in the act of lying down ; was located in the left inguinal region, and was so acute and agonizing that she fainted three times in succession and remained in a half comatose condition the whole afternoon. Then the flow returned very severely. There was cold sweat and collapse ; and her family, for she was in a suburb, thought she would surely die at once. She did not send for me, but kept her bed for three days, and

then, although very weak, came in town and to my office. At this visit she told me that just before this attack came on she had first noticed a lump in the left inguinal region, which she could not find after it was over. The abdomen remained quite tender. This led me to make a careful local examination, which disclosed a tumor at the left side of the uterus, and resulted in my diagnosis of *probable* extra-uterine pregnancy. I sent for Prof. Ludlam to see the patient with me; he confirmed my idea of the case, and advised that she be taken to the Hahnemann Hospital for operation without delay.

This clinical picture is exceedingly interesting, for among the causes assigned for such an accident is a diseased condition of the tube following a previous delivery, with a long interval since the last conception.

Seven years of infertility had elapsed since the birth of her last child. This symptom is a frequent and suspicious one in the history of extra-uterine pregnancy. In such cases it is probable that a portion of the mucosa, or of the ciliated epithelium lining the oviduct, is cast off, and therefore the ovum is deprived of its mode of transit, and arrested on its way to the uterine cavity. The spermatozoön having an independent motion reaches the ovum, fecundates it, and the process of nidation is established wherever it happens to be.

The occurrence of a severe menorrhagia in such cases is a frequent source of diagnostic error. It is sometimes, but very rarely, due to the rupture of an interstitial pregnancy with discharge from the foetal sac directly into the uterus, a utero-interstitial abortion. Taken with the absence of menstruation for a month or two, more especially in those who are unaccustomed to it, the physician may easily be led to decide that it depends upon an early abortion. This is especially true if the uterine mucosa is exfoliated. But the absence of uterine pain and the presence of a tumor at the right or the left of the uterus, if you can find it, would be diagnostic of extra-uterine pregnancy, or of pyo- or hæmato-salpinx. In either case it would be very wrong to resort to the curette, while in all

of them extirpation of the tumor is the remedy. It is possible that both tubes may be gravid; or both may be the seat of hæmato- or of pyo-salpinx, the differential diagnosis of which must be considered at another time. The significance of such an attack as this patient had, with the peculiar tearing and unbearable pain in the affected side, which resembles that of hepatic and renal colic, accompanied by sudden fainting, shallow breathing, shock, collapse, pallor, pulselessness and threatened death, is very pronounced. The return of the hæmorrhage and the subsidence of the tumor, so that the patient could not feel it again, were very suggestive, and Dr. Stettler knew enough to interpret their meaning. Evidently the internal loss of blood was not large else the atrocious pain would have continued for hours, and an acute peritonitis would have followed; so that she could not possibly have visited the doctor's office as she did within a few days thereafter.

Under the circumstances when a false diagnosis would probably have been fatal, the doctor's skill in detecting the left tubal enlargement, and in so reading the symptoms as to reach a probable, and a very probable diagnosis of ectopic gestation is much to be commended. For to detect such a lesion when it is present, and not to declare it when it is absent, is the proper thing to do. In fifty of his cases Tait could only make the diagnosis of extra-uterine pregnancy *after* the rupture. The correct diagnosis, the history of the peculiar attack that the patient had already had, and the moral certainty that another and a worse one impended, led us to advise an operation as soon as possible, before the primary rupture of the tube-sac took place. Fortunately that advice was taken and the removal of the pregnant tube was safely accomplished.

Operation. September 16, the operation was made in the hospital before sub-class 3. Laparotomy disclosed a tumor involving the left Fallopian tube, which was distended to the size of the adult fist by a foetal sac. At the point of rupture on the anterior surface some of the vessels had doubtless broken and discharged into the peritoneum

at the time of the terrible paroxysms that occurred just two weeks before. The larger part of the sac was filled with compressed blood clots. The embryo with its delicate, threadlike cord and its smooth compartment, was shown on cutting open the tumor.

The members of the sub-class who saw the operation will not forget the appearance of this ectopic mass as I delivered it through the abdominal incision. Involving the left tube, it was of a dark color especially at its outer portion, where it was very vascular and ready to bleed. This evidently was the site of the placenta, and being its weakest part, it would almost certainly have ruptured there, if Dr. Stettler had failed in the diagnosis, and if the tumor had been left a little longer. There were no adhesions, and there was no free blood or clots in the peritoneal cavity. When the tumor was laid open afterward its bulk was found to consist of condensed blood clots, enclosing the foetal sac with its little embryo. You can pass it around, and you will observe these points and also the tubal decidua that was formed for the nourishment and protection of the miniature tramp. This false decidua is, however, very different from the true one which is formed within the uterus in normal pregnancy.

But suppose that this sac had ruptured at or near the fimbriated extremity of the tube. It is almost certain that the poor woman would have died of abdominal collapse with a concealed intra-peritoneal hæmorrhage, and which would have been sudden in its onset and absolutely without relief, unless the tube could have been exposed and tied off in the shortest possible time. I therefore insist that the patient from whom this product of mal-conception was taken owes her life (1), to an intelligent diagnosis and recognition of the dangers that beset her condition; (2), to a prompt and careful aseptic operation; and (3), to the faithful after-treatment and attention that were given by Dr. Hendy, our house physician, and the nurse.

At an earlier period and with a smaller growth a tubo-ovarian accident of this sort is always a serious affair, ac-

complicated as it is by pain, collapse and hæmorrhage, with a resulting hæmatocele; but rest, remedies, stimulants and especially the reversed position, with peritoneal absorption and time, may possibly effect a cure. In all cases, however, where the tubal rupture and discharge of the embryo is outside of the uterus the true conservative resource is surgical and not medical, electrical, or in any sense expectant.

The second case was a very different one. The subject was a private patient of Dr. N. C. Kemp and Dr. O. G. Tremaine, our excellent lecturer on physiology. At the request of the latter I saw her in counsel with himself and Prof. Leavitt on Sunday, September 16. She had first been in the care of Dr. Kemp, who gives the following history thereof:

Extra-Uterine Pregnancy at Term. Removal of a Dead Child Weighing Eight Pounds. Recovery of the Mother.
—*Case.* On the morning of January 2, 1894, I was called to see Mrs. —, æt. 26, the mother of two children, the youngest four years old. She said that she had on the previous evening exchanged her heavy winter clothing for an evening dress and had gone to a ball; that she went in a carriage, but had been quite chilled on coming home. She was resting quietly in bed, although she had had severe abdominal pain, accompanied with vomiting during the latter part of the night. The menses had appeared the day before, but had stopped with the chill; a month previously the flow had been slight, and she supposed she was pregnant. Her temperature was 101° , and the nausea continued, with a moderate tenderness in the left ovarian region. She had been prescribed for by myself before for ovaritis, from which she suffered at intervals. I advised quiet in bed and left some remedies. During the day I was called in haste to her bedside, the messenger saying that she was suffering great pain and was vomiting. These paroxysms of pain, usually accompanied or followed by vomiting, continued to be the order of the day, and of the night too, for six weeks, in spite of all remedies. Her temperature was never above 102° . As the nausea simulated that of pregnancy, I thought that to empty the uterus of its contents might effect a cure of it, and I accordingly curetted her on the 17th of January. No fœtus was found in the

cavity of the uterus, and a very moderate amount of blood and débris was the only result of the curettement. There was no abatement of the nausea, although the patient was relieved in her own mind somewhat, for she was strongly impressed with the belief that pregnancy was the cause of the gastric trouble.

This condition with slight variations continued until early in the following month, when she began to retain some food, such as koumiss and clam broth. She was out of bed by the first of March, but could walk only a little, nor could she up to the time of my leaving the city on March 20. The sickness of the stomach had at this time almost disappeared. The pain and vomiting all through the case was that of peritonitis.

Dr. Tremaine's notes are as follows: I first saw her April 2. She was up but had considerable pain in the pelvic region, especially on the left side; some days she was able to walk three or four blocks, at other times motion aggravated the pain. About May 1st she first felt foetal movements; then she became stronger and went East for several weeks. For from five to seven months she had most of the time but little pain from the foetal movements. Quite severe pain having developed, I made her one visit July 18, after which she twice called at my office: so that in four months I saw her but three times. August 27 she had quite severe pain for several hours. September 13 I was again called for the relief of pains resembling the false pains of labor. *Believing that I had a case of extra-uterine pregnancy to deal with*, I called Profs. Leavitt and Ludlam in consultation.

When the gestation sac has become intra-ligamentous, as it almost always does, the nature of the tumor is more easily determined by a careful pelvic search. It is lower down in the pelvis (but not so low as in retroversion), and there is a marked increase of its size because of the accompanying hæmatocele. This peculiar hæmatocele is styled extra-peritoneal because the hæmorrhage is into the cellular tissue lying between the two folds of the broad ligament, and not into the free peritoneal cavity. By dissecting those folds and distending them it may continue so as to form a large, bulging or boggy tumor.* If it occurs

*For such a case see Ludlam's Clinical Lectures on the Diseases of Women. Sixth edition, p. 428.

in the left side, that tumor may push the uterus to the opposite side of the pelvis; or, if it is moulded about the rectum, it may cause an annular stricture of the bowel. But usually the resisting tissues of the broad ligament furnish a safeguard against an excessive and fatal loss of blood by the direct compression which they afford. Moreover, the fracture of the tubal wall with the discharge of its contents directly downward toward the pelvic floor, is less likely to involve the larger veins and vessels than if it occurred at almost any other point.

Besides a self-limited hæmorrhage and a circumscribed hæmatocele there are other clinical possibilities that may result from this contingency. In such a nest the embryo is more likely to live than if it had been thrown overboard into the peritoneal cavity. In case it is destroyed it is more safely disposed of along with the contents of the sac; and if an intra-ligamentous abscess finally results, that will be accessible and can be treated by tapping, or incision and drainage. If its development continues the encysted fœtus is inclosed within the broad ligament in the same manner, but more completely, as happens with a parovarian tumor. As the child grows the sac, which is always lateral, enlarges in an upward direction until it fills the abdomen, when its surface may become intimately attached to the peritoneum lining its parietes.

While the surrounding tissues are being changed there is dilatation of their vessels and increased determination of blood to the foetal tumor, which is always immobile, and which, as a rule, is not as sensitive as other pelvic growths. As with this second case, there is, however, an inability to walk freely, and easy fatigue on motion. The pelvic pains may cease at quickening, or they may be excited by the movements of the fœtus. Perhaps the most singular feature of this condition is the remarkable exemption from peritonitis, which, while it lessens the incidental suffering, protects the life of the mother and permits the development of the child. As the case progresses the usual self-limited symptoms of pregnancy, such as nausea and vomiting, the

growing abdominal tumor, the changes in the breast, etc., are present. and, if the patient consults her physician during the latter months, it will be for the relief of some casual and transient difficulty.

And so it may happen that the doctor will have no occasion or opportunity to make a diagnosis of the actual condition, nor to recognize a deviation from normal pregnancy until he is finally called to the patient when she is supposed to be in labor. Dr. Tremaine had seen the case under review but three times in four months, and then, finding the pains spurious and the labor a false one, with a total cessation of the foetal movements and signs of its death, he recognized it as one of extra-uterine foetation and very properly insisted upon additional counsel and help. The patient's general health was breaking down very rapidly, her nights were wretched, with little sleep, much pain, anorexia, and a pulse of from 120 to 130.

The peculiarities of this kind of false labor, where the child has lived to term in extra-uterine pregnancy are that, although the pains may be regular, there is no hardening of the tumor while they are on; the discharge from the uterus is slight and unnatural, with the expulsion of shreds and bits, or of an entire cast of the uterine decidua; and only a slight dilatation of the cervix, the uterus being empty, undeveloped and lying at the side and low down in the pelvis. These symptoms may continue for from a few hours to a week or more. The escape of the foetus by the natural outlet being impossible, the result is that its life is the penalty: its movements cease, the foetal heart sounds can no longer be heard, and its delivery goes by default. In such a case of missed labor, or impracticable labor, the pains may subside and the system accommodate itself to the unusual condition in a conservative way. Sometimes the child is carried within the mother's body for months, or even for years, without any very serious consequences, and finally disposed of by the absorption or transformation of its soft parts, and the ulceration and discharge through the rectum, the vagina, or

some other extemporized outlet of its bony members. Sometimes it shrivels and undergoes a calcareous degeneration (lithopedion), in which condition its presence may be tolerated for an indefinite period.

After the death of the fœtus, in such a case as this, certain symptoms are remarkable and very suggestive. The breasts which have filled with milk, become flabby, the abdominal tumor is shifted toward the opposite side, its volume diminishes and, with the cutting off of the fœtal circulation, the placenta begins to shrink and detach itself. These conditions favor a resort to operative interference for the removal of the dead fœtus, because the absorption of the liquor amnii, which makes the fœtal outlines more distinct, lessens the risk of sepsis, and the partial closure of the placental veins diminishes that of hæmorrhage; so that it may be safer for the mother if we remove a dead than a living child. This explains the fact that in only a very few cases have both the mother and the child been saved by operation in extra-uterine pregnancy. And it also gives a warrant for the advice *not* to operate upon such a case after the inclusion of the embryo within the broad ligament until term or later. In this case there was no option, for the child was already dead when the doctor arrived.

Operation. On Thursday, September 20, I made an operation in this case at the patient's home. There were present Drs. Kemp and Tremaine, Profs. Leavitt and Honberger and my two assistants, Drs. R. Ludlam, Jr., and C. S. Stettler. The incision disclosed the fœtal sac, which was nowhere adherent to the abdominal parietes. With proper peritoneal precautions that sac was opened, and a female child weighing eight pounds was quickly removed through the wound, as if it had been a Cæsarean section. The large umbilical cord, which was flabby and pulseless, was clamped with two pairs of forceps and cut. The child was dead, its epidermis peeling off here and there as if it had been macerating for some time. The field of operation was thoroughly cleansed and the sac stitched to the margin of the wound with a running suture of catgut. The peritoneal cavity was entirely shut off; the cord was left at the

lower angle of the wound ; a glass drainage tube was inserted ; the placenta was left undisturbed and the wound closed and dressed in the usual way, the strictest aseptic precautions being observed.

Fortunately the placenta did not lie in the line of the incision but was attached at the left and out of the way. In three of my former operations I have cut down upon it. One of them was in a patient of Prof. Bailey, and the placenta was not only beneath the linea alba, but it was badly disorganized and extremely vascular. The woman died a few days later of sepsis. Of the other two, one was saved.

In the case of which we are speaking, however, we had to contend with another source of danger that is almost equally serious. The fœtal sac was entirely separate from the abdominal parietes. It had not formed the usual anterior attachment that furnishes such a safeguard in many, and perhaps most cases of the kind. It was therefore impossible to make an extra-peritoneal operation, for the incision of necessity exposed and opened the peritoneal cavity. By careful sponging, and by stitching the retained cyst wall all around with the special suture, the placenta was shut in by itself and abdominal infection was rendered impossible.

I have often said that in some of these operations, it takes more pluck and courage to stop than to go forward, and it certainly is so when you feel and know that it is best not to detach, or in the least to disturb the placenta in a case like this. When you remember that it takes from one to two months or more from the death of the child for the placenta to come away piecemeal or *en masse*; and when you reflect upon the risks of sepsis and pyæmia from the decomposing and purulent changes in the retained placenta, you are tempted to tear it away at all hazards. But that will not do, for the utero-placental circulation in a case at term is chiefly venous, and may persist for a long time ; besides which, if you tear it away from an ectopic cyst there is no such possibility of arresting the hæmorrhage

as there would be if the bleeding surface was where the uterus could contract upon it as it does, or should, in ordinary post-partum hæmorrhage.

[The first of these two cases had a typical convalescence. At the tenth day after the operation the menses returned, continued for three days and were normal in every respect. October 11, she left the hospital for her home in an excellent condition.

The second one, thanks to the unremitting care of Drs. Tremaine and R. Ludlam, Jr., and the most faithful nursing, has also done well. The pulse varied from 110 to 138, and the temperature from $99\frac{1}{4}^{\circ}$ to $103\frac{1}{2}^{\circ}$, the former falling to 96 and the latter to the normal on the nineteenth day. On the seventeenth day there was an active hæmorrhage into the sac, which was relieved by filling it and packing it tightly with iodoform gauze. She is now, October 15, at the end of the fourth week, eating and sleeping well and sitting up in bed with every prospect of a certain recovery. The placenta is coming away piecemeal, most of it having been already discharged.]

AN ADDRESS

DELIVERED BY M. H. WATERS, M. D., PRESIDENT, AT THE MEETING OF THE INDIANA INSTITUTE OF HOMŒOPATHY, AT INDIANAPOLIS, JUNE, 1894.*

As a Society we have congregated from our different fields of labor at an expense of time and material substance. It is for us to determine the extent of the beneficial results which may accrue to us. It has been my earnest endeavor to serve you with fidelity and I bespeak your hearty coöperation in the effort to make this the most helpful session the Institute has ever held. This will in part compensate our loss in the omission of the session of last year. The necessity for this omission is to be regretted for other than professional reasons. Physicians as a rule do not occupy the prominent position in public and social life for which their endowments and training qualify them. This arises no doubt largely because the demands of those in distress are so exacting, that when relieved from these, the desire for rest causes them to forget

*Published by request.

that they are not physicians only. This leads them to undervalue the privilege which our meetings, both state and national, afford not only of advancing themselves in their chosen profession but of renewing old friendships and forming new acquaintances. That we may make the most of such opportunities I recommend that more attention be given to making the acquaintance of new members, and promoting good fellowship among all those in attendance.

This contact with others who in different fields and with varied experiences are devoting themselves to the same work, enables us for the time to live beyond the narrow confines of the little world in which our daily routine duties tend to limit us. We realize that there are generous hearts, broad and cultivated minds, acting in unison with our own, whose touch is an inspiration which prompts to increased effort, and stronger determination to make ourselves more worthy of the confidence and esteem of the profession. While it is a source of great pleasure to extend the hand of greeting, to enjoy the social privileges, and reap the benefits of our sessions, we must not overlook the fact that we are not here for ourselves alone. We are representatives of the medical profession in Indiana. In unison with those of our school of medicine in other States, we claim to occupy advanced ground. The basis of this claim is, that in addition to the armamentum of other schools, we have a scientific principle, a natural law to guide us in applied therapeutics, a law which removes the practice of medicine from the domain of empiricism, and makes of it not only a science, but an exact science. To use this law successfully requires more thought and careful individualizing in each case, and a more definite and fuller knowledge of the action and relations of each individual drug used than any other method of practice. To secure this has been the constant purpose of our school from its inception, and we still have the honor of being the only one to thus carefully study drug action upon the healthy body. By this method we also avoid the danger of mingling pathogenic symptoms with those produced by disease.

The formulating of these symptoms and arranging them in our materia medica in such a manner as to make them available in the treatment of disease has been an important and a very difficult work, and it is one that is far from being complete. From a lack of knowledge either through defects of our materia medica, or from an imperfect mastery of it, rather than from any limit in the scope of the law, must we attribute our failures. But even

these failures, as well as our successes, may aid us if we properly use them. Instead of resorting to polypharmacy, the easier but less successful method, we should be students, ever on the alert for some new pathogenic fact; or earnestly seeking to unfold or make some new application of one that is imperfectly understood, and not be content until we have solved the problem by finding the desired similitum. This is not infrequently a difficult task. To make the application of the law, "Similia," less difficult and more exact is worthy of the intelligent, persistent effort of every follower of Hahnemann. The failure on the part of some to do this, and the diversity of opinion relative to dose, method of administration, and frequency of repetition have been pointed out as evidences of a process of disintegration which is sure to work our destruction.

But these are not new phases in the contest. They have served year by year for the past century as a basis for false prophets to predict our early demise. But investigation does not show that there is any occasion for alarm. Admitting that an increasing number does not promulgate their therapeutic views by signboards; it is not that they adhere to them with less fidelity, or that any considerable number of professed homœopaths ignore them. To make the statement positive, they do not fail to subscribe without reservation to our basic law, "Similia Similibus Curantur." Neither should we overlook the fact that it is only a few years since the majority of homœopathic physicians were recruits from other schools, and therefore in need of special knowledge to successfully apply this new therapeutic law. But notwithstanding the additional work required, they so completely divorced themselves from their former methods that many of them have become bright exponents of the new faith.

Ostracized by their former colaborers, they formed closer relations with their new allies. Thus they found that many of the seeming incongruities did not exist, while others were merely the results of individual hobbies, and were not in accord with homœopathic principles, nor accepted by representative leaders.

It is interesting to review the steps by which medicine has reached its present position. Its progress has apparently been marked by cycles, each with its distinctive features. The right of each to remain has been determined by that cruel arbiter, the empirical law of experience. Retarded often by a factor or semblance of truth which the theory contained, or by the popularity or prestige of the

originator, this tribunal has at times been slow, yet invariably just in its decisions. While this law has added nothing to our fund of knowledge, it has blest mankind by eliminating much of error. Were proof required we need only to follow the course of the history of medicine and point to "the way," which all along is strewn with the wreckage of endless theories and expedients. By degrees, as the nature and causes of different diseases were better understood the fact was conceded, that though often modified in their course by extraneous influences, they were governed by fixed laws. By the side of this and parallel with it, was developed that other fact, that there were just as positive laws which regulated and governed drug action. While using one to control the other, they failed to discover that they sustained any fixed mutual relation. It was left for Hahnemann to point this out, and give it a practical value. Many outside of our school while admitting that drugs often do act as we claim, and that they have a primary and a secondary action are yet unable to grasp the truth in its entirety. To do this requires at some points, the exercise of a certain degree of faith. There are powers and influences operating and inherent in drugs, and in disease, which even now we do not fully understand. We designate them by certain names, such as energy, force, spirit and the like. We can as yet trace their action only within certain limits; beyond these we must accept results, but we cannot explain the process by which they are attained. Plausible theories have been advanced, but their right to acceptance is not established. That these limits to our knowledge are not fixed points is certain, for at no period in the history of medicine have such prolific fields for investigation been opened, as the present day affords. These are rendered doubly so, not only on account of their extent and richness, but because of the ever increasing facilities for exact investigation which modern methods and improved apparatus afford.

To describe these processes or enumerate the results, is not within my province, but permit me briefly to refer to the additional light thrown upon the causes and complications of zymotic diseases by the investigation of bacteria and their products. They have established the fact that many symptoms in disease are caused by these products, and by other basic substances formed in animal tissue during normal life; and it is a significant fact that in vegetable tissue similar basic substances are formed, and that many of these vegetable products hold prominent places as curative agents in this class of diseases.

They have also shown that our bodies are not defenseless against the ravages of myriads of microorganisms which seek to destroy them; but that it is the province of wandering white corpuscles to act as guardians of living tissues and to seize invading bacteria and destroy them. This increased knowledge of infectious diseases has led to improved methods in sanitation and given prominence to preventive medicine until now it is considered possible not only to hold in check, but to stamp out diphtheria, cholera and kindred diseases.

If I read the signs of the times correctly, consumption in the near future will take its place with these as a preventable disease; and the same care will be exercised in disposing of the expectoration and dejections that is used in cholera or diphtheria. To accomplish this, the masses must be enlightened until they learn its necessity. Now they would consider the repressive measures necessary in the home, in the public assembly, and the public conveyance to secure this result as too severe. In this educational work as in all advanced ground occupied in medicine, we as a school should be found in the van. By the continual increase in our membership, we have reached a point where it is impossible for the president unaided, satisfactorily to assign the entire membership to the different bureaus. To secure the best results some feasible plan for doing this should be adopted. * * * *

The resulting demands of this progress have made necessary a division of work. The time when all that pertained to medicine and surgery could be embodied in one man is relegated to the past, and has made the specialist a necessity. As the different departments or sections thus formed are developed, further segmentation will certainly be required. But the physician of the future must be more than a dispenser of drugs, or the skillful knight of the scalpel. He must not only be able to correct the ailments of his patient, but must teach him how to become a patron rather than a patient. To do this he must outline habits and methods of correct living, and by physical culture correct weak points resulting from heredity. Understanding the laws of health as well as those of disease, he must be able to detect any deviation from them, and recognizing danger signals, he must give timely notice of even the insidious approach of disease. He must in fact become the custodian of the health of his patrons, and answer more frequently the question, Doctor, am I in perfect health to-day?

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

SEPTEMBER MEETING, 1894.

The regular monthly meeting of this Society was held in the amphitheatre of the Hahnemann Medical College Saturday evening, September 29, the President, Dr. B. S. Arnulphy, in the chair. Beside a good attendance of the members, a large number of students from the medical class were present. The following papers were read and discussed:

XXXIV. TORTICOLLIS OCULARIS, By C. J. SWAN, M. D. At the June meeting of this Society I presented a patient suffering from spasmodic wry-neck, a disease of three years' standing, during which time the patient had been treated by all the known methods by many different prominent physicians. One interesting feature of the case was the care with which he had recorded each diagnosis (and the diagnoses differed widely), by whom made, and the treatment. In my paper printed in the July issue of the CLINIQUE (page 349) I gave my own diagnosis, reasons for arriving at that conclusion, and my method of treatment. At the time he was before the society he was slowly improving after being in my hands for two weeks. Within a month he was apparently a well man, and up to one week ago when I heard from him from Detroit he had had no return. The treatment consisted in carefully correcting refractive errors, which were of a high degree, with glasses, and his muscular errors by means of graduated tenotomies.

Now I consider this an extremely interesting case, and I will tell you why. The question whether refractive or muscular errors, or in a word, eye strain, is a cause of serious functional nervous disorder is probably to-day more in discussion and is occupying more of the attention of the profession than any other one question. It is discussed everywhere, in our special journals and in our general journals, in ophthalmological societies and in general

medical societies. Here we have a perfectly healthy man with no hereditary taint, no personal vices, no history of traumatism or of anything else to account for a nervous disorder so serious as to disable him from following his occupation. We have a detailed history of his treatment, which comprised all sorts of internal and local treatment and mechanical appliances, as used by the best known nerve specialists in our part of the country. I do not claim any special credit for making the correct diagnosis. Every other one had been proven to be wrong, and the whole history of the case pointed to the eye as the reflex cause of the disorder. Others had not this history before them in all its completeness. However, the correct diagnosis was hit upon at last, the eyes were systematically treated, and a cure resulted. This case is especially interesting for this reason. It proves as far as one case possibly can that eye strain is sometimes the cause of nervous disorder. No one can say of this case that the cure was the result of suggestion; that the cure was due to the physical effect of the operation and that any other operation would have done as well. This man had had all sorts of things done to him by men much more imposing than myself and without any result whatever, but when the eye strain was relieved a cure followed as day follows night. In a person of less sound nervous make-up this reflex irritation might have resulted in explosions of the cortical cells—epilepsy. Later I hope to make my second report upon the eye treatment of that disease. In closing let me guard against any mistaken conception of the meaning of this paper. It does not mean that every case of wry-neck is ocular in its origin, but it does mean that before the examination is complete, in functional nerve disease, the eye must be looked to and it will be found as often at least as other parts to be the seat of the reflex irritation.

XXXV. SUGGESTIVE THERAPEUTICS. By DR. B. S. ARNULPHY. A change is coming upon the face of medical thought. After having busied itself most industriously with the multitudinous details of the material structure of man, our century, now drawing to its close, (in its dotage, some malicious people might say), seems to have suddenly discovered that the mind, no more a negligible quantity, had really something to do with the human body, in disease as well as in health.

There comes to us from skeptical France a small book

due to the pen of Dr. A. Cullerre, the title of which is in itself a program and a revelation: "*La Thérapeutique Suggestive*."*

It is a survey, couched in clear and brisk language, of the advance lately accomplished by a phalanx of progressive men in the medical aspect of hypnotism. One perceives immediately that the author is not a dreamer, but a man of a positive, even critical, turn of mind, a scientist and a thinker. All the more remarkable do the facts appear which he presents and ably discusses, all the more fascinating the subject and hopeful the horizon thus disclosed.

I have thought that a brief review of the work, bearing mainly on the clinical results obtained, would interest this society.

While according to Charcot and the Salpêtrière school their due need of praise, one sees that the author is ready to recognize the greater value of the work and claims of the Nancy school, represented by Liébaux, Bernheim and their following.

Charcot and his school have only made use of hypnotism for experimental purposes, and restricted it to the comparatively limited area of hysterical disturbances. Liébaux and the school of Nancy, on the contrary, take a broader and more practical view of the question, and would extend the application of hypnotism to therapeutics.

The great merit of the school of Nancy, in my estimation, is to have simplified the conception of hypnotism, and done away with all the paraphernalia of mesmerism and animal magnetism. While the Charcot school persists in considering hypnotism as a functional disturbance of the organism, a sort of artificially induced neurosis, more or less smacking of hysteria, Liébaux's school takes the ground that all the phenomena of hypnotism are due to the exaltation of a physiological disposition common to all, viz: *suggestibility*.

Viewed in that light, hypnosis or provoked sleep, is nothing but a *mental state* in which susceptibility to suggestion is heightened. It follows from this that suggestibility exists apart from hypnosis, that is, that people are open to suggestion in and out of hypnosis.

"Suggestion, says Dr. Bernheim, is the act whereby an idea is introduced into the brain, *and accepted by it.*"

* "*La Thérapeutique Suggestive et ses Applications*" par le Dr. Cullerre, Paris. T. B. Baillièrè et fils.

This last condition is indispensable. If the brain refuse the idea presented to it, and will not try to act upon it, suggestion will remain inoperative. Suggestion, therefore, supposes receptivity, a passive faculty which varies very much among individuals, and goes by the names of confidence, faith, credulity, belief.

This disposition to believe is inherent in the human mind. We are all bound to believe in our own existence, in the exterior world; we are instinctively prone to accept an affirmation and only repel it, if upon reflection it is found to shock our reason. In fact, do we not live in a world of suggestion? Is not the best part of our lives devoted to working out suggestions unconsciously absorbed? Thus firm belief appears to be an automatic tendency of our brain; and the more our psychic automatism is developed the greater our suggestibility.

In the normal state, few people are endowed with sufficient credulity to accept and act upon a given suggestion without some degree of resistance, unless the suggestion be spontaneously developed, or be made to penetrate the brain in an indirect way. No doubt the regular epidemics of cures accomplished by alleged miraculous agencies, or by such celebrated healers as Gassner, Greatrakes, Cagliostro, belong to the latter order of facts. And nowadays the same agency is visibly at work at Lourdes.

The idea of cure, borne on the wings of a firm belief with irresistible power, implants itself in the mind of the subject, annihilates his judgment, wipes out his reason, and tends forcibly toward its own realization, with the result that if no irreparable organic lesion stand in the way, it *does* attain it. But these are exceptional cases. In order to make *verbal suggestion* acceptable to the generality of subjects, a particular state of the brain is to be obtained in which the spontaneous activity of the organ is inhibited, leaving it open to external incitations. This is precisely the mental state created by hypnotism.

No patient, be he ever so intelligent, can resist the influence of hypnotic suggestion, if only the hypnosis be deep enough. If it be allowed that the idea of a cure effects a cure in many cases, there can be no doubt that suggestion is an integral part of therapeutics.

Some of the figures presented by the author are significant. Thus, according to the most authorized exponents of the Nancy school 80 per cent of all subjects are susceptible of hypnosis and therefore of suggestion.

Prof. Bernheim furnishes 105 cases of various affections in which suggestive therapeutics have yielded the following results: 90 cures; 12 ameliorations. Van Renterghem and Van Eeden out of 414 recorded cases have obtained cures, 100; amelioration, 190; negative results, 71; unknown results, 52. Lloyd Tuckey, of London, reports 500 cases treated by suggestion, in the main with success. Mr. Bérillon gives the results obtained in his clinic for nervous diseases; in the course of eighteen months 360 patients are reported cured, of which 265 were women, 50 men, and 45 were children.

This enumeration could be considerably lengthened, but it is not necessary.

The healing power of suggestion is now a well-established fact. The time is rapidly coming when no educated physician will be excusable for ignoring the resources afforded by the suggestive method in the treatment of disease.

As to the dangers of hypnotism, they are more imaginary than real; for it will be found that suggestion, when properly used, is at least as harmless as electricity.

It is perhaps too much to say that the more substantial part of therapeutics is its "mental aspect," and that the measure of success of the physician resides in the confidence that he inspires; but I feel convinced that hypnotism and suggestion will one day thrive and flourish, to the benefit of all sufferers, when most of the medical creeds and crazes of the present day have long been forgotten.

I will now outline a brief review of the clinical results presented by our author.

Here is a very interesting case from Dr. Burot :

Woman of twenty-eight, married, mother of three children; has been an hysterical subject since the age of eleven, at which time the first convulsive attacks appeared. For the last six months, under the influence of fright, the attacks have been very frequent, lasting sometimes a few hours, and accompanied by extensive movements. In the interval of the paroxysms the patient was subject to migraine and gastralgia. There was anæsthesia on the left side of the body, no analgesia; diminution of the visual field, deafness, anorexia. Marked hyperæsthesia of the left ovarian region. Alterations of motility confined to the inferior limb on the right side.

The attitude of the patient is that of coxalgia; the limb is in extension and apparently shortened; the foot in

outward rotation. There is a peculiar claudication ; the woman drags her leg so as to avoid the movements of the hip joint; she complains of pain at the hip and knee. There is a marked contraction of the vagina.

The patient presents in a high degree a tendency to muscular contraction, and the slightest pressure on either of the limbs provokes tonic contraction.

Hypnotism was at once resorted to. To produce sleep it was sufficient to lay the hand flat on the forehead and to tell her to go to sleep. After the third sitting, deep hypnosis (fourth degree) was obtained, with loss of memory, on waking. The convulsive attacks ceased after three sittings ; since then no hystero-epileptic attack has appeared.

After fifteen days of treatment the coxalgia had disappeared. A number of surgeons, friends of Dr. Burot, who had examined the patient, did not hesitate to declare that had the woman been in their hands, they surely would have immobilized the limb.

The rebellious vomiting with which the patient had been afflicted every morning for years past, was promptly stopped after three or four suggestions. The gastralgia disappeared likewise, and the appetite progressively returned. The menstrual flow which had been almost entirely suppressed for a long time, was recalled by suggestion; it now appears and stops at a given order. The bowels have been regulated in the same manner. When ordered to do so, the patient would have three or four operations a day.

A refreshing sleep has replaced the former insomnia, and the most persistent foe of all, the constant migraine has left her entirely.

This sounds almost like magic. Still the case is perfectly authentic. But all cases of hysteria are not influenced so favorably by the hypnotic method of treatment.

Prof. Pitres states that two-thirds only of the female cases of hysteria are hypnotizable, while in the male the proportion is only one-third. It also happens that subjects who once were easily put to sleep, are found to be refractory later on. On one point all observers are agreed, viz., that the older the trouble is, the more liable will suggestive therapeutics be to failure.

Remarkable cases are cited showing the wonderful power of suggestion in dispelling the many disorders of sensibility and motility due to hysteria, as paraplegia, con-

tractions and long-standing deformities resulting therefrom, also amaurosis, deafness and mutism.

The same good results are obtained in visceral hysteria. As everyone knows who has had such cases to deal with, one of the most intractable diseases of that order is chronic anorexia. These are precisely the cases in which suggestion seems to be most efficient. Visceral hysteria may appear in the guise of excessive polyuria, and at times assume the garb of pseudo-angina pectoris.

The author reports two cases of polyuria observed in male hysterical subjects. In one case the patient, although the flow of urine did not exceed six or seven quarts in the twenty-four hours, was losing strength rapidly. A permanent cure was obtained by means of suggestion, in a few sittings.

In the second case, the flow of urine was enormous, varying between twenty-two and twenty-five quarts a day. It was possible, under the influence of suggestion, to reduce the flow to seven quarts, but the amelioration did not prove permanent.

As to the case of pseudo angina pectoris, I wish I could cite it "*in extenso*" as it certainly deserves, but space forbids. Suffice it to say that the patient, a young woman of twenty-three, suffered for years with severe attacks, that she was successively treated for myocarditis, for muscular rheumatism of the heart, etc., without any avail, until finally she was induced to take hypnotic treatment at the hands of Prof. Bernheim, who cured her completely in a few sittings. He simply affirmed, while she was asleep that the attacks would never return, and they never did.

It is well known that Charcot's teachings would lead one to believe that hysteria is the only field in which hypnotism will flourish and yield therapeutic results. That such is not the case we have superabundant proof in the numerous instances of varied forms of disease, cited by the author, as well as in cases adduced by scores of scientific and reliable observers, who have been testing the resources of hypnotic suggestion within the last few years.

It now looks as though it might confidently be stated that the whole tribe of functional disorders of the nervous system are to a large extent amenable to suggestive therapeutics. In fact this seems to be the true sphere of action of this new (to most of us, at least) and promising branch of the healing art.

Take for instance neurasthenia. This is, it will be

admitted, a rather ill-defined affection, though alarmingly on the increase. An affection with an insidious march, a slow evolution; with which the physician generally comes in conflict when it is pretty deeply anchored in the system, and consequently with but a doubtful measure of success, irrespective of school or creed.

Here it is that suggestion shows its full value. The author cites a most interesting case from Dr. Berillon, of a man in a high official position, who as a result of bad hygienic habits and excessive intellectual work had become a wreck in mind and body. A prey to insomnia, with no trace of appetite, almost constant precordial anxiety, and the sensation of an ever increasing numbness: although able to command the most enlightened care, he was steadily growing worse, and had reached the stage where suicide appeared as the only relief, when he was prevailed upon to try hypnotism. In the course of three weeks of suggestive treatment, Dr. Berillon says that all the untoward symptoms had disappeared, that sleep, appetite, vigor of mind and body had returned, and that the patient had returned to his arduous duties.

Among the functional disorders that suggestion has cured, I will cite all forms of neuralgia, sciatica included, epilepsy and chorea. Nor is the cerebro-spinal axis alone visibly influenced by suggestion, but also the sympathetic. If physiology had not already shown the existence in the brain of centres, the excitation of which induces nervous action, whether motor, sensitive, or secretory in distant organs (thus demonstrating the real though latent influence of the mind on the vegetative functions of life), hypnotism would have supplied the proof.

Prof. Beaunis has shown how the cardiac action can be accelerated or slackened by suggestion, without any alteration of the respiratory rhythm. The therapeutic application of this experiment to tachycardia, and certain forms of exophthalmos is obvious. In one case of excessive palpitation accompanied with precordial pain and anxiety I have succeeded in dispelling the distressing symptoms after two sittings.

Likewise is the vaso-motor innervation under the sway of suggestion; witness the cases in which Dumontpallier and Krafft-Ebing have been able to bring about partial congestion of different parts of the body with a rise of temperature. No wonder, therefore, that the suggestive method should be so successful in controlling and regu-

lating the disorders of menstruation, clinical evidence of which is not lacking, for quite an array of instructive cases is presented by Liébault, Bernheim, A. Voisin, Burot, Gascard, etc.

Nor does the scope of suggestion seem to be limited to the functional disorders of the nervous system. Almost all the physicians who have experimented with the new method have published cases tending to demonstrate that it may render important service in acute and chronic affections *cum materia*. In cases of this sort the psychotherapist takes very good care to point out that he does not pretend to modify the lesion itself by means of the suggestive process, but he claims to be able to inhibit and suppress the functional disturbances set up by the said lesion.

We all know that a great many painful sensations are provoked at a distance by certain lesions without any direct link between the latter and the pain arising from them. Some diseases of the bladder, the kidney, the uterus, the liver, the heart, the lung, are well capable of setting up intense neuralgic pains in distant plexuses. From the medullary centres corresponding to diseased organs, incitations are started which irritate neighboring centres, thus bringing about the most unexpected morbid associations. Is it unscientific to admit that the inhibiting influence of suggestion may to a certain extent control such sympathetic or reflex disorders?

It seems to me that if we admit the efficacy of suggestion in the sphere of functional nervous troubles, we are bound to admit the possibility of its action in reflex neuralgia, inasmuch as the painful symptoms in such instances are practically independent of the original lesion.

Some hypnologists go farther than this. They claim that it is possible in some cases to modify and even suppress the organic lesions themselves. The gist of their plea is that the functional disorder being removed, the corresponding lesion will in its turn be modified in an indirect way. The irritative congestive perturbations upon which the lesion fed, so to speak, being allayed, the nutritive exchanges being restored to a normal condition, the lesion will slowly fade away.

All that can be said on this all-important question, is that while we all would hail with delight the day when these therapeutic deductions can be supported by extensive and unimpeachable clinical evidence; and while it

would be unphilosophical to deny any such possibility from *a priori* considerations, especially if we bear in mind the wonderful effects of suggestion upon the domain of organic life, still as practitioners of medicine we are bound until further notice to take such statements with a grain of salt.

The author cites a number of cases of acute disease, typhoid fever, pneumonia, hepatic colic, in which the painful symptoms have been controlled by suggestion. But it does not appear that any modification has occurred in the evolution of the corresponding lesions. Still there is one case of Asiatic dysentery which yielded remarkably well to suggestive treatment after all other means had failed.

The oculists may be surprised to be told that Dr. Delbeuf has successfully treated by suggestion many inflammatory lesions of the eye.

Bernheim reports instructive cases in which the peripheral phenomena of anæsthesia, contraction or motor incoördination attendant upon central cerebral lesions have been entirely cured. In some instances the influence of suggestion had to be supplemented with applications of the magnet. But among spinal affections, locomotor ataxia seems to be most susceptible of suggestive treatment. Finally one province of human suffering, which more than any other perhaps, calls for active sympathy, but which unfortunately has received only doubtful help at the hands of the profession, namely, the hideous nightmare of insanity, would also seem to seek shelter under the healing wing of psychotherapy.

But here a capital distinction must be drawn, without which the results obtained might appear confusing and perhaps discouraging.

The best observers in this particular field, among which I may cite Séglas, Lombroso, Dufour, Ford, Ladame, Jules Voisin, Burckhardt, Luys, Bernheim, Mierjewski, etc., are pretty well agreed that in the confirmed forms of insanity, that is in those forms that are preceded by a well marked incubation, the evolution of which follows a regular march, in which the cerebrum is altered at least in its nutrition, as a consequence of the profound degradation of the whole system, suggestion will accomplish little or nothing.

The main obstacle in such cases lies in the fact that those subjects cannot be put to sleep, and even in the rare instances where hypnosis is possible, they are not suggestible.

But all around this last circle of the inferno there is a

vast borderland in which hovers a throng of individuals whose mental disorders only depend, so to speak, upon a lack of equilibrium of the psychic dynamism ; here it is that we observe those perversions of character and of moral sensibility which bear the impress of degenerative or hereditary taint ; the disordered tendencies, the irresistible impulses of the growing tribe of the disaffected, half irresponsible unfortunates which the tide of civilization casts upon its shore.

It is upon that flotsam and jetsam of elements, upon that pallid and restless tribe wherein consciousness may be obscured, but personality is not destroyed by some fixed automatic delirious conception, here it is that suggestive therapeutics seem to find their most fruitful sphere of application. It is in this atmosphere of the psychoneuroses that suggestion has yielded the best results, and promises more. It acts like a wonderful mental tonic, enabling the subject to lay a strong hold upon his dissolving personality, restoring moral life, dispelling the cloud of hallucinations and besetments by the devil from the tottering brain.

This beneficial influence extends with full force to the allied domain of the toxic forms of alienation, to dipsomania, morphinomania cocainomania, etc., and this is no mean triumph in itself.

Hospital Notes.

THE SURGICAL CLINIC.

SERVICE OF PROF. SHEARS.

REPORTED BY FILIP A. FORSBECK, WEDNESDAY, SEPT. 12.

LARGE ENCEPHALOID CARCINOMA OF THE THIGH.—*Case 34.* German, age 67. Brought to this clinic by Dr. Hicks of this city. Six months ago this old man bruised the knee; three weeks later he noticed a small lump about three inches above the knee on the inner side. Two months later this swelling moved to the upper and inner side of the thigh. It gradually increased in size and during the last two weeks has grown very rapidly. It now extends from one and one-half inches below Poupart's ligament to the lower third of the thigh. Over a large portion of this surface the skin is red and shiny. The leg and foot are œdematous. He has quite severe pains on motion and a sticking, throbbing sensation on touching the parts. There is some fluctuation at the most prominent portion of the tumor. There is increased heat in the tumor, but the general temperature of the patient is not increased. (See Fig. 15.)

This case presents several interesting symptoms, some of which, in a diagnostic way seem to be contradictory. The history of an injury; the claim on the part of the patient that the tumor first appeared near the knee, and afterward changed to the upper third of the thigh; the sensation of heat when the hand is applied to the tumor; the red and shiny appearance of the integument; the fluctuation and the accompanying œdema, are all symptoms which might be expected in an inflammatory condition of the parts attended by suppuration and the formation of an abscess.

On the other hand, I am assured by Dr. Hicks, who saw him a month ago, that the tumor was then freely movable under the integument, a condition that one would hardly expect were this the result of ordinary inflammation.

Again, as I take hold of the growth away from the inflamed portion, it has the inelastic feel associated with noninflammatory growths.

From the rapidity of growth, the pain, the tendency toward ulceration as well as from the other symptoms mentioned, I believe we have here a malignant growth, probably carcinomatous. The fluctuation is probably due to commencing cystic degeneration of the more superficial parts of the growth.

The patient's story as to the shifting of the tumor is undoubtedly due to inaccurate observation. I cannot tell



FIGURE 15.

from examination whether this tumor has its base upon the deep fascia of the thigh, or whether it has included that in its progress and dipped down between the muscles and vessels. If the former is true we will thoroughly remove it. If the latter we cannot expect to do so except by making an amputation at the hip joint, for the making of which operation we have not received the consent of the patient.

The tumor, as you see, extends in an oblique line from about one inch and one-half below Poupart's ligament for about eight inches.

An incision over its most prominent portion follows accurately the line of direction of the femoral artery.

I shall start my incision exactly at Poupart's ligament and uncover the artery, vein and nerve, in order that we may have them under our control. They lie here, you know, very superficially in this order from the inner side out, vein, artery, nerve, their initial letters spelling v-a-n.

(The incision was made over the entire length of the tumor, and the integument dissected back.

A large encephaloid mass was exposed entirely, surrounding the femoral vessels as far as the Hunterian canal, and dipping down between the muscles of the thigh.

An untied ligature was placed about the femoral vessels at their upper portion, in order that the hæmorrhage might be controlled, should any accident occur during the removal of the growths, and the mass was then carefully scraped away from the sheath of the vessels. After removing the diseased tissue the temporary ligature was removed from the vessels and the wound closed in the usual way.)

We have here, I believe, an encephaloma, a variety of carcinoma, which is known also sometimes as the medullary cancer, soft cancer, or the cerebriform cancer. Sometimes also the term fungus hematodes is applied to it, because it ulcerates readily, and through the opening thus produced, a mass of foul, bleeding granulations spring forth. It very commonly attacks the lymphatic glands, and it is probable that in this case it started in the deep glands which accompany and surround the femoral vessels, gradually uniting them as it extended along the vascular canal.

On section you see it has that gray and whitish appearance that is common to brain matter, and from which it receives its name, cerebriform cancer.

It is one of the most malignant forms of cancer, and grows with great rapidity, often terminating life in less

than six months. It usually returns promptly after removal, this being due to the fact that its tendency to infiltrate tissues makes it an extremely difficult matter to thoroughly remove it. I have no expectation in this case, now that I have seen the growth, that the operation will prove curative. Nothing but the removal of the entire limb would completely remove the disease.

The age and feeble condition of the patient would make this operation impracticable even if his consent could be obtained.

VESICAL CALCULUS IN A CHILD. LEFT LATERAL PERINEAL LITHOTOMY.—John V., age 8 years. Brought to this clinic by Dr. Ripley, of Kenosha, Wis.

This little boy has had phimosis with firm adhesions to the glans. There has been some obstruction to urination and always more or less pain. About one year ago he came under Dr. Ripley's care, he relieved the phimosis by operation, made an examination of the bladder, and discovered the stone. He then advised further operative proceedings which were not acceded to by the parents. The pain on urination has increased, and the parents now recognize the necessity of further treatment.

The urethra is rather small but admits a number six sound. As I turn it from side to side you recognize the distinct click which indicates the presence of stone. I shall make here the operation of lateral perineal lithotomy, an operation which is almost devoid of danger if properly made.

Let me call your attention to certain anatomical points which must be taken into consideration in making this operation.

The perineum is bounded by the symphysis, the ramii of the pubis and ischii, the ischial tuberosities, the great sacral sciatic ligament and the coccyx.

The anus is in the middle line between the tuberischii, in the raphe midway between the centre of the anus, and the spot where the scrotum joins the perineum is the central point of the perineum.

The two transverse perineal muscles, the accelerator urinæ and the sphincter ani meet at this point, which also corresponds to the inferior edge of the triangular ligament. The bulb is just in front of it, as is also the artery to the bulb. Our incision, therefore, must not commence in front of this spot.

The incision is made from a point just to the left of the median raphæ, and just behind the central point of the perineum, to a point between the left tuberischii and the posterior part of the anus, one-third nearer to the tuberosity than to the gut. The incision is made deep at first, and is made shallower as it proceeds outward and backward.

In this incision are divided the skin and superficial fascia, the transverse perineal muscle, artery, and nerve, the lower edge of the triangular ligament, and the external hæmorrhoidal vessels.

The left forefinger is now introduced into the wound and the staff felt for. The knife is passed along the back of the forefinger until it hits the groove.

The knife is pushed cautiously along the groove until it reaches the end of the staff and enters the bladder. It should be kept parallel with the line of the surface wound. An escape of urine announces that the bladder has been entered and its neck divided. As the knife is withdrawn it is pressed gently down and outward so as to enlarge the opening in the prostate and neck of the bladder.

In this incision are divided the membranous and prostatic portions of the urethra, the compressor urethræ muscle, the anterior fibres of the levator ani, and the left lateral lobe of the prostate.

The artery to the bulb is a vessel about the size of the posterior auricular. It runs inward between the fibres of the constrictor urethræ muscle. It may be given off from the pudic earlier than usual and may cross the perineum further back. In such a case it is usually divided in the operation and may give rise to troublesome hæmorrhage.

The bladder having been entered the index finger is introduced along the staff into the bladder and the stone felt

for. Forceps closed are now introduced along the finger, the stone seized in its smallest diameter and carefully extracted.

It should be remembered that in the child the anatomical conditions are slightly changed from those in the adult. The pelvis is relatively narrower and the neck of the bladder is higher up. The bladder is more movable and has less firm attachments. The urthra is thin, delicate, and easily torn. The prostate is undeveloped, it is easy to go beyond the prostatic area and open up the pelvic fascia.

No force must be employed in introducing the finger, neither should forcible dilation of the neck of the bladder be attempted.

For fear of missing the opening into the bladder, a probe should be introduced before the staff is withdrawn and left there as a guide for the finger and forceps.

The operation was made as indicated and a stone the size and shape of a good sized olive was found and extracted.

The patient was immediately relieved of all pains and made a prompt recovery.

SUPERNUMERARY TOE.—Sept. 27. *Case 38.* M. L., age three months. This little child has a congenital deformity of the right foot, namely a supernumerary toe, six toes instead of five, each of which seems perfectly developed. There are, however, only five metatarsal bones. This condition, known as polydactylism, is not of unfrequent occurrence, frequently occurring as the result of inheritance, sometimes occurring in every generation, sometimes skipping a generation or two. A case came under my observation some time ago in which a deformity of this kind had occurred in some member of the family for four generations, it invariably being found in a member of the family having fair skin and red hair.

The deformity is generally symmetrical, usually occurring on both feet. In this instance it occurs only on one foot the other foot being perfect. Usually there is only one extra digit, but cases have occurred where there were as many as thirteen toes upon one foot.

These deformities may be classed under four different heads. Those in which the extra digit is attached loosely by a narrow pedicle, those in which the digit is free at its extremity and articulates with the side of a phalangeal or metatarsal bone, which is common to it and another digit, those in which the supernumerary toe exists as a fully developed organ, having its own phalanges and separate metatarsal bone, and those in which the supernumerary toe is bound throughout its whole length with another digit, and having another additional metatarsal bone, or articulating with one which is common to it and the other digit. The case which we have to-day belongs to the second variety.

The treatment of these deformities depends upon the circumstances in the case. In the case of an extra toe covered as it is by the shoe it is not necessary that any treatment should be instituted unless it causes inconvenience. Inasmuch, however, as most people are sensitive to such malformation, the prompt removal of the offending digit is desirable.

In the first class of cases the extra digit may be removed close to the skin and one or two sutures taken to bring the parts together. In the second class where two digits share the same articulating surface, in removing one, it is necessary to open the common synovial capsule of the joint. If this is not done with proper regard to asepsis ankylosis of the joint may occur. Fortunately this is not a matter of much importance in the case of a toe as in case of a finger but is undesirable in either case.

In the third variety where there is also a full metatarsal bone, unless the foot is very much enlarged, thereby, it had best be left undisturbed. In the fourth, either leave the part undisturbed or amputate the combined member. In this case we shall amputate the toe.

This was done and the wound hermetically sealed. It healed promptly in one week by first intention.

THE CHILDREN'S CLINIC.

SERVICE OF PROF. JOS. P. COBB, M. D.

REPORTED BY H. J. PAYNE, CLERK OF THE CLINIC.

HABITUAL CONSTIPATION.—*Case 783.* Edwina G., æt. five years, was brought to the clinic August 11. The family history is good. For three years this child has been constipated. Sometimes three days would pass without any movement of bowels. Her mother has been in the habit of giving her castor oil at such times to bring on a movement, and at these times the first part of stool is hard and dark, almost black. The last of the stool is lighter colored, generally yellow.

At intervals, the child will have a passage each day for two or three days in succession; and at these times the stool is normal in color and consistency.

When the stool is very hard it is often streaked along the side with blood. There is a good deal of superficial inflammation around the anus.

There is pain before and during the movements. Many times this pain will cause the child to put off going to stool; has frequent desire for stool without effect; is more troubled in the summer. She was given sulphur 6 four times daily and calendula cerate was ordered to be used externally around the anus.

This treatment was continued for two weeks when the bowels were moving regularly every day and the character of the stool was normal. The improvement was marked at the end of a week and there was no lapse of good behavior in the following month during which the child was under observation.

This case is an example of a bad habit. I take it that there was no pathological change or faulty digestion upon which this constipation depended. The girl in the first place was not taught to evacuate the bowels with any method. The desire probably had been frequently postponed; the fæces remaining longer in the large intestine than they normally should be allowed to, gave an opportunity for over-absorption and left the residue unnaturally dry and hard. The character of the stool described after one of these spells is that the first part is large, hard and dark, while the after part is practically normal. The

streaks of blood upon the side show that this hard, large stool would tear the mucous membrane at the lower outlet and of course cause pain. The child dreading this pain contracted the habit of putting off the promptings of nature and thus helped the bad habit of the bowel by obviating the natural excitability of the rectum. The occasional dose of castor oil, under such circumstances, soon becomes a necessity and the bowel lazily declined to do its duty except when spurred up by unusual excitation.

This is apparently a simple difficulty, and when taken early is easily remedied; but too little attention is frequently paid to the necessity of establishing a regular habit in this function, and it may be the source, and frequently is, of serious troubles. These cracks in the mucous membrane which readily heal for ninety-nine times, perhaps, may the very next time retain a little fæcal matter, inflame, suppurate and become a fissure or give rise to a fistula; hæmorrhoids may be a result and are not uncommon among such children.

Furthermore, the retention of fæcal matter in the large intestine too long, and the over-absorption consequent thereto may introduce into the system toxic elements. We know to-day that even digestion develops toxic compounds, and the safety of the individual depends upon a constant elimination of these substances. An obstruction of one route of elimination will overtax the others; too prolonged overtaxing will result in a refusal on their part to do even their normal amount of work. The subject of auto-intoxication by absorption from the intestinal tract is not new, but is often forgotten.

The lazy habit followed by many physicians in such cases as these, of prescribing a laxative medicine and dismissing the case without calling the attention of the parents to the importance of regularity is to my mind very reprehensible.

PROBABLE SYPHILITIC DIATHESIS.—*Case 792.* Mamie McD., æt. four and three-fourths years. First appeared at the clinic August 29. This is one of four children.

Two are dead; one dying when twenty-two months old, of cholera infantum, the other at four years of age, of scarlet fever and diphtheria. This child has never been well. Has always had the sniffles and a cough. When very young, and until three months old there was a rash on the abdomen and under the arms. This was vesicular in form, the vesicles would break and leave a blue spot. When eighteen months old, a scaly rash broke out on the face which has never been healed. Occasionally the tongue is sore. Always has a cough, which is much worse about bedtime. Has no appetite; the bowels are regular; she does not sleep well; is restless at night; starts up from sleep as if frightened and wakes coughing and crying; always complains of being tired; complains sometimes of a pain in the chest. On examination find hoarse bronchial breathing and some rales. Merc. iodide 3 was given four times daily.

The child improved on this treatment. The rash almost disappeared, and the cough grew less troublesome till September 12, when the rash began to reappear. There was still a slight cough, hoarse bronchial breathing both in inspiration and expiration; a congested condition of the pharynx. The appetite was not good, bowels regular and stool normal.

Hepar sulphur 6 was given four times daily.

September 29, a marked improvement was reported, the child is very well for her. A slight trace of the rash remains on the face under the eyes and across the nose. Cough and coarse bronchial breathing have disappeared. Appetite is good, bowels regular and she sleeps well. The remedy is continued.

We label this case "probably syphilitic" because it bears so many of the earmarks of that disease. The sniffles and cough dating from infancy, the persistent bronchial catarrh, the skin eruptions and the general impaired nutrition are all very suggestive of this vicious dyscrasia. We are able, however, to find nothing in the family history to substantiate or disprove our suspicions, and lacking the evidence of hepatic or splenic enlargement, cannot be sure of our diagnosis. A longer observation of such cases is necessary to establish the point under consideration. Should this prove to be syphilitic there

will certainly be a return of some of these conditions which have yielded so readily to our treatment. The appearance of the permanent teeth when they erupt may help to settle the doubt, though here too you must remember that a child properly treated while the permanent teeth are forming, years before they erupt, may so far overcome the dyscrasia and the faulty nutrition depending thereon as to present fairly good and well-formed incisors. Do not judge either that this cannot be syphilitic because it has changed so markedly in a short course of treatment. Syphilitic children who have survived the struggle of the first year often respond marvelously to proper medication.

CLINICAL ITEMS.—M. Zoole advises to add castor oil to vaseline in order to dissolve it in water, but M. Denis employs an entirely different method which consists in mixing it with a small quantity of pulverized gum arabic.—Beside the well known hypnotic effect of the hydrate of chloral, its use has been extended for the relaxation of the unstriated muscles, when they are spasmodically contracted, and as a powerful dilator of the peripheric vessels. In bronchial asthma, hæmoptysis, aneurism of the aorta, coldness of the extremities, in anæmic patients, chloro-anæmia, neurasthenia, hysteria with fits of delirium and hallucinations, and even in chronic constipation, it has accordingly been of decided service.—A case has been reported to the Hospital Society of Paris in which a chronic tonsillitis that resisted the most active treatment, was finally cured by amputation of the organ, after which a bacteriological examination of the specimen disclosed the presence of large numbers of coli bacillus.

Clinical Reviews.

AN AMERICAN TEXT-BOOK OF THE DISEASES OF CHILDREN; Including special chapters on essential surgical subjects, and on the diet, hygiene and general management of children, by American teachers. Edited by LOUIS STARR, M. D., assisted by THOMPSON S. WESCOTT, M. D. Price, \$7.00 cloth, \$8.00 sheep, \$9.50 half Russia. Published by W. B. Saunders, Philadelphia. 1894.

It is a pleasure to acknowledge that the editor has very satisfactorily accomplished what he states in his preface to be his object, viz.: "To present to the profession a working text-book which shall be closely limited to, while completely covering, the field of pædiatrics."

The chapters devoted to the hygienic care and feeding of children are an excellent résumé of the best thoughts of the day, and show that the study of bacteriology has done as much in the prevention of the diseases in children as it has in the prevention of sepsis in surgery.

The etiology of diseases has been discussed in the main from a modern standpoint in a brief and concise method. Compared with other works of its class, the space devoted to treatment is very brief. Many valuable suggestions, however, are included in this part, and its strength lies in the fact that the writers nearly all recognize that little medicine is needéd, frequently disclaim the possession of any special medicament for the disease under discussion, and avoid complicated, compound formulæ.

The work is modern, well arranged, and fairly complete. It will prove a useful text-book for students, and a valuable addition to the busy practitioner's library.

J. P. C.

A TEXT-BOOK OF ABDOMINAL SURGERY; A CLINICAL MANUAL FOR PRACTITIONERS AND STUDENTS. By SKENE KEITH, F. R. C. S. Ed., assisted by GEORGE E. KEITH, M. B., C. M. Illustrated. Philadelphia: J. B. Lippincott Company, 1894, pp. 598.

CLINICAL GYNÆCOLOGY: BEING A HANDBOOK OF DISEASES PECULIAR TO WOMEN. By THOMAS MORE MADDEN, M. D., etc., etc. Illustrated. J. B. Lippincott Company, 1893, pp. 562.

A TEXT-BOOK OF GYNÆCOLOGY. By JAMES C. WOOD, A. M., M. D., etc., etc., etc. Illustrated. Philadelphia: Boericke & Tafel, 1894, pp. 858.

If we may judge by the number of books upon gynæcology that are being published in these latter times, it will be fair to infer that students and practitioners will soon be better informed upon whatever concerns the diseases of women than they heretofore have been. New and attractive as the branch is, however, we can hardly expect that so many books could be filled with carefully arranged and digested articles based upon the exclusive experience of the author; and compilations drawn from the hot-house products of the medical journals all over the land are not always of the most stable and satisfactory kind. One who is thoroughly familiar with this subject, and a careful observer, could not fail to note the practical differences between these three companion volumes, each of which has its own peculiar merits and defects.

Briefly, while the first of them contains some useful material, and some useful suggestions also, its scope is too large for a single volume, its arrangement defective, and its treatment of the different subjects incomplete and unsatisfying. For one must needs write much better and more compact English in order to compress, even in a text-book, the "Surgery of the Abdomen," of these modern times within three hundred pages; while the "Surgery of the Abdomen Peculiar to Women" is certainly entitled to more than the remaining two hundred pages. Coming from such a source the text should have had the plain and homely merit of the Scotch directness and ripeness, as well as the unmitigated clinical temper of the Edinburgh school.

Dr. Madden's book is much more readable, is better illustrated, and quite comprehensive and practical. Being cast in the lecture form it has the advantage of completeness, method, and the clinical flavor and suggestion that go with the spoken word. Such books as this are invaluable for reference as well as for consecutive reading. This volume will help to build up the structure of a sound medical education, and, although over-ripe in some particulars, should be in the hands of all our students and practitioners.

The third of the listed books is the best in the lot, and far away the best of the three that our good publishers, Boericke & Tafel, have issued upon this specialty.

Miscellaneous Items.

In answer to Dr. B. we are glad to say that Prof. Shears has *not* resigned the post of surgeon either in the college or hospital, but is still holding two clinics per week to which his friends are at liberty to send their patients as heretofore.—Prof. O. L. Smith will report at the next meeting of the Clinical Society, October 27, upon "A rare case of myelitis," with a living specimen.—The Muskegon, Mich., dailies announce the election of Dr. G. L. LeFevre as county physician. *Bon.*—Dr. N. C. Kemp has returned from Vienna, and formed a partnership with Dr. O. G. Tremaine.—Dr. Sara E. Bacon has located in Pueblo, Col.; Dr. Ada B. Morgan in South Bend, Ind., and Dr. Sarah Emery at the Bancroft Hotel, City.—The death of Dr. Léon Simon, *père*, founder of the Hahnemann Hospital of Paris, at the age of seventy-one, is announced; also that of the excellent wife of our old friend, Dr. T. J. Patchen, of Fond du Lac, Wis.; as well as that of Dr. Charles Woodhouse, of Rutland, Vt., formerly Professor of Medical Jurisprudence and Insanity in the "Old Hahnemann," aged eighty-three, and of Dr. H. L. Bradley, formerly of Horicon, Wis., at Oakland, Cal., October 1.—The interior of the new hospital is rapidly being furnished and equipped; the clinics are booming as never before; the class is bigger and more enthusiastic than it has been for some years; the money is in the bank with which to make the last payment on the building, November 1, and everybody hereabouts, including the Editor of *ye CLINIQUE*, is superlatively happy.—Having reduced the mortality of malignant diphtheria by inoculation with the anti-diphtheric serum from fifty to twenty-six per cent. it is proposed to found an Institute in Paris like that of Pasteur, for its further study and treatment.—The newest thing in surgery is the proposal of ventro-fixation, gastropexie, for a prolapsed stomach.—The best local treatment for ivy poisoning is the use of Labarraque's solution in full strength.—The ambulance service connected with the south division of the city has been secured for the new Hahnemann Hospital.

THE CLINIQUE.

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CHICAGO, NOVEMBER 15, 1894.

[No. 10.]

Original Lectures.

DISEASES OF THE LACHRYMAL APPARATUS.

A CLINICAL LECTURE DELIVERED BY C. H. VILAS, A. M., M. D.,
SENIOR PROFESSOR OF EYE AND EAR DISEASES IN THE HAHN-
EMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

In asking your careful consideration of the cases before you to-day, I shall direct your attention to a class of diseases of no slight importance. Not usually considered sufficiently in detail before treatment is undertaken, I warn you that complete success is not easily attained; and I shall therefore invite a close following with me as I consider the anatomy and physiology before undertaking a description of the pathology and the local and general methods of relief.

The lachrymal apparatus, a delicate and sensitive structure, has a two-fold organization—secretory and conductive. At the outer angle of the eye, slightly above it, lies the lachrymal gland in its fossa. It consists of two portions, the superior and inferior; the former is the larger and in a general way is (rather more than) the three-fourths of an inch in length, the half of an inch in width, and the quarter of an inch in thickness. It is held in its place by a number of small delicate bands of connective tissue, and empties by five to ten ducts into the conjunctival sac, though the lower portion has a few more ducts of its own. Un-

der the impulse of the sympathetic nerve, this gland secretes and throws out a watery fluid highly charged with sodium chloride, which passing into the conjunctival sacs is distributed over the globe by the action of the lids, and combined with the discharge from the various glands forms the cleansing and oiling so constantly needed by the eye in its movements. Variable, but about a quarter to a half-inch from the inner canthus of the eye, and situated on the edges of both the upper and lower lids will be observed small holes, the lachrymal puncta. These puncta are the openings into the lachrymal canals, imbedded channels which pass respectively down and up to a common junction about equi-distant from their origin. The common channel then makes a slight curve and continues on into the lachrymal sac. At first about a millimeter in diameter these channels increase five or six fold as they enter the sac or often shortly before; are lined with epithelium and have numerous small fibres of muscle tissue. The lachrymal sac is located at the inner side of the inner canthus in a sulcus formed by the nasal process of the superior maxillary and the lachrymal bones. Elliptoid in form with the longer axis vertical, it measures about a half inch in its long axis and a quarter inch in its short one. About four lines from its upper edge it is joined to the lachrymal canals, and at its lower end to the nasal duct, a tube about eight lines in length and two to three lines in width of similar structure and lining to the sac. Both are composed of delicate connective tissue and lined with epithelium. As we have much to do with the nasal duct in probing, it is well to remember that it is placed in a thin bony canal, formed by the superior maxillary, lachrymal and inferior turbinated bones, which may be easily punctured by careless manipulation. This duct is also lined with a delicate epithelium, and discharges into the inferior meatus of the nasal fossa.

From this description it will be seen that the lachrymal apparatus is an extremely complete affair, and I have only to trace the origin and flow of the lachrymal secretion to

show you that its function is very effective and simple. Thus the secretion, or tears, is discharged by the gland through the ducts into the palpebral and ocular lachrymal sacs; here it becomes more or less contaminated by the dust and foreign bodies which have found their way into the eye, and by the secretion of the palpebral glands; thence the tears thus composed are passed through the puncta, less the amount spread upon the globe and evaporated, into the lachrymal canals, on into the lachrymal sac, through the nasal duct into the inferior meatus, and there are evaporated during the act of breathing.

Diseases of this apparatus, unless quickly subdued, are likely to prove very obstinate and trying to the practitioner.

The gland may take on inflammation, probably from infectious origin, developing dacryo-adenitis; or it may result from cold or injuries. It is first noticed by a swelling at the outer canthus, more or less swelling and redness of the adjacent conjunctiva, accompanied by a slight pain in the temple. Three or four days' duration brings it to suppuration, and the pus being evacuated, eight or ten days will be its duration. Hepar sulphur or silica will be required if suppuration actually begins; before that aconite and belladonna may be indicated, and hot fomentations locally. It is a rare trouble compared with the other diseases of this apparatus. Still rarer is hypertrophy of the gland; its only remedy is extirpation.

Inflammation of the lining membrane of the sac, dacryocystitis, is the disease of this apparatus oftenest encountered in practice, and is associated with imperforate or misplaced puncta, nasal catarrh, and a chronic altered condition of the secretions of the mucous membrane of the eye. Exposure to rough winds or a severe conjunctivitis may bring it about or it may result from a chronic inflammation of the tear passages. In the acute form the earliest symptoms are tenderness, redness and a swelling over the region of the sac and lids, with excruciating pain. If allowed to progress, an abscess forms and may burst through the skin and intervening tissue, forming a lachrymal fistula, which usually remains unless surgically closed.

Strictures of the nasal duct and closure of the lachrymal canals may prevent the evacuation of the sac and confine the abscess, thus causing the excruciating pain.

It is probably rare that this trouble arises unless favoring conditions are at hand. In the beginning of catarrhal inflammation of the sac and associated structures, the patient usually notices little beyond the mild overflow of tears, and may allow it to go on for years. A sudden complete closure of the duct or canals from any accidental cause, as a severe cold or any catarrhal inflammation precipitates a severe attack of inflammation.

Hot lotions should be applied locally if the case is well advanced before seen; if not, iced compresses should be used and a thorough endeavor made to abort the attack. Failing in the latter, if unable to slit the canaliculus, it is better to open the abscess with a sharp puncture directly over the sac than to allow it to burst. Suppuration should then be encouraged with internal remedies (hepar sulphur or silica) as well as local, and the case then treated as in the chronic form.

A chronic form of this inflammation called mucocele, is brought about by the same causes, but is much more difficult to cure. There is a constant irritability of the eye and a watery condition. This latter condition, called epiphora, or stillicidium lachrymarum, is, however, an accompaniment of lachrymal troubles and proves very annoying. Strictures form in the duct, the sac varies in size according to the accumulation, and on pressure, a sticky, viscid fluid exudes. Owing to the unpleasant sensations, the patient usually presses out this exudation several times a day, obscuring the vision. After a time the caruncle sympathizes, and a very troublesome complaint is the result.

The treatment consists in allaying the irritation by internal and local remedies, and opening up the canaliculi and probing the duct to remove the strictures. Seemingly not difficult, success is not attained easily in old cases. The channel once opened, astringent and antiseptic solutions should be syringed into the sac, and the membrane restored

to a normal condition. Mercuric bichloride, one part to five thousand of distilled water, thus injected, is a valuable remedy. Persistence and thoughtful care oftener succeed than routine treatment. Silver probes are the best to use ; of varying forms and sizes, they should be gently insinuated through the canals ; when the strictures are obstinate and unyielding, they may be forcibly dilated or cut, but as the bone sometimes becomes affected, complicating the case, care must be taken not to perforate this bony canal. Inasmuch as syphilis plays an important part in lachrymal troubles, the probability of its presence should at least be considered.

Calcareo carbonica, hepar sulphur and silica are among the best internal remedies in these affections, the latter especially meeting many of the manifestations of disease.

Whether for acute or chronic cases various forms of knives have been devised for opening the nasal duct, and called after the various inventors. They all consist essentially of a probe pointed knife with a longer or shorter shank to the handle, which may be malleable or not as the operator desires. The probe point of the knife is inserted in the lower punctum usually, though the upper may be chosen if desired, and the edge of the knife being held upward and slightly inward, as you see me hold it, it is passed thus into the canaliculus and pushed firmly on into the sac and against the lachrymal bone. This will divide the upper part of the canaliculus, if the lid be stretched in the opposite direction. The knife is now raised up and pushed down into the duct, and all strictures freely cut. Silver probes, like these I show you, called Bowman's, should now be passed into the duct and this probing continued at intervals of twenty-four to forty-eight hours until proper healing is assured.

After many years of treatment of lachrymal and nasal duct troubles I am of the opinion that many cases are improved, but few cases completely cured by the ordinary courses of treatment. Too much force is used in probing, the probe rammed down and the delicate membrane lacerated and false passages made. There is a strong analogy be-

tween these troubles and those of the male urethra, and the results are much alike. Perfectly smooth, clean probes must be used and antiseptic solutions syringed into the tubes and sac by small syringes made for this purpose.

Unless as a last resort, I seldom make use of anything but the simplest treatment in old cases. Experience in the use of probes and internal medication produces the best results.

I have said a lachrymal fistula is usually permanent unless surgically closed. This may be accomplished by first clearing the natural openings by which fluids run into and from the sac, removing all adventitious growths, as granulations, freshening the edges of the wound, etc., and then bringing the edges of the opening together by a touch of caustic or a stitch in unusual cases. I cannot recall that I have seen a fistula which did not recover when the natural channels were fully restored.

Hypertrophy of the gland, and cystic and cancerous degeneration require small mention from me, as they are easily recognized and all are amenable only to the same treatment, removal at the earliest practicable moment.

GENERAL SURGERY.

EXTRACTS FROM PROF. SHEARS' CLINIC IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO, SESSION 1894-95.

REPORTED BY J. P. LEWIS, CLERK OF THE CLINIC.

EPITHELIOMA OF THE SHOULDER.—*Case 19,735.* Mrs. H., aged 69, patient of Dr. Walters. Ten months ago this lady noticed a small nodule developing on the tip of the right shoulder. Shortly after she was thrown from a buggy sustaining a fracture of the right clavicle. The tumor began immediately to grow rapidly, and sharp darting pains were felt in the growth. At present the tumor is about three inches in diameter and is raised about one and one-half inches above the surrounding integument. It is hard, nodular, and covered by prominent blood vessels. At its apex is an area of ulceration about an inch in diameter.

The edges of the ulcer are irregular and excavated, and its surface is covered with a foul discharge. The tumor is slightly movable. The axillary glands are involved but not the cervical. Figure 16.

The history of this growth, its nodular character, the pain, the ulceration, the involvement of the lymphatic glands, and the age of the patient, indicate that we have here a malignant growth, probably the form of carcinoma known as epithelioma. This form of cancer has its primary seat,

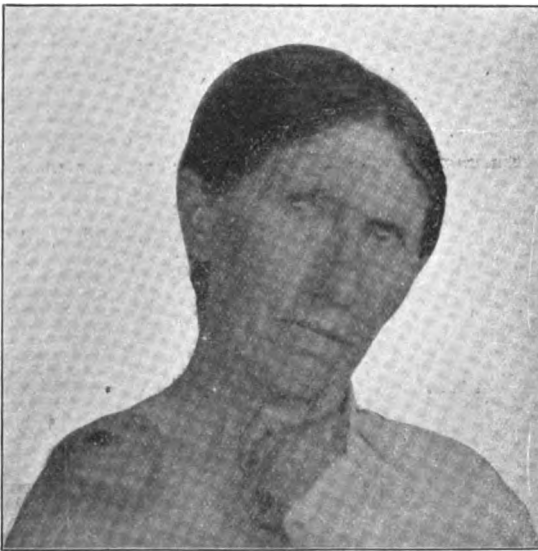


FIGURE 16.

in or just beneath the skin or mucous membrane. By extension from its initial locality it may affect any tissue, thus in its progress the muscles; and the bones may be involved and destroyed by it.

It may present many varieties of external shape and relations, dependent chiefly upon the situation in which the cancerous structure is placed. If it predominates chiefly

in the lower layer of the integument and the sub-integumental tissues, it forms a deep-seated, flat or rounded mass, such as we have before us to-day. Whereas if it predominates in the papilæ it forms a warty or exuberant growth such as I was able to show you upon the head of the old lady upon whom we operated some time ago, (Fig. 17). In that case, you will remember a large area on the posterior surface of the head was covered with clusters of en-



FIGURE 17.

larged papilæ, the appearance of the surface being something like that of the syphilitic condyloma.

The form we have to-day is the more common form in cases in which the integument is affected. The cauliflower-like growths being most frequently found on mucous surfaces, but this form, however, may appear on the integument as is proven by the case referred to. The case before us is somewhat unusual, both on account of the rapidity of

the growth and the early involvement of the axillary lymphatics.

Cancer of the integument is usually of slow growth and is the form most amenable to treatment. It is unfortunate in this case that the lymphatic glands have become involved, as the probability of a cure is thereby lessened. I shall, however, attempt to make a thorough operation, and try to remove all the involved tissue.

[An elliptical incision was made about the base of the tumor, and the growth, together with a part of the deltoid involved, removed. The axilla was then opened and cleared of its glandular contents. This patient made a prompt recovery.]

UNDESCENDED TESTICLE—HERNIA—CASTRATION—RADICAL CURE.—*Case 19,751.* F. J., age twenty-eight. At the age of fifteen years neither testicle had descended. About this time he was struck a severe blow on the right side just above the pubic bone. This caused him severe pain. Two days later while riding a horse at a rapid rate, experienced more pain upon this side. Upon examination a small tumor was felt near the inguinal ring. This received no treatment for several days, when it became tender and a physician was consulted.

He said that it was a protrusion of the bowel and that the testicle could be felt above it. He could not, however, return the protrusion until he had kept on an ice-pack for several days.

A truss was then applied. After wearing the truss for two years he was examined by another physician. He was told that the testicle was trying to descend and was advised to leave off the truss.

This he did, and one day after a long walk the testicle descended, followed by a hernial protrusion.

The hernia was repositied and a truss applied. Five or six years later he had treatment by injections which cured the hernia on the right side.

When eighteen years of age he noticed a bulging on the left side in the region of the inguinal ring. This has been treated in various ways, by application of truss and by injection, but has constantly grown worse, and it is for this condition that he now applies for treatment.

Examination shows the pressure of the right testicle, the absence of the left testicle, and the presence of an omental hernia.

We have here two very interesting conditions, an undescended testicle and a hernia.

The testicle, you know, develops originally from the Wolffian body and is then an abdominal organ as much so as the ovary, its prototype, in the female. Between the seventh and eighth month of foetal life it makes its descent. The function of the testicle is not destroyed if it be retained within the abdominal cavity. Cases are recorded in which the descent of neither testicle has taken place, and yet the power of procreation has not been interfered with.

This is effected largely by the gubernaculum testis, a mass of unstriped muscular fibre connected with the bottom of the scrotum below and with the peritoneum and with the epididymis above. This is also aided by a portion of the cremasteric fibres. The latter aids in pulling it down as far as the inguinal canal, where its fibres are found with its characteristic loops, further downward movement being accomplished by the gubernaculum alone.

As the result of peritonitis in the foetus during intra-uterine existence, adhesions may form between the testicle and the bowel, the omentum or the iliac wall, which may be strong enough to hold the testicle within the abdomen; or if the adhesions are not too strong, the testicle may be drawn into the inguinal canal, but not below it. Again the gubernacular traction may not be sufficient to draw down the testicle, but may draw down the peritoneum, into which a portion of the bowel or omentum may press, thus forming what is known as a congenital hernia, in which there is no real sac, the sac being formed by that investment of peritoneum which in a normal case forms the tunic of the testicle and the cord.

It is probable also in these cases, there is a lack of development in the cremaster and gubernaculum, which may fail to perform their part in drawing down the testicle.

Sometimes the cord is drawn down while the testicle remains in the abdominal cavity, a very interesting case of which was operated on in my clinic a year ago. The testicle has even been drawn down and afterward drawn back into the abdominal cavity. I saw a very interesting case of this kind in consultation with Prof. Genius, of our college. The patient, now forty-five, declared that both testicles descended when he was about fifteen years of age, and that soon after in handling one of them, he pushed it up in the inguinal canal and it never again descended.

We will make this operation by the usual method for the radical cure of hernia, commencing our incision above the internal ring and carrying it a little below the external ring. We will open the inguinal canal its entire length.

[This was done and an atrophied testicle was found at the internal ring just engaging the canal. Also a congenital emental hernia, the omentum being adherent to the sac at a point just below the external ring. The cord of the testicle was ligated and the stump dropped into the abdominal cavity. The omentum was pulled down, ligated, and the stump returned. The descended peritoneum was cut off and the peritoneum stitched together as in an abdominal wound. The divided anterior wall of the canal was united to Poupart's ligament by sutures, and then the anterior wall united to the posterior wall by quilted sutures of silk. The different layers of fascia were united in similar manner, and the external wound closed without drainage.]

I do not advise the removal of a testicle in the treatment of the radical cure of hernia, unless exceptional conditions are present. One of these is the presence of an undescended testicle which can neither be dissected from its part and pulled down into the scrotum, or pushed back into the abdominal cavity without endangering its vitality. If it is normal, one of these plans should be tried. If, however, it is manifestly degenerated, as it is in this case, the placing of it back into the abdominal cavity might endanger the life of the patient, and it is impossible to bring it down into the scrotum.

No doubt some of the adhesions here found are due to the inflammation resulting from the irritating injections used in the attempt to cure the hernia by this method. That it could not succeed in this case is due to the fact that the hernia was irreducible, although it is probable that the irreducibility was due to the irritation produced by the injection.

I feel sure that the present operation will result in a cure, because the entire canal has been obliterated, and the abdominal wall reinforced by the sutured peritoneum.

[Union occurred promptly without suppuration.]

HIP DISEASE ; THE MALPOSITION OVERCOME BY TENOTOMY AND FORCED FLEXION.—This little patient illustrates one of the incidents in the clinical history of hip disease, namely, a distorted attitude of the limb. It is rare that this disease terminates even if suppuration has not taken place without more or less deformity, either of flexion, abduction, or adduction. Here we have both a flexion to an angle of about 90° , and also pronounced adduction.

Flexion of the thigh has been supposed to be due to an effusion within the capsule of the hip joint, but in this case there has been no history of effusion, and the trouble is undoubtedly due to muscular contraction, a constant condition in chronic diseases of the joint.

Hilton says that the irritated or inflamed condition of the interior of the joint involving the whole of the articular nerves excites a corresponding condition of irritation in the same trunks which supply both sets of muscles, but that the flexors, by virtue of their superior strength, compel the limbs to obey them and so force the joint into its flexed condition. Simple flexion is not so objectionable if ankylosis takes place as flexion and adduction, this latter condition making locomotion very difficult.

This deformity may often be corrected early in the disease by traction in the line of deformity. The patient should be fixed in bed and traction be applied either by the weight and pulley or by the traction splint. The limb can

be placed in a more normal condition day by day, until it is nearly, or absolutely straightened.

We have had many cases in the Hahnemann Hospital in which pronounced deformity has been overcome by this method. In the present case the deformity is pronounced and the muscular fixation very firm. We shall therefore give the patient an anæsthetic and after dividing the tense sartoris and the adductors, forcibly straighten the limb.

The operation was made as suggested, and adhesive plaster placed along the thigh and leg. The patient was then placed in bed and traction maintained by weight and pulley.

There is, as a rule, little danger in this operation if carefully made. It is possible to light up the inflammation by the force applied. The setting free of an incapsulated focus of tubercular material might produce unfortunate results.

One is warranted, however, in taking some risks, for should the patient recover with the limb in its distorted position, it would be of little or no use to him. I am convinced moreover, that the subsequent treatment will overcome any tendency of this character.

TUBERCULAR ADENITIS. EXCISION OF THE CERVICAL GLANDS.
—*Case 19,744.* Miss B., age 22. Two years ago this patient noticed an indurated lump just underneath the angle of the jaw. It increased in size until it reached that of a hen's egg. Showing evidence of suppuration the tumor was incised and some pus escaped. The wound healed but the enlargement did not entirely disappear. During the last year it has increased in size and other nodules have made their appearance at varying intervals from the angles of the jaws to the clavicle.

The age of the patient, the slow growth of the tumors, their comparative painlessness, their location in the neck, the fact that healing took place after pus had formed, indicate that these tumors are not malignant, but are probably inflammations of the cervical lymphatics. The very fair and clear skin of the patient, the delicate appearance and

the long eye lashes would indicate a scrofulous or tubercular diathesis.

It is a fact also, that tuberculosis of the lymphatic glands occurs most frequently between the fifteenth and thirtieth years of age and the cervical glands are commonly affected. Progressive infection is one of its characteristic clinical features, the disease extending from gland to gland until the whole chain in a certain region has become affected. In such instances the first gland affected may be as large as a walnut, the others diminishing in size until the last one is hardly discoverable. The individual glands as a rule do not reach a large size, but if many glands are affected they may become knotted together in a nodular mass giving the appearance of a large tumor.

Regional infection is not limited to the lymphatics on one side of the neck. The course of progression is usually in the line of the first glands affected. Thus, if the first infection has involved one of the superficial glands, progress will be made in the line of the superficial glands. If primarily one of the deep glands has been infected, the deep lymphatics which follow the larger blood vessels of the neck will be invaded.

In extensive disease, both the superficial and the deep glands may be affected at the same time, or enlargements may appear in both sides of the neck, apparently simultaneously. Some of you may remember a case of this character that was presented in our clinic near the close of the term last year, a case in which the glands of both sides of the neck all the way from the ear to the clavicle were involved. Above this bone on each side were masses as large as your fist, made up of an immense number of small glands. A tubercular gland is always a source of danger. Rapid regional and general infection may take place at any time. The prognosis is especially grave where both sides of the neck are affected at the same time. Even in the lighter cases the outcome is usually unsatisfactory. If only a few glands are affected and suppuration results, all the infected tissue may be destroyed. Where many glands are

affected, suppuration only hastens the progress of the disease. Sooner or later general or pulmonary tuberculosis results.

You are more interested to-day, however, in the course of treatment, than in a review of the pathological condition, but the latter must be referred to in order that your line of treatment may be intelligible.

Looking, as we do, upon tuberculosis in this locality as a local infection, the extension of which is favored by the general condition of the patient, two lines of treatment are demanded. The removal of the local disease which is a source of infection, and the building up of the general condition of the patient in order that subsequent infection may take place less readily. As in a case of cancerous disease, the earlier the removal and the more thorough the removal, the greater the probability of cure. Statistics indicate that many cases of pulmonary tuberculosis might have been prevented had the primary foci been removed.

This operation should be made as early as possible, for if many glands are involved it may be impossible to make the operation a thorough one.

In the case of the young man referred to, operation was not advised, it being impossible in my judgment to remove all the infected tissue. But, in the case of the patient before us, although I may feel some seven glands that are enlarged, they are all in the same line and can, I believe, be easily removed.

An incision was made from the angle of the jaw to the clavicle, the platysma myoides being divided throughout the whole length of the incision. The incision being turned somewhat backward in order to reach the posterior superficial glands. The external jugular vein was divided and all the infected glands removed. The parts were united and usual antiseptic dressing applied. This was reinforced by a plaster of Paris bandage, in order that the head might be kept perfectly quiet during the healing of the wound. The wound healed promptly without suppuration.

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

OCTOBER MEETING, 1894.

The regular monthly meeting of this society was held in the large clinical amphitheatre of the Hahnemann Medical College, Saturday evening, October 27. The attendance was large and the occasion was one of unusual interest, the President, Dr. B. S. Arnulphy, being in the chair. The following papers were presented :

XXXV. A CASE OF SPINAL HÆMORRHAGE. BY ORRIN L. SMITH, M. D.—If I promise not to inflict you with Anglicanisms or the more modern fad of *ennui*; if I decline to quote Olive Schreiner, or to exploit the most recent medical fad, anto-infection, the least you can do in return for my magnanimous forbearance is to permit me the unusual statement that I have to present you with a rare case, replete with interest.

Curiously enough, no two disciples of either the Hahnemannian or the Æsculapian belief have agreed as to the diagnosis. Stranger still, one of these men of physic said to our patient, "Louis, your case is a bottle of ink!" But the unkindest cut of all emanated from friends, students who were pursuing the study of medicine, and incidentally such cases as this, who, after examining him said: "We think everything of you, Louis, but you should join the angels that we may find out what is the matter with you."

This patient has appeared before and been under the care of many foreign physicians and specialists, chief of whom was the late celebrated Dr. Charcot, of Paris. I have secured every available scrap of his clinical history, have examined him and by strange chance evolved a diag-

nosis coinciding with one of the many, and incidentally, the particular one which secured him a pension, as I have since learned, a diagnosis that you may be assured he is not loth to quarrel with. The history is as follows :

Case. Louis T., of the 16th dragoons in the French army. Seven years ago in addition to cavalry duties was preparing for competitive examinations. He celebrated Christmas eve of 1887 by studying until one o'clock A. M., when he retired to a restful, quiet sleep, to arise at eight o'clock of the holiday morning, busying himself with customary duties until eleven, when in full dress, he joined an equestrian party of comrades. During the ride his mount fell down in the front legs only, he following down, glued to the saddle, as it were, there being no stirrups, but quickly pulled up his horse, each recovering without the rider dismounting ; at once resuming the ride to return at 2 P. M. with aching pains above the small of the back.

3 P. M. The pain in the back increases but is not severe. The muscles of the lower body feel weak and tired. Urination impossible.

5 P. M. He is unable to stand and has but slight control of voluntary motion from the waist down, the structures being almost entirely flaccid. Thinks he has no fever. Late in the evening he was removed to the hospital where he passed a very restless night due to the pain from the vesical distention.

December 26. Absolute paraplegia, the legs feel swollen as if distended with cotton, and there is entire suppression of perspiration in the lower body. Is catheterized at regular intervals. This day initiates a period characterized by frequent and extreme penile erection, sphincteric spasm to the point of much difficulty in obtaining catheterization; and a condition of constipation alternating with diarrhœa, in either instance the movements occurring without his knowledge. The muscles are rigid, and bedsores have developed. The physician in attendance, having failed to elicit the fact of his fall, but remembering there to have been specific infection some five years before, orders the iodide of potassium, also the thermo-cautery and the interrupted current.

Twentieth day. Voluntary movements reappear, very slight, internal rotation becoming possible, there being present constant adduction. Involuntary movements much in evidence ; the thighs being suddenly flexed upon the abdomen, especially after sitting for some time.

Ninetieth day. He begins to walk, if supported upon each side, the toes dragging and the over or unapposed action of the adductors occasionally marked cross-legged progression, the unusual exertion required giving rise to much trembling weakness. For the first time sensation is tested and found to be intact. There is considerable urinary incontinence.

Two hundred and fifteenth day. He walks with the aid of crutches, the involuntary movements occurring mainly on the left side after sitting, upon going up stairs and when urinating. The first examination is now made of the reflexes which are proven to be exaggerated. During the ride to Bourbonne-les-Bains painful sensation in dorsal region. Here, under the regime of the water cure the reflexes temporarily increase, then diminish, and the catheter is discarded.

Three hundred and sixty-fifth day. The reflexes approach more nearly the normal; he walks with but the aid of a cane, and great frequency is the only abnormal feature of the urination.

Four hundred and seventy-sixth day. Permanent cautery now applied in the interscapular region, the patient by a series of contortions applying the dressings himself, the entire proceeding giving negative results.

Four hundred and eightieth day. Was given the suspension treatment for two or three minutes every other day for one month with resulting improvement in the gait. Thereafter this treatment was alternated with vapor baths and douches with considerable benefit.

Status praesans. Monsieur T., has observed and noted the progress of his case with much interest, and has very kindly consented to come before you to-night. Here is one of his shoes which is quite worn away at the toe as you will see, chargeable to the extensor muscles. He will now show you the initial extent of the cross-legged progression and the improvement, which you see is quite marked. Further than this I will not obtrude the many tests familiar to you all except to show you the condition of the knee reflex as an index of the others. It has been quite a month since I saw him last, when I found the left knee reflex slightly exaggerated by employing "the reënforcement," and taping the quadriceps tendon instead of the

patellæ ; but you see to-night the reaction is normal, or if anything subnormal, possibly because he is very tired.

The plantar, cremasteric, abdominal and epigastric reflexes I do not find abnormal. Neither is the reaction to pain, tactile or muscle sense, though the sensibility to heat and cold is somewhat lessened.

The various muscles contracting to the faradic current, galvanic examination was omitted. I am unable now to detect positively any signs of muscle degeneration, or wasting. He has fairly good control of the bowels and the bladder, urination being so frequent, however, as to compel the wearing of a rubber urinal. The perspiration now begins to appear slightly.

As previously intimated various diagnoses have been made ; syphilis of the cord being the first one, to which have been added spinal meningitis, meningeal hæmorrhage (spinal), multiple neuritis, beri-beri poisoning, anterior polio-myelitis, myelitis and hæmorrhage into the cord substance. This is certainly one of the cases in which the diagnosis must be reached by exclusion.

That syphilis ever directly causes an acute spinal disease is authoritatively denied. It does appear, however in this location, either as a slow transverse myelitis or as a Brown-Sequard paralysis. Now, that these symptoms were not slow, or of a chronic nature in their appearance you will be willing to admit, and later in the paper we shall prove to you the other half by excluding initial myelitis.

We may unhesitatingly rule out the Brown-Sequard paralysis as : 1. There were no premonitory symptoms in our case. 2. The attack developed rapidly. 3. The symptoms were those of paraplegia and not those of hemiparaplegia. Therefore, remembering that syphilis does not directly cause acute spinal lesions ; remarking the rapid and not the slow, or chronic appearance of the symptoms ; and disproving the existence of the Brown-Sequard paralysis, we not without some reason rule out the various lesions in which syphilis is a direct ætiological factor. As to whether syphilis was an indirect or predisposing factor,

neither you nor I, nor any one else can adduce satisfactory evidence, pro or con. It may be remotely related to the disease, for the manner in which organic changes in the nervous system result from syphilis is not fully understood; in all probability many of them depend on the action of a toxalbumen, the result of the life processes of micro-organisms, which are with reason considered the agents of infection, but about whose character there is still no positive information.

Might not the case then, have been one of hæmorrhage into the meninges of the cord? No, and for three good reasons: 1. Radiating paræsthesiæ, or what are known as irritative symptoms occurring in consequence of irritation of the meninges and nerve roots, were absent. 2. The paraplegia was much too complete for but a meningeal hæmorrhage. 3. It is rather characteristic of meningeal hæmorrhage that muscular spasms, local or general, *rapidly* supervene, which was not true of this case.

We decline to believe that spinal meningitis occasioned these symptoms because that affection displays: 1. Initial fever. 2. Excruciating pain attendant upon the least movement. 3. Peripheral radiating pains. 4. Rigidity of the spine or back muscles. 5. A more gradual invasion. 6. Rarely a paraplegia and then late only and slowly, due to gradual cord compression.

We are content to rule out multiple neuritis, for in that morbid condition, 1. There are usually premonitory and constitutional symptoms. 2. There is always initial fever. 3. There is always much peripheral pain. 4. The knee-jerk is constantly lost, and that beginning pretty early in the attack. 5. It is rare that there is sphincteric involvement, either vesical or anal. 6. In twenty out of every thirty-one cases there is a history of alcoholism and there is no such history here. If to these reasons we append: 1. General œdema. 2. Serous effusions into the pleural and peritoneal cavities. 3. Gastric and intestinal disorders, we have paid our respects to beri-beri poisoning.

We have finished with anterior polio-myelitis when we

remember: 1. The present knee-reflex. 2. The involved sphincters; 3. The absence of muscle wasting.

By exclusion therefore we have proven the diagnosis to rest between acute myelitis and hematomyelia, my opinion favoring the latter, and I shall endeavor to substantiate it by excluding the former, and this is my argument: 1. Up to the time of the accident the man was well. 2. There were no constitutional or premonitory symptoms. 3. No cause for myelitis could be adduced except syphilis, and that factor we have ruled out. 4. The fever, what little there was, succeeded or followed the major symptoms instead of preceding them, as it would have done had the case been one of myelitis. 5. To begin with, the reflexes were lost, but returned shortly in an exaggerated form, and it is this important point, I have no doubt, that secured him a pension. Now had there existed primarily a myelitic inflammation, to have lost the reflexes it would have to occur in the lumbar enlargement of the cord, and had such been the case, the reflexes would have remained *continuously* absent for months, at best, whereas in reality it was but for a day. But you will very properly ask, why would not initial dorsal myelitis satisfy the equation? Had there been such a lesion present the reflexes would have been continuously exaggerated from the first, which forges the last ring in the chain of evidence, and we are forced to conclude that the symptoms were occasioned by a hæmorrhage at some point in the spinal cord, and that the reflexes were temporarily abolished by the shock therefrom.

Now where did this lesion occur? We are convinced that it was not in the cervical cord as the arms were not involved in any way. Neither did it occur in the lumbar or the lumbo-sacral region, for once the effects of the shock were over, the action of the centers and reflexes became exaggerated. Then it must have been and is at some point in the dorsal cord, but at what particular spot only a post-mortem, and possibly not that, would reveal; as no systematic or thorough examination was made of the su-

perficual reflexes, or the various "sensibilities" until such time had elapsed that the observations were but little short of worthless. I was much surprised, and not a little disappointed, for it is the knowledge of these paræsthesiæ, etc., that enables us positively to locate the lesion.

Of course we are able to say that the lesion was not a unilateral one and that the anterior and lateral columns were involved. I should say that in all human probability there was a slight dorsal myelitis succeeding or dependent upon the hæmorrhage. Finally, I am well aware that I have avoided some interesting points, but at the same time I fully realize the consideration of them, for two good reasons would be entirely speculative, thus extending a paper, already prolix, with no practical benefit.

DISCUSSION: DR. ARNULPHY: I have listened with vivid interest to the narrative of this remarkable case, and I am sure we all thank Dr. Smith for having brought it to our notice. I also thank him for having brought the patient before us. It is always a good thing to do and the example ought to be followed. I hope it will prove to be contagious; not the case, but the example.

We certainly understand the case better for having seen the patient, having observed his peculiar gait, which no description however terse could picture to the mind's eye with perfect satisfaction. The exhibition of the patient's shoe with its characteristic deformation is a good piece of clinical evidence. I think we always ought to try and illustrate the cases we report to this society by some tangible object. The eye is a great educator.

The graphic history of this French dragoon's misfortune which Dr. Smith drew for us is very instructive and not a little disquieting. Here was a splendidly built fellow, of vigorous constitution, in the pink of health, sporting with his comrades. An accident happens to him—the horse stumbles; he is not thrown, he remains firm in the saddle, there is only a shock, a slight concussion, which perhaps, owing to the position of the horseman at the very instant

in which the horse struck the ground, must have centered at one particular point of the spine, resulting in localized hæmorrhage at the corresponding point of the cord.

Shall we admit that there was in the small vessels of the region an abnormal condition of brittleness, due to some degenerative process of the vascular coats? Is syphilis at the bottom of the trouble? There does not seem to have been either lead or tobacco poisoning, nor any alcoholism. That a moderate shock of the body could bring on bleeding at the nose, nobody seriously doubts; but when it comes to effusion of blood, and subsequent lesion of an organ, the inflammation of which experience shows to be generally fatal is, as I said, a little disquieting. Although the interest attaching to the case be mainly retrospective, Dr. Smith has infused considerable life in the presentation of the case. In spite of many deficiencies and obscurities in the record, he has been able by a strict application of the method of exclusion, to reconstitute the absent or neglected symptoms and arrive almost at the localization of the lesion.

I would like to hear some expression of opinion on the case from the members present.

Dr. H. B. FELLOWS: This paper is an exceedingly interesting one as well as the case that illustrates it, and the Doctor deserves our thanks both for writing the paper and bringing the case before the society, and there is no doubt of the correctness of the diagnosis. One fact especially strikes one in the case as being important in the diagnosis and that is the suddenness with which the paraplegia developed after the accident. It could have been but a very few hours from the onset of the first symptoms to the complete paraplegia. The suddenness with which it developed would point to the circulation of the cord being deranged in some manner. And while it is doubted by some authorities whether hæmorrhage even takes place in the cord substance, we most certainly find a hæmorrhagic condition there, and most authorities, especially Gowers and Fagge as I remember them, speak of a hæmorrhagic my-

elitis. In these cases there may be some doubt as to whether the hæmorrhage precedes the inflammation or whether it occurs in its very earliest stages. This case at least if not strictly dependent upon the hæmorrhage, would seem to have been a hæmorrhagic inflammation and, as subsequent symptoms have shown, must have been in the dorsal region. This being the case and the pyramidal columns injured, we have the groundwork for the subsequent excessive reflex action in the legs, because whenever these columns are injured in the dorsal region or above, leaving the reflex centres in the lumbar region intact, there will be excessive reflexes. It is a pity that the observations seem to have been so incomplete in the earlier stages. We have little or no account of the sensory symptoms such as would have been shown by good observations properly reported. We have therefore to infer largely from the present condition of the case what they were in its earlier weeks. The lack of the wasting of muscles and the contraction of muscles to the Faradic current, would show that the anterior gray horns are not now and probably were not involved seriously.

The lack of sensory symptoms, such as occur in locomotor ataxia, also rules out serious affections that would have been progressive in their nature in the posterior columns of the cord, while so many symptoms point to deranged functions of the pyramidal columns that we are obliged to conclude that they sustained the chief shock of the attack. This persistence and the suddenness of their occurrence, the entire lack of fever in the earlier stages, justify us in believing that it must have been hæmorrhagic in its nature, and that in all probability some hæmorrhagic difficulty was coincident with or preceded the myelitis, which probably developed to some extent afterward. This certainly is a very rare case and deserves to have your especial attention, as well as the analysis so carefully given by the essayist.

Dr. ARNULPHY: I cannot help thinking that there was some bungling in the early management of the case. The

application of the Faradic current was certainly unfortunate, and the patient may thank his luck and good constitution for having escaped with his life.

It seems to me the patient would have been better off, had he been taken care of in Hahnemann Hospital. A few doses of arnica, followed by aconitum, belladonna, possibly phosphorus or causticum, might have brought a very substantial change in the evolution of the spinal lesion.

We would like to hear what Dr. Smith has to say about the treatment of the case.

Dr. ORRIN L. SMITH: You ask as to treatment. Of course we would think at once of causticum, hypericum, silicea and arsenicum iod. I should prefer the last named remedy, and in addition employing patiently and persistently faradism, massage and hydrotherapy.

XXXVII. A CASE OF POST-NASAL ATRESIA.—By Wesley A. DUNN, M. D. *Case.* F. M. M., thirty-six years of age, was kindly referred to me by Dr. F. A. Benham, Jr., of La Grange, Ind. He was of good physique and gave the following history:

From early childhood he was unable to breathe through the nose owing to permanent occlusion for which he could give no primary cause. Mouth breathing was absolute, with the usual symptoms that follow this condition. Three years before he applied for treatment he had suffered from acute suppurative otitis which resulted in a permanent discharge from both ears.

When applying for examination he was quite deaf, only being able to distinguish sounds much louder than the normal voice. An examination of the anterior nasal opening showed this portion of the nose to be normal. The rhinoscopic examination showed the posterior choanæ to be completely closed by a whitish, firm membrane, resembling somewhat the appearance of myxomatous growth. By more careful examination with the glass and probe, it was found that the tissue formed a diaphragm over the posterior end of the nose, terminating at the borders of the nasal openings, except on the septal side where the tissue of the two sides were united, involving the posterior end of the septum which seemed to be incorporated in the

mass. The tissue was about one-eighth inch in thickness and made up of firm homogeneous material. No microscopic examination was made and it is therefore impossible to give the exact pathological formation of the tissue. It was not extremely vascular, with about the usual irritability of the nasal tissue. It did not involve the eustachian tubes completely, but had caused much swelling, especially on the anterior border of the eustachian openings, causing partial closure and much inflammation of the tubes.

Three years prior to this time, an acute inflammation of the throat and nose and acute otitis had destroyed the membranes of the tympani, resulting in chronic otitis. For the last two years he had noticed the ears were filled by some sort of material which I found to be large polypoid growths, springing from the diseased tympanic cavities. The left ear was completely filled, the growth projecting far out into the external ear. In the right ear the growth did not reach the surface.

Upon removing the growth of the left ear with a snare, I found the upper portion of the ear completely filled with decomposing, cheesy material which had been secreted for months and as it decomposed, gave off pus which emitted an extremely unpleasant odor. The right ear was not so seriously affected and the growth had not retained such decomposing material and was therefore in a more healthful condition.

I removed the aural polypi with a snare and by the usual antiseptic treatment of boracic acid was able to completely heal the ears and stop the discharge.

Dilatation with the catheter, after the operation of the nose, was successful in restoring the hearing. I determined to remove the tissue from the nasal choanæ by the use of Loenberg's post nasal forceps. After anæsthetizing the nose with cocaine, by the use of the laryngeal mirror I was able to place the forceps against the growth and grasp a large portion of the tissue. It was impossible, however, to cut the tissue directly away, and therefore, by cutting and tearing the new tissue from its place I was able to remove a large part of it from each side at the first sitting. After three or four days I was able to remove much of the remaining tissue in the same manner, taking off large portions between the side of the nose and the eustachian opening. After three or four such operations but little of the tissue remained; a small portion on the septum and in the top of the nose and around the eustachian opening.

This was removed by the electro-cautery at different sittings and finally allowed to completely heal. By proper disinfection the tissue healed rapidly and has shown no disposition to return, as the patient writes me that he still remains in perfect health, and that the operation had proved perfectly successful. The nasal stenosis was entirely relieved; the general health was much improved and the nasal discharge that had been severe during all his life was quite removed.

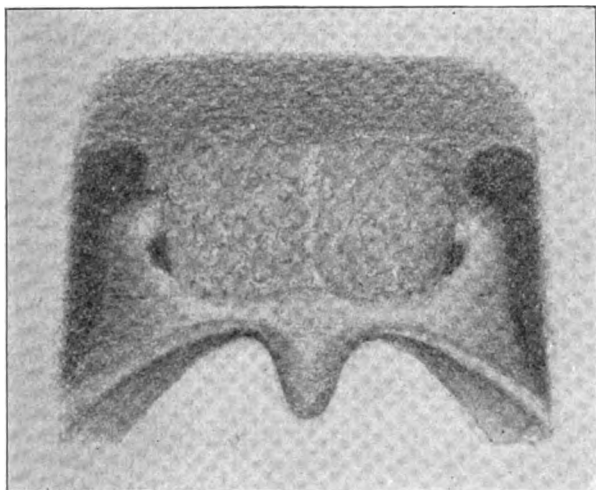


FIGURE 18.

The accompanying cut will illustrate the extent of the new formed tissue and the degree of closure of the Eustachian openings. See Fig. 18.

I have not before seen such a condition as presented in this case, but other forms of nasal atresia are not uncommon. The most prolific type, perhaps, is that produced by hereditary syphilis, especially in children. In early life the nose is very small and if syphilitic inflammation takes place, with its peculiar plastic tendency, it is not uncommon for the nose to be welded together, as it were, by the resulting disintegration and granulation. It sometimes involves the whole nasal chambers, causing complete stenosis and the massing together of a lot of homogeneous plastic material in place of the normal nasal passages.

It often results from inflammatory conditions of other types, involving only the anterior wings of the nose; burns, septic inflammation attending diphtheria, scarlatina, measles, tuberculosis, etc., may produce plastic adhesion of the walls of the nose in the anterior portion, producing complete or partial atresia.

A remarkable case of this type was reported by the *Journal of Ophthalmology and Otology* for 1893, in which the anterior openings of the nose were completely closed by plastic inflammation.

In specific cases it not infrequently happens that the external nose is destroyed or allowed to become totally depressed by the destructive inflammation that takes place. In such cases the restoration of the nose is difficult, because of the extreme tendency of the granulation to completely fill the nose after the original mass of tissue has been removed, but with properly arranged plugs it may be retained patent and good results obtained.

One should be careful not to associate this condition with nasal stenosis of other types, in which the walls have not become adherent, as the treatment depends upon the proper diagnosis, and the result is much more promising in the usual type of nasal stenosis than in atresia.

Atresia is very liable to follow the removal of the internal portion of the nose for cancer or other conditions requiring such an operation. Care should be exercised from the first to prevent the complete union of the walls by the use of proper dressings and afterward by a hollow plug which will prevent the walls from becoming united.

The operation for atresia will depend on the location and extent of the adhesion of the walls of the nose. Adhesion of the turbinated bodies at the septum may be readily removed with the saw by separating each side of the adherent tissue, removing enough to leave the proper nasal passage free. A carefully placed plug of jute covered with absorbent cotton and saturated with calendula cerate will avoid the possibility of re-adhesion from granulation.

In the case reported in the *Journal of Ophthalmology and Otology* the doctor was successful after much time in restoring the nose to its normal condition. I think, however, the removal of the plastic material with the knife and scissors and carefully bringing the edges together with sutures would be quicker, with equally good results. Each case, however, is peculiar to itself and no specified treatment can be put forth in advance for that particular condition.

Hospital Notes.

THE CHILDREN'S CLINIC.

SERVICE BY PROF. JOS. P. COBB, M. D.

REPORTED BY H. J. PAYNE, CLERK OF THE CLINIC.

ERYTHEMATOUS ECZEMA.—*Case 805.* Margie, æt. eleven months, was brought to the clinic August 30. The family history reveals tuberculosis on the mother's side. Margie has always been apparently well until one week ago when an erythematous eruption appeared upon the nates. It has spread very rapidly covering the nates, thighs, groin and genitals. It is angry red in appearance, very sensitive and easily irritated.

The mother says that her other child, a girl also, had a similar rash appearing in the same locality when she was about the same age, which lasted for a long time. The child is restless and uneasy during the day-time, but not cross; she sleeps fairly well but not quietly; her appetite is good and her digestion is normal. Rhus tox. was given four times daily, and aristol cerate was recommended as an external application.

This form of eczema is peculiar to infancy and is much rarer in older children and adults. It may run its course as such, gradually improving when the causes producing it are eliminated, or when it has been relieved by proper treatment. If not relieved, or if the exciting causes continue active, it may run into the vesicular form or even into eczema rubra.

The etiological factors in its production are first a dyscrasia, inherited or acquired which renders the skin more sensitive; the effects produced upon the offspring by tuberculosis and syphilis in the parents or grandparents render them very liable to catarrhal inflammations; the location for its manifestation depends largely upon its environment and the special forms of irritation to which it is subjected. The clothing applied to this part of a

child's body is often of entirely different texture from that which is used elsewhere. It is frequently allowed to remain for hours in contact with the skin after it has become soiled; if the child's digestion is at fault the urine will be heavily loaded with irritating compounds and all of the favorable factors for the production of eczema will be present, viz.: heat, moisture, friction and the presence of irritating substances.

This explains why I so frequently recommend some form of ointment for local use; one of its important uses is to do away with some of the causative factors; to protect the skin; it is equally as important to remove the other factors as well; cleanliness and the use of soft fabrics next to the skin must be insisted upon.

The child improved on the treatment, and September 26, the eruption had entirely disappeared.

ENURESIS.—*Case 837.* This little girl was brought to the clinic September 29. She has been troubled since a baby with enuresis. There is a frequent desire to urinate both day and night. Sometimes through the day she can control herself very well, but always urinates several times at night without waking. The urine is described as being of a dark color like blood and of an offensive odor. The trouble is aggravated after physical or mental exertion. She is a very nervous child, easily frightened. She does not sleep well, cries, screams and throws herself about in her sleep. She complains of a pain across the back and often has a frontal headache. Her general health is good.

Pulsatilla 3 x was given four times daily.

There was an immediate improvement on this remedy and one week afterward she was reported as sleeping much better; had not so frequent desire to urinate and could control herself better through the day, but was still troubled at night.

The remedy was continued and October 13 she is very much better. For three nights she has slept well without any trouble whatever. Her appetite is good and her bowels move regular. The stool is normal. The remedy is again continued.

I have called your attention on different occasions not only to the frequency with which enuresis occurs in

children, but also to the different types which the condition assumes and the different causes which may be operative.

The trouble may be solely in the nervous system, which is not a common form for children; it may be due to imperfect development of the muscular wall of the bladder and a consequent lack of resistive strength on the part of the vesical sphincter. This is a very frequent form in children. The most common type, however, of those appearing at this clinic are those where we have a history, as in this case, of an irritating form of urine; a dark, foul, heavily loaded urine, the primary cause of which can be traced back to the digestive system, produces enuresis by the direct irritation of the vesical mucosa; if this goes on to an inflammatory action we may have the secretion of mucus, an alkaline urine and mucous fermentation, giving rise to carbonate of ammonia in the urine by splitting up the urea.

In this case we have the general nervous irritability due partly to the local irritation and the evidence of excessive elimination. These are just the cases that can often control the desire during waking hours, but when the mental inhibition is removed by sleep the lumbar centres are alone inadequate to control the reflex stimulus that comes from the bladder wall. When tired or affected the same effect is produced because the will loses its power to exhibit well-ordered inhibition and all of the reflex centres are in a state of overexcitability. The careful study of the physiology of this viscus will repay any physician who proposes to care for children.

ACUTE DYSPEPTIC DIARRHŒA FOLLOWING WEANING.—*Case 834.* George H., æt. ten months, was brought to the clinic September 29. The family history is good. The child has always been well until he was weaned three weeks ago. One week ago he took cold, has a slight dry, hacking cough, the tonsils are inflamed and swollen. He has frequent urging to stool with much tenesmus and the passage of only a little fæcal matter at a time; the stool is yellow or dark green, watery, containing mucus and of an offensive odor. The child is cross and restless day and night, is only quiet while he is carried. During the first two days of

the attack he had a good deal of fever. He was given belladonna four times daily and careful directions for feeding.

One week later the child was again brought to the clinic. His appetite was good, the cough better, the bowels were normal and he slept well. He was good-natured. The mother said that he still sweats profusely about the head when sleeping. He was given calc. carb. four times daily.

A week later he was brought to the clinic with the following symptoms: For three days he has been very cross and restless day and night. He has been feverish, especially at night, the fever coming on about 9 P. M. and lasting till midnight.

His appetite is good, the bowels move regularly and the stool is normal. He has a tight hacking cough and cannot breathe through his nose. He is cutting his bicuspid teeth. He was again given belladonna and reported very much better the following week.

This is a common report not only in our clinic but wherever we find children: "The baby was well until a few weeks before when he was weaned;" you are usually informed that the child is teething and that that is the cause of the indigestion and diarrhœa; the question of change of food has not been considered as a factor; when children are teething they are often more easily affected by changes of temperature and take cold more easily, but my observation teaches me that teething is never the sole cause of these digestive disturbances.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

REPORTED BY CORNELIA S. STETTLER, M. D.*

CYSTS OF THE FALLOPIAN TUBE. — October 25. In speaking of salpingitis as illustrated by several specimens obtained in operations before the class, Prof. L. said: All tubal cysts, whether they contain blood, or pus, or serum, are retention cysts. And so likewise is the fetal cyst of

*Continued from page 432.

the gravid tube. The retention may be due to the closure of either, or of both extremities of the oviduct; to an abrupt twist in its convolutions, or to their becoming sacculated; and may or may not find periodical relief by an overflow into the uterus, or into the peritoneal cavity. This is the source of certain kinds of uterine leucorrhœa, menorrhagia and pelvic hæmatocele.

Sometimes there is a fracture of the tube along its lower margin with an escape of the cyst contents downward into the broad ligament, as usually occurs with the primary rupture of extra-uterine pregnancy. This may give rise to intraligamentous abscesses, and hæmatic or serous tumors of which we have had several interesting examples in our clinic.

But, you may ask, if in these cystic forms of salpingitis the tumor is due to a retention of fluids why not relieve them by tapping? For the simple reason that when it depends upon either of the mechanical causes just named, to empty it would not be to cure it; and because it is not always a safe or an easy matter to puncture such a cyst with a trocar of any sort. The introduction of the electrical needle to fry its contents would be murderous, and massage is likely to do more harm than good in such cases. Sometimes, however, they can be drained through the uterus and finally disposed of without extirpation. Others are decanted into the Douglas pouch and discharged through fistulous openings into the rectum; but unless recourse is had to extirpation the most of them go from bad to worse until the poor woman becomes a helpless and hopeless invalid.

There is no doubt that the radical operation of tubo-ovariotomy, and even of vaginal hysterectomy, has often been needlessly made in slight and unimportant cases of salpingitis, with and without retention cysts; but it is equally certain that a much larger number of women should be, and can only be relieved and cured by these identical measures. The proper thing is to discriminate carefully, and then do what is best for the individual case in hand.

CYSTOSPASM. EXPLORATORY DILATATION AND INSPECTION OF THE INTERIOR OF THE BLADDER BY KELLY'S METHOD.—
Wednesday, October 31. The case (22,011) which subclass four saw with me in the hospital two days ago presented some points of clinical interest that should be care-

fully considered. The patient, who is twenty-seven and unmarried, underwent an operation for the removal of both ovaries by the justly celebrated Dr. Battey, eleven years ago, for the cure of an atrocious and intractable ovarian pain and dysmenorrhœa. Since that time the menses have not reappeared in any form. For about a year she was as bad as ever, after which for some time she had fairly good health, being, however, very anæmic and nervous. Two years ago she had the subjective symptoms of uterine prolapse, with vesical irritation and decided and very painful attacks of vaginal spasm, or vaginismus. The bladder trouble finally became so bad that she was obliged to urinate every five minutes, especially if she went down town, walked about, or became in the least excited. She was kindly referred to this clinic by Prof. Snow, March 7, now eight months ago. April 6, the remains of the hymen were excised and for two months the vesical and vaginal symptoms almost entirely disappeared. Then the vaginismus returned and became so tormenting that on July 27 I made Sim's operation for its relief; but when that symptom had been disposed of the painful urging to urinate returned and became, as she said, worse than ever. When she re-entered the hospital a week ago it was torture to urinate and the act had to be repeated several times each hour, day and night. The urine had a specific gravity of 1.020, was acid and contained neither albumen, pus, sugar, nor blood. The urging and tenesmus were accompanied by a sensation as if something dropped, or was forced into the passage thus checking the flow and increasing the pain. She had observed that drinking freely of warm water made the flow more free and easy, but it was never natural.

On October 29, an exploratory dilatation of the urethra was made with Kelly's graduated dilators, after which my index finger was passed and a digital examination of the bladder was carefully made by conjoined manipulation. Then the speculum being introduced the interior of the bladder was illuminated and exposed to the view of the members of the class.

This mode of examining the bladder by palpation enables us to observe any urethral lesion, to detect the presence of a stone (of which she had more than one prominent symptom) and also to find other foreign bodies, polypi, fibrous and other tumors and neoplasms, and nodular, follicular and tuberculous growths, none of which, however, were present in this case. But in order that the finger

may readily pass into the bladder, the urethra must be dilated throughout its whole extent, which it is impossible to accomplish without injury by any other dilator than the graduated metallic bougie.

Visual inspection of the interior of the bladder by Kelly's method will satisfy you of the existence of hyperæmia, ulceration, and lesions connected with the orifices of the ureters as well as with the lumen of each of them, for they can be readily catheterized through the speculum. This sort of examination in the case before us disclosed no lesion whatever and no signs of infection within the bladder.

Such a thorough vesical exploration with negative results enables us to exclude the more direct local causes of dysuria. But we must remember that the same kind of suffering may arise in a reflex way from ovarian and uterine irritation and pressure, and intra-pelvic neuralgia and adhesions, as well as from rectal troubles of various kinds, such as ulceration, fissure, hæmorrhoids, prolapse, stricture, spasm of the sphincter ani, or the presence of worms or foreign bodies within the bowel. In this case the ovaries are absent, the uterus is so atrophied that it is not much larger than my thumb, and there is nothing wrong with the rectum. Sometimes this last possibility is a very important one.

Case. In June, 1883, I was called to Richfield Springs, N. Y., in the case of a young lady who for several years had suffered almost incessantly with frequent and very painful urination. She had become a nervous wreck from the tormenting affection; for although she had been under the skillful treatment of one of the best physicians of our school in New York city for eighteen months, and of others elsewhere, of specialists in America and Europe, and had spent two years at the different spas in Germany, the trouble had increased and become unbearable. I made as careful an exploration of the bladder as was possible in those days; passed my finger within it and satisfied myself that there was nothing there to account for the agonizing tenesmus that had made such a chronic martyr of the patient. I then everted the rectum after Storer's method, which you have seen practiced in my clinic, and just at the margin of the internal sphincter found a large and very irritable ulcer. That lesion proved to be the thorn in the flesh, for with the local use of calendula and appropriate remedies internally she made a speedy recovery.

Now, having failed to find a local pathological cause for our patient's suffering, what is the clinical inference? That the case is one of cystospasm, which is a vesical neurosis, or a neurotic affection of the bladder that depends upon trouble with the detrusor and sphincter muscles of that organ. Their contractions are spasmodic and choreiform, but painful, exaggerated and almost tetanic. Instead of acting in sympathy and unison they antagonize each other, and directly a small quantity of urine is passed into the bladder the most agonizing desire to void it follows. That desire is irresistible and the distress is almost unbearable. It may recur as often as from two to twenty minutes in a sort of rhythmical order, or the paroxysms may be less frequent with the escape of a relatively large quantity of urine. Sometimes there is a clonic spasm of the sphincter with tenesmus and a jerky flow; again there is a temporary retention of the excessive secretion, and the cystospasm alternates with hysterical ischuria. In such a case the depth of the bladder is very much increased, and the passage of the catheter without anæsthesia is practically impossible, as indeed it is in most cases of cystospasm.

This brief review of the causes and complications of a very painful disorder not only suggests the various kinds of treatment, medical and surgical, that may be necessary, but also the difficulty, and the impossibility, in most cases of curing it promptly. No one remedy or method is suited to all of them alike. Where the case is purely neurotic, depending upon spinal irritation, or some central nervous lesion, excessive venery or onanism, the best powers of the nervous specialist should be brought into requisition. Galvanism, repeated and careful dilatation of the urethra, the sitz bath, appropriate internal remedies, and the proper diet for body and mind may be of service provided they are intelligently and persistently applied. The same is true of all the hysteroneuroses that may coexist with vesical disorders in women, more especially in those of an hysterical and neuralgic temperament.

MULTILOCULAR CYST OF THE OVARY WITH CLEAR CONTENTS. REMOVAL. RECOVERY. *Case 23,026* brought to the hospital by Dr. Paul, of Rock Island, was a large fleshy woman upon whom an ovariectomy had been attempted eighteen months before by a surgeon in a neighboring State. On account of the adhesions and the extreme vascularity of the growth it was declared malignant and the operation

was relinquished. The tumor had of late increased in size and she determined, if possible, to have it removed. Prof. L. accordingly made an ovariectomy September 26 before sub-class 6. The adhesions were formidable and the operation was a serious one, but the patient came out all right and afterward made a prompt and complete recovery. The clinical peculiarity of the case, apart from its once having been declared malignant and inoperable, even after the exploratory incision, was that each and all of its cysts of which there were many, were filled with clear, spring water fluid such as is usually found in parovarian cysts.

INTERSTITIAL UTERINE SARCOMA. ABDOMINAL HYSTERECTOMY. DEATH. *Case 23,042* is reported as a striking instance of the possible result of delay in instituting the proper treatment for uterine fibromata. The patient was brought to the hospital by Dr. Effie T. Straub, of this city, who had prepared her for the necessary operation and who furnished the following report of the *Case*:—aet. 42, married thirteen years, was never pregnant. About eight years ago she first noticed some enlargement of the uterus and suffered considerable from a leucorrhœal discharge, pain and excessive menstrual flow; lost her appetite and flesh. Thinking it due to some local condition she consulted her home physician and after several months of local treatment he advised a change of air; so she went to visit friends in the South, remaining absent almost a year. While there the menstrual flow became hæmorrhagic at several periods. For the next two years she grew steadily more uncomfortable and suffered much at the hands of many physicians, including a six months' course of treatment at a celebrated sanitarium in New York. There the growth was pronounced polypoid in character and the womb curetted several times. Electricity was also employed, but with no improvement whatever. Four years ago a copious watery flow commenced which continued constantly with the exception of one week while under my care, to the date of operation. It was odorless, colorless and very irritating, so profuse at times as to come gushing involuntarily and to saturate her clothing.

May 5th, 1894, she came to me from a "magnetic physician" from whom she had been taking "treatments" for several months. She sought relief from this most annoying flow and what she called "nervous dyspepsia." Every particle of food taken into her stomach distressed her; con-

stant eructations, sleepless and restless all night; could not bear pressure from clothing; afraid of being touched; tenderness to touch, especially over the lower part of the abdomen, which was distended as much as if seven months pregnant; constant desire to urinate, with burning pain after urination; obstinate constipation, only relieved by enemata. Face pale, skin harsh and dry; puffy around the eyes; shortness of breath and fluttering around the heart; she could not speak of her condition without tears, was very despondent and frequently expressed herself as tired of trying to live any longer, although she was naturally of a vivacious, hopeful disposition. The enlarged uterus could be easily outlined by palpation, seemed as large and firm as a five months pregnancy. I did not pass the sound because she objected so much to my doing so. The os was slightly inflamed with some granulation and very tender. A few local treatments with proper internal remedies and general supervision of her condition relieved all of the distressing symptoms except the flow which still persisted.

August 16th I persuaded her to accompany me to Dr. Ludlam for examination. His diagnosis was an intra-mural fibroid and advised an abdominal hysterectomy is the last resort. At this time her appearance was such that the ordinary observer would have supposed her to be in perfect health; skin fresh and elastic; color good; appetite normal, food agreeing and causing no trouble; the bowels moving nicely, the sleep refreshing and spirits so gay that she was the life of the house. She said indeed that she had not felt so well for years as in the six weeks between this time and the date of the operation.

A supra-vaginal hysterectomy was made October 6. Abdominal section disclosed a tumor that completely filled the lower pelvis and extended above the superior strait half way to the umbilicus. It was raised above the brim with difficulty and was found to include the uterus, which was completely lost in the growth. The surface of the tumor was of a dark purplish hue, covered with large veins and a very thin capsule. The pelvic peritoneum was ecchymosed, thick and pulpy, and very easily stripped off, which condition extended as far as the top of the tumor. The uterus and ovaries were taken with the sarcomatous mass. The patient did extremely well for two days when a diaphragmatic peritonitis with an inveterate hiccough set in. This was followed by a general peritonitis and she died on the fourth day.

In remarking upon this case the following points were made for the benefit of the class: Experience proves that many, perhaps most uterine fibroids are seeded, so to speak, with sarcomatous elements that sooner or later will grow and assert themselves. It also proves that their early and prompt removal is a thousand times safer and more efficacious than any kind of symptomatic tinkering and temporising whatever. The whole history of this unfortunate case prior to its coming under Dr. Straub's intelligent care shows that the patient was a fit, suitable and promising subject for hysterectomy; and I have no doubt that if the uterus had been carefully removed by the vagina five or six years ago, that beautiful and lovely woman would have been alive to-day.

THE LONG INCISION AS A SAFEGUARD IN OVARIOTOMY.—*Case 23,046.* Miss — æt. 34, from La Porte, Ind., first observed in January last, an enlargement low down in the left side of the abdomen. At the same time she began to menstruate every two weeks, the flow being profuse, dark and offensive, and continuing for eight days. Ten years before she had received an injury in the left inguinal region. For fifteen years she had suffered severely for a day or two in advance of the monthly period.

October 23 an ovariectomy was made before sub-class 3 and a polycyst weighing fifteen pounds was taken. The cysts proved to be filled with a thick, soapy, greenish, gelatinous fluid, but as a precautionary measure the growth was removed *en masse* and without tapping any of them. This, said Prof. L., I have found to be the safer way with such tumors, for it prevents the possible escape of any of the noxious fluid into the abdominal cavity; and with careful asepsis and the proper adjustment and dressing of the wound there is no more risk from a long incision than from a short one. The essential point is to keep the infectious fluid from coming into contact with the peritoneum and with the edges of the wound. Where the parent cyst is a large one the better way is to empty it and so to reduce the size of the tumor as to render a large incision unnecessary; but when there are several cysts of about the same size, I prefer to make the incision long enough to permit the removal of the tumor as if it were a solid fibroma. And the worse the quality of the cyst contents the greater the value of this simple and sensible expedient.

Miscellaneous Items.

The death of our good friend and colleague, Dr. J. P. Dake, October 28, in his 68th year, of paralysis, is the saddest bit of news that we have had to chronicle for a long time; for while Dr. Carroll Dunham was the Melanchthon, Dr. Dake was the Erasmus in the reformation that the Homœopathic School of Medicine has wrought in this country. Other recent deaths are those of Prof. Goodell of Philadelphia, the celebrated gynecologist; of Dr. Oliver Wendell Homes and of Dr. Charles S. Duncombe, for many years a most reputable practitioner of our school of medicine in Racine, Wis.—Dr. W. C. Duncan has removed from Fond du Lac to Wauwatosa, Wis.—Our monthly list of marriages in the medical family includes that of Dr. Howard N. Lyon to Dr. Ellen Flower Hancock, both of this city; and of Dr. P. F. Netherton to Laura Hanson of Eureka, Kas.—The proposed Missouri Valley Homœopathic Medical Association will hold its initial meeting at Omaha, Neb., November 21.—Prof. Cobb will attend the meeting of the Southern Homœopathic Medical Association which is imminent in Chattanooga, Tenn.—If the doctors who are complaining of hard times and too little to do will look in upon our clinics in the OLD HAHNEMANN about these days, they can spend their spare time very profitably.—One more number will close volume XV. of the CLINIQUE and one more meeting closes the *seventeenth* year of the Clinical Society.—The forthcoming issue of the *Pulse* is being looked for with especial interest.—For lack of space a lot of reviews must go over to next month.—The new Hahnemann hospital building is so attractive that after-dinner parties visit it instead of going to the theatre.

THE CLINIQUE.

Vol. XV.]

CHICAGO, DECEMBER 15, 1894.

[No. 12.]

Original Lectures.

COCA AND COCAINE.

A LECTURE BY J. E. GILMAN, M. D., PROFESSOR OF MATERIA MEDICA AND THERAPEUTICS IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

Within a very recent period another agent has entered the list of the anæsthetic group that is in some forms of diseased conditions and for some operations unique in its sphere of action. I refer to cocaine. This is obtained from the erythroxyton coca, a small bushy shrub which grows from two to five feet in height. It has a purplish brown, wrinkled bark with smooth twigs and bright green leaves. It is a native of South America, being found in Peru, Bolivia, Colombia, Brazil and the Argentine Republic. It flourishes best in the warm, moist mountainous climate of Bolivia and Peru, at an altitude of two to five thousand feet above the sea. It has been known to the inhabitants of these countries for a period so long that it is traditional, but in this country it was unknown until about 1870, and it gained admittance to the Pharmacopœia in 1882.

The leaves of the coca contain the medicinal virtues of the plant, and these are, when fully grown, picked one by one carefully, so as to avoid breaking them, and after drying in the sun are packed in bags or bales for merchandise.

Many of the coca leaves are more or less injured and despoiled of their value and strength by careless preparation, such as too rapid or too slow drying, or other faults in the manner of curing them. When dried the leaves have

a pleasant tea like odor and an aromatic bitter taste. A peculiar, benumbing effect on the tongue is characteristic of this plant when masticated, depriving it of sensation and taste.

When the first accounts of coca were given to us in this country it was one of the marvels of medical literature. Travelers reported the most extraordinary stories of its enormous consumption and wonderful effects on the natives. Such feats of endurance while under its influence as couriers running at great speed over the mountain ranges, without stop or stay, in such a rarified atmosphere that the slightest exertion would render ordinary mortals almost breathless. Its power was so beneficent that cold and hunger were unknown and unfelt. Chewing the leaves a runner could keep up his speed for many hours, then with a brief period of rest would resume his course and continue it, day after day, until immense distances had been covered without food, or the desire for it. The coca in some occult, unknown way was nutrition, life, warmth and nerve force. As we become acquainted with the plant we are able to look at it without the glamour of romance, and understand its true rationale of action and its value.

The native Indians do use it in large quantities, as follows: "The Indian always has the leaves by him, as the tobacco user has his pouch and pipe, and carries them in a bag or wallet attached to his belt. He also carries a small gourd filled with powdered lime or with the ashes of some favorite plant, to use with the coca. Several times a day, if practicable, he rests from work for about fifteen minutes, takes some of the leaves and chews them into a pulpy ball. Then dipping a stick into the lime or ashes, puts some of it upon the half masticated coca. Then he continues the chewing until the mass is exhausted, generally swallowing the saliva. But if his work is particularly arduous he may chew the leaves almost constantly while employed. So necessary is this substance deemed by him that he cannot be induced to do without it, and contractors for labor in mines and forests and the builders of the new mountain railroads are obliged to furnish daily rations of coca as a part of the food supplies."

There is no doubt of its possessing a considerable stimulant action on the nervous system, bearing a general resemblance to the action of tea and coffee. Its power to relieve the pangs of hunger is not due to any great extent to a real nutritive value, but more largely to its anæsthetic

influence on the stomach and its stimulant effect upon the central nervous system. While it removes the sense of hunger, it will not postpone death from starvation as in the event of deprivation of food ; death will ensue as speedily with as without the coca. After chewing the leaves the ability to eat is increased, so that enormous quantities of food are often eaten by the coca users after one of their fasts under its influence.

From the coca an alkaloid has been prepared by Merck and others called cocaine, which crystallizes in colorless, inodorous prisms of a slightly bitter taste, very slightly soluble in cold water, but dissolving more readily in boiling water and alcohol, but not in ether. The proportion of cocaine found in the coca leaves is somewhat variable, being sometimes about $\frac{1}{4}$ of 1 per cent, while in some specimens scarcely a trace can be found.

The cocaine itself owing to its insolubility is not used to any extent, but its salts dissolve in water readily, and there are several of them in use. The one most known and in general use is the hydrochlorate of cocaine. This is soluble in almost all proportions of water and alcohol, and is described in the pharmacopœia as "Almost colorless acicular crystals or crystalline powders readily soluble in water, alcohol and ether. Its solution in water has a bitter taste." This aqueous solution of the hydrochlorate of cocaine is the one that is used for producing anæsthesia of the eye, ear, nose and the mucous surfaces. For subcutaneous injections, atomizations and all the numerous methods of inducing local insensibility. It requires nothing else to mix with it and all such materials as glycerine, alcohol, etc., render it less valuable and more inclined to produce unnecessary irritation. Solutions of cocaine will not retain their integrity indefinitely, as they become decomposed and weakened by the growth of microscopical fungi ; when it is necessary to keep a solution some time an antiseptic substance like thymol, boric or salicylic acids is used, but of course, the freshly made solution is preferable. For the anæsthetic effect required, a 2 to 4 per cent solution is prepared. It is as a general rule inadvisable to use a stronger solution than this. Often a 2 per cent solution is all that is needed. Two or three applications of this five minutes apart will produce an anæsthetic effect under some circumstances, and upon some tissues, that is speedy but transient in its action. The anæsthetic effect beginning within two to four minutes of its applica-

tion and remaining for from a half to three-quarters of an hour.

The growth of cocaine with its present multifarious uses was as follows: The peculiar benumbing effect upon the tongue led to the use of a concentrated solution upon the larynx and pharynx to relieve some painful disorders of their tissues, and in this manner first came into use by the laryngologists. Then Dr. Kaller, of Vienna, experimented with animals to test its effect upon the eye, and convinced of its anæsthetic power introduced it in operations upon mankind. In so doing he paved the way for a very valuable adjunct to the surgeon's operations. In September, 1884, Dr. Kaller reported his experiments and conclusions to the convention of German Oculists at Heidelberg, and Dr. Bull, of New York City, used it a month later for the first time in this country. Its use rapidly became general, and was extended to other surgical operations besides those of the oculist and aurist. New uses for it and novel methods of utilizing the anæsthetic effects are being constantly introduced. For operations on the eye it has superseded all other substances and all general anæsthetics. Koller first experimented on the rabbit's eye. After a few drops had been instilled (3 to 100), the pupil became somewhat dilated, fixed and remained insensible to touch, to pricking and to cauterization. He then found that in the human subject the same effect was produced. The sensation at first felt was for the moment a dryness, an increase of the lachrymal secretion, and a sensation of warmth, then the sensibility of the eye diminished little by little, and the reflex movements were abolished, and even when there was some vague uncertain sensibility to touch, the analgesic effect was complete. For operations upon the deeper tissues of the eye to secure the freedom from pain care must be taken to apply the cocaine as these tissues are approached.

The effect of cocaine is cumulative, that is, one application to the eye may induce an anæsthetic effect for say ten minutes, but if in five minutes it is repeated, the anæsthesia will be prolonged for half an hour or more. So in operations on the eye, as for surgical use, a repeated dose is the method required to prolong the effect beyond the very transient duration of the initial application. Fauvel and Coupard applied the coca in affections of the larynx and pharynx. In this use of it it is painted on the mucous surfaces, or it is applied in the form of fine

spray. This latter a method that requires care from certain causes, of which I shall speak later. On the skin the anæsthetic effect is not as well marked as upon other tissues. Still the skin is not absolutely refractory, but it requires much stronger solutions to produce the required effect, ten to fifteen per cent being used for the purpose. Wyeth says, "that injected into the tissues it produces anæsthesia wherever it reaches in bone, muscle or the subcutaneous structures. Thrown into the substance of a nerve, or immediately around it, it is readily absorbed, and produces anæsthesia in all parts in the range of distribution of the nerve trunk beyond the point of insertion."

It is this observed fact which serves to point the danger in its use on those nerves which might too greatly influence the motion of the lungs or heart. So when the cocaine is used in close proximity to nerve trunks or even large nerve fibres whose distribution is to the respiratory apparatus or to the heart great care must be taken or a paralysis of motion will ensue. Where cocaine is used as an injection, if in small doses there is a condition of exhilaration similar to the effect of coffee or tea. There is a feeling of increased mental activity and desire for action, muscular as well as mental. The effect of cocaine is a perturbation of the central nervous system, and this is the first and direct action upon the nerve cells themselves. The respirations are more frequent, and the pulse beats more rapidly. There is an increase of action in the heat making centers, and an increased blood pressure. This initial exaltation is followed by a period of depression of greater or less degree according to the amount of coca used, and may extend from a simple lassitude and inertness to complete inaction and stoppage of the heart in diastole.

In large doses injected into the veins or subcutaneously, cocaine produces excessive excitability, epileptiform convulsions, general analgesia and mydriasis and loss of muscular power. The circulation which is not affected by small doses to any great extent with the larger dose is at first increased then retarded, and the peripheral arteries are contracted and death occurs from the final failure of respiration as the heart beats after the breathing has ceased. The disturbance of the central nervous system is the marked feature of the great action of cocaine in doses extensive enough to reach the nerve centres. But for the purpose of producing local anæsthesia in minor surgical

operations a small amount may be used without inducing the more marked irritation and excitation of the brain, and when larger quantities are desired and the tourniquet or Esmarck's bandage applied, the cocaine can be kept out of the general circulation and the excess may be washed out and so removed.

Wyeth is an exponent and advocate of this method of inducing anæsthesia. His method consists of injecting the fluid into the part to be anæsthetized, waiting from two to five minutes for absorption of the solution by the vessels and the keeping the cocaine in the tissues by arresting the circulation with a rubber tourniquet applied between the injection and the heart. "Twenty or thirty minims of a 4 per cent solution should be equally distributed in the line of incision. A single puncture with the hypodermic needle will suffice to allow the fluid to be thrown over an area of an inch in length and the effect is so rapid that the second puncture can be made through the anæsthetized skin. The needle after passing through the integument travels along just beneath it to its full length. One or two minims are then forced out, the needle withdrawn a quarter or a half inch and a like quantity discharged. If a deep incision is required the needle should go into the deeper tissues. One advantage of this method is that a smaller quantity of cocaine will produce a greater degree of anæsthesia and with less constitutional effect.

It is not always necessary to absolutely arrest the circulation in a part if the anæsthesia is a superficial one, "for if the elastic is applied close behind the part to be incised the superficial compression will retard the flow at this point while the deeper vessels and remote capillaries are not materially interfered with." Then if the incision is made promptly along the line of anæsthesia the excess of cocaine escapes by being washed out and does not enter or interfere with the general circulation.

For local anæsthetic effect for the opening of an abscess, a bubo or an external strangulated pile without pain, twelve or fifteen minims of a 4 per cent solution is used of the hydrochlorate. The needle is introduced for a very minute distance, say the eighth of an inch, and three or four of the drops forced out. A minute later it can be carried farther and the maneuver repeated until the needle has transfixed the whole mass to be operated upon. Within five minutes the anæsthesia is complete enough to allow of a painless operation.

The dangers in the use of subcutaneous injections of cocaine are much less at a distance from the nerve centres. When it comes within reach of the fifth pair of nerves or the sympathetic nerves, the administration of it must be very cautiously made for the reason before mentioned. The quantity that may be used without injury must from the nature of the case vary greatly, being determined by the location of the injection and the readiness with which it may be carried into the general circulation. Partial or threatened respiratory paralysis has occurred in several instances after the injection of fifteen minims of a 4 per cent solution in the supraorbital region and in other portions of the face. One effect of cocaine must be noted, and that is if an injection of it is made into loose connective tissue it may cause a very considerable and annoying swelling. As examples of this "an adult thirty years of age, suffering from toothache, was given hypodermically in the cellular tissue between the cheek and gum about five drops of a 4 per cent solution. Relief was obtained almost immediately, but in the course of five minutes the entire side of the face became enormously swollen, tense and painful and so rapid and extreme was the swelling that the physician was thought to have punctured some blood vessel. To allow the escape of supposed clotted blood operative measures were resorted to, but revealed the non-existence of any coagulum.

The ill effects here were probably due to paralysis of the vaso-motor nerve filaments causing dilatation of the blood vessels and intense congestion of the part. I had a similar experience with hydrochlorate of cocaine in an operation for circumcision. Twelve drops of a 3 per cent solution were injected into the marginal border of the inner membrane and external integument. Almost as quickly as though stung by a bee a swelling arose that within fifteen minutes was very great, and although the operation was performed and the parts washed to free from any excess of the solution, yet the swelling was so severe that ice and hamamelis were necessary adjuncts to reduce the enormously swollen member. The larger dosage of cocaine with solutions of 5 or 10 per cent are much more dangerous in application than those of lesser amount, so the 2 per cent solution in some cases could be used with marked benefit when the 5 per cent solution would not be well borne. In this latter instance a 3 per cent solution was sufficient to induce such a vaso-motor paraly-

sis as to allow a stasis of circulation and a deleterious after-effect. So also the use of cocaine on the surface of the eye or the mucous surfaces is less dangerous than subcutaneous injection.

Cocaine is one of the drugs the use of which must not be often repeated in a given case on account of its effect on the nervous system. A single dose has been known to produce prolonged and painful disorders such as persistent headache, profound malaise, insomnia, trembling of the extremities, vertigo and much cerebral excitement characterized by loquacity and much agitation. These symptoms may continue for many months. The cases in which the single toxic dose has induced one or more of the above symptoms were those of individuals with an excitable nervous system and were due to the elective affinity for certain nerve tissues.

Chronic cocaineism is very quickly induced and on overwhelming and insane desire for the drug established. San Martin instances the case of a diabetic female that used an ointment containing cocaine as a relief from the annoyance of pruritus vulvæ. The effect was agreeable and the patient used it four to six times daily. After a few days she began to exhibit the symptoms of acute domination of the drug consisting of insomnia, extreme mental excitement with hallucinations, the sensation of impending death, rapid and irregular pulse and sighing respiration. All of these symptoms disappeared after the discontinuance of the drug.

Leven reports a case of a man who formed the habit of using the drug for a nasal trouble. In this case there were hallucinations which caused him to twice commit assaults and the attacks might almost be called cocaine epilepsy. Very frequently the opium and cocaine habits are mixed together, the individuals using one or the other or both simultaneously. Zenner reports two cases, both physicians, one of the mixed habit, the other of the cocaine alone. The latter first began to use cocaine to relieve the fatigue during a stress of work. He took five to eight drops of a 40 per cent solution hypodermically at the beginning, once daily. Within two months an irresistible demon had him in full control. He abandoned himself to the intoxicating influence of the drug, lost his business, squandered his property, and was brought to the brink of ruin. The period of extravagant and pleasurable ideas and visions was but transient and was followed by the stage of depressive

feelings, anxious forebodings and the development of delusions, of suspicion and persecution and hallucinations of sight and hearing. After four attempts at abstinence within two years, he finally succeeded but remained as an attendant at the hospital where he was treated. The other case was a man who used at first the cocaine as a substitute for morphia. Of the morphia he had for a considerable time taken 16 grains a day hypodermically. He used the cocaine during the term of four years, reaching at one time 60 grains of cocaine a day hypodermically with but small doses of morphia. He had the delusions and hallucinations characteristic of the cocaine habit, such as being watched and persecuted by pictures and images flashed upon the walls by his enemies, and combined visual and sensory hallucinations of "jiggers" in his skin and tongue. These he would attempt to pick out with a scalpal and put under the microscope. He died of tetanus after an injury from stepping on a fork. Another case reported by Laury, also a mixed case, the cocaine having been originally used as a substitute for the morphia and the morphia having been used to bolster up the effects of the cocaine. He presented the condition of impaired health, sallow skin, loss of appetite and strength, sleeplessness, vertigo, syncope and epileptiform attacks, hallucination, suspicious jealousy and ideas of persecution. He also had the symptom that is characteristic of the cocaine habit, the hallucination of animalcules or parasites in the skin. The sensory and intellectual derangement develop much more rapidly under the use of coca than under that of morphine and it is a much more dangerous habit to acquire than morphinism.

Death from cocaine given in this way, comes from anæmic condition of the brain and the disturbances involved by the paralyzing effect on the nerve centres. When death comes from acute poisoning, it is due to spread of the anæsthesia to a paralytic condition of the brain and the respiratory organs.

Huever gives a case of poisoning by cocaine. A healthy young soldier had about $1\frac{1}{2}$ grains of a 2 per cent solution dropped into the nostril to permit of the removal of a polypus. Shortly after the patient became unconscious with a weak pulse and a cold skin. He was revived with stimulants but did not make rapid improvement, as he suffered for some time afterward from extreme weakness and quivering of the muscles. He was confined

to his bed for fifteen days and did not return to duty for about ten weeks. Another case where a man sixty-five years of age was given hypodermically three-fourths of a grain and it produced an alarming depression. To another case, ten minims of a 15 per cent solution was given. Immediately after there was distressing dyspnoea, pallor of the face, widely dilated pupils, spasms of the flexor muscles of the arms and legs, hurried respiration (40 per minute) and a very small wiry pulse (140 per minute). There was profuse perspiration but no loss of consciousness. The remedies used for these cases were stimulants such as whiskey and ammonia and inhalations of nitrite of amyl and the injection of nitro glycerine. When the respiration is feeble, artificial respiration must be maintained. Cocaine used for its anæsthetic action, is neither homœopathic nor allopathic to any given case, but there are some effects that have been noticed which would indicate the use of cocaine as Homœopathic in nervous diseases to certain phases and conditions. Nettle rash or that form of it in which, with no external appearance, there is formication and itching, and the sensation of insects crawling on and in the skin. Nervous dyspnoea with weak heart, asthma with nervous exhaustion, restlessness and sleeplessness. All the symptoms of asthma are induced by this drug and we have as examples of this, irritation in the larynx, exciting cough, paroxysmal cough at four P. M., when walking in the hot sun, paroxysmal cough in the evening in cold wind, expectoration in the morning of tenacious, thick white yellow mucus, as in chronic catarrh, dyspnoea with pressure on the whole chest and a constant desire to take a deep breath, difficult breathing continuing even in bed with palpitation, short breath on ascending a height with oppression. Heaviness in the forenoon when walking, with dyspnoea, sometimes painful pressure on the chest.

Heaviness in the evening when walking slowly, with short breath, continuing when sitting still after walking, with a constant need to take a deep breath, and a sensation as if the lungs were too much distended on walking or ascending steps, obliging him to take deep breaths frequently. An asthma with a weakened action of the heart, and made much worse by motion, and the trouble continuing after the motion has ceased, and the same effect is noticed with neuralgic pain about the heart, indicating its use in angina pectoris. We have the palpitation and erethism; the heart beats may be nearly quadrupled, with op-

pression and severe pain. We have a similar erethism after the excessive use of tobacco in some individuals, and there is a very similar condition found in individuals deprived of opium after a prolonged use of that drug.

Coca has been used to advantage in the treatment of the liquor habit, the drug stilling the craving of the stomach by virtue of its benumbing effect on the stomach nerves. It also is quite homœopathic to the insomnia and insane delusions and the fantastic visions of delirium tremens. It is a close similia to the symptoms of chronic alcoholism, and markedly so to this nervous explosion of delirium tremens.

The face is pallid or burning redness in spots, and pale or white spots, or a yellow tinge which finally gives way to a leaden hue. There is an aversion to food, with thirst, nausea, uneasiness, gnawing, burning sensation in the stomach, sleeplessness and excessively nervous. Black and glittering spots appear before the eyes, which to the onlooker present a staring appearance. The pupils are dilated and the light is painful, and then hallucinations creep on, with waking dreams of horror and discomfort. The hands and legs tremble, the body is shivering, and there is an inability to keep still. The throat and mouth are parched and burning, the tongue coated white or red, and there is an irregular and feeble circulation, cold feet and extremities.

From its effect on the stomach coca has been used in sea sickness, gastralgia and morning sickness of pregnancy, given in the form of an infusion of coca leaves or by chewing them. A rectal injection of cocaine or coca has given relief from tenesmus and colic.

As an instance of its use in intercostal neuralgia I can report a case, as follows: An elderly gentleman was suffering from an attack of intercostal neuralgia that had defied the efforts to relieve of several prominent physicians. When I saw him he was almost in a collapse from the pain. Opium I could not use in his case, as there was a special idiosyncrasy forbidding it, and it was evident to a casual observer that unless the suffering could be checked the patient must soon cease to live. With a hypodermic syringe I injected fifteen drops of 3 per cent solution at the seat of the pain in the right side. Eight minutes later I injected ten drops more and the trouble was over and did not return. In this case the neuralgia was of malarial origin, taking that rhythmical regularity of return so characteristic of malarial disease, and with each attack it had been gaining in

intensity and duration until the pain had reached the limit of endurance. Whether the cocaine was the final cure for it I am unable to say, but that it preserved the patient's life that night I feel quite confident, and as the pain did not return I am constrained to give it credit for more than the temporary relief of the anæsthetic influence.

THE HISTO-CHEMISTRY OF DIABETES.

A LECTURE ON GENERAL PATHOLOGY DELIVERED AT HAHNEMANN MEDICAL COLLEGE, OF CHICAGO, BY B. S. ARNULPHY, M. D., PROF. OF THEORY AND PRACTICE.

PART I.

You have all heard of diabetes. You know that it is a disease in which a considerable amount of sugar is abnormally present in the blood, and finds its way into the urine. Few diseases have exercised the ingenuity of the physiologist and of the pathologist to the same extent as diabetes; and in spite of innumerable laboratory experiments and careful clinical observations, the true inwardness of the theory of diabetes, I mean such a theory as will explain away *all* the facts in the case, is still veiled in mystery.

Enough, however, is known nowadays of the chemistry of the liver, and of the tissues at large, for us to attempt to present an explanation of the main facts pertaining to diabetes, with a reasonable degree of accuracy, and that without forgetting for a single moment that pathological conceptions, however brilliant and seductive, are worthless when not in perfect consonance with the main trend of clinical observation. I shall never weary of repeating to you that the clinical test is the final one in medicine, and as long as we guide our theories by that beacon we run but small risk of stranding our craft on the reefs of misconceptions which so abound in medical waters.

We have seen how a slackening of nutrition may allow an accumulation in the system of organic acids, of cholesterolin, and of neutral fat, thus creating various diseases apparently due to a lack of proper oxidation of these substances; also that these diseases may coincide in the individual, or run in the family, being only the varying expression of a common nutritional trouble.

We have studied the mechanism of obesity, and have

seen how the accumulation of neutral fat in the system occurs, and under what conditions it takes place.

Here we have still another ternary substance, sugar, or rather glucose, which the system is found at times to contain in excess. Let us scrutinize, as far as we may, the mechanism and the rationale of this pathological condition.

■ We know that, as in the case of cholesterin and fat, sugar plays a double role in the system. It is a source of caloric and energy spent in the play of functions; it helps to build up the anatomical elements at large. It is therefore both *plastic* and *respiratory*. That sugar is taken up, transformed and fixed in the framework of the anatomical elements is proven by the fact that there is formed in the system every day much more sugar than all of the oxygen absorbed can possibly take care of.

As in the case of fats the sugar has a double origin. It is partly supplied by the food, and is partly manufactured within the system. Claude Bernard, as early as in 1848, formulated the great truth that animals can generate sugar as well as plants do. And he located in the liver the substance from which the glucose arises, which finds its way into the blood, a substance quite analagous to dextrin, which by hydration becomes glucose, and called by him *glycogen*.

This passage of the glucose into the blood is the result of an act of disassimilation on the part of the hepatic cell, probably with the coöperation of a special ferment; but this act is necessarily preceded by another act, equally important, one of assimilation, whereby the hepatic cell creates the glycogen.

The wonder of it is that the hepatic cell not only builds the molecule of glycogen from the starchy material supplied by food, but also from the fatty and the proteid substances.

Glucose being thus constantly formed in the liver and handed over to the circulation, we must expect to find it in the blood, as a constant element, as a normal constituent. And such is the case. During life the proportion, though variable, is generally 80 centigrammes to 1 gramme per 1,000 grammes, say about 12 grains to a quart of blood. The proportion is much larger after death. We must note this fact that there is constantly more sugar in the arterial than in the venous blood, except, however, in the hepatic veins and the inferior cava.

The hepatic gland is not the only place in the system where glycogen is found; some exists also in the muscles, but it does not find its way into the blood. It is spent on the spot, for the benefit of muscular contraction, and when it emerges from its conflict with the muscular fibre and the nervous current which sets it contracting, only lactic acid remains.

Now let us investigate the further avatars of the glucose. Here we find it in the blood. We know it is constantly poured into that fluid from the hepatic veins; we know of no special emunctory through which it can escape from the system, and still its proportion in the circulation remains the same, always small, with but trifling variations.

Are we not driven to the conclusion that this glucose disappears from the blood in a measure as it flows into it? It must be either destroyed in the blood, or at least transformed, unless it be taken up by the tissues. No doubt part of the sugar is burned, not in the lungs however, as at one time it was thought to be, but in the capillaries, which is proven by the fact that venous blood contains less sugar than arterial blood; but the larger portion of the sugar that reaches the blood escapes oxidation altogether, and still in the healthy organism no accumulation of sugar takes place anywhere.

I have already told you that glucose ought to be considered as a proximate principle capable of furnishing material to the ever active renovation of the anatomical elements. I want to give you the proof thereof, and you will pardon me for going somewhat into the details of the organic problem that is involved.

As the result of very numerous experiments it is now conceded that 1 kilogr. of arterial blood loses 40 centigr. of sugar when it turns to venous blood. Let us be generous and admit that the loss is only 20 centigr. Now, then, assuming that the total mass of the blood represents one-thirteenth ($\frac{1}{13}$) of the weight of the body, we find that the total mass of the blood of a man weighing 65 kilogr. will lose just *one gramme* of sugar while it passes from the arterial to the venous condition. This gramme of sugar is, therefore, the quantity of that principle which disappears from the system during one total circulatory cycle.

In order to know the rate at which sugar is thus spirited away, we must know the number of total circulatory revolutions in the 24 hours. According to the best observers, and taking into account those regions in which the circula-

tion is slowest, it takes 46 seconds for such a revolution, thus giving a total of 1,850 revolutions in the 24 hours.

Now, if the blood of man loses 1 gramme of sugar at each revolution, the total loss in one day will be 1,850 grammes. Such is the daily grocery bill of the human organism for sugar. Well, let us follow up our line of reasoning. Chemistry shows us that in order to burn 1 gramme of sugar it takes 1.066 grammes of oxygen. Therefore if all the sugar that disappears from the blood had to be burned up it would require a supply of 1,973 grammes of oxygen, which is more than twice the total amount of that gas consumed in the 24 hours.

The healthy man never consumes more than 850 grammes of oxygen under the most favorable circumstances: we may set the average consumption at 720 grammes. Even if we should concede that all of the oxygen absorbed goes toward burning the sugar at the rate it is supplied without regard to the other combustible materials of the system (fats, acids, proteids), no more than 798 grammes could possibly be consumed, leaving a residue of 1,052 grammes to be accounted for.

Let us sum up; here we have one kilogr. of sugar thrown into the blood of a healthy man every day, which is not burnt, which is not eliminated, and which for all that constantly disappears from the blood. Now all this surplus sugar must go somewhere. Whither? It goes to the tissues at large. There is no better explanation. We must conceive that it is taken up by the tissues, there to undergo new changes; this is on the face of it, an act of assimilation. Shall we wonder at the greediness of the tissues for sugar? Not if we observe the ways of nature. Wherever anatomical elements are actively formed we find sugar, or substances readily converted into sugar. Look into most of the seeds and you will find masses of starch, which will turn to sugar at the time of germination. In the embryo of the mammalia, the sugar is represented by the glycogenic matter diffused throughout; and the same material is found in the larvæ of insects wherein cellular formation is active. Sugar is a necessary element of tissue growth and renovation, similar to fat in that respect, and the pronounced taste of our children for sweetmeats is only a palpable instance of the craving of our bodily tissues. It is indispensable to their growth, renovation and welfare.

It is no exaggeration to say that nearly two kilogr. of sugar daily pass through the blood and disappear, all of

that quantity being manufactured by the hepatic cells. This shows what an insignificant source of supply is the amount of saccharine or starchy food ingested. It shows that the liver knows how to build up its provision of glycogen out of the circulating matter furnished by the tissues. And we see that this glycogen is but an intermediary stage through which pass certain substances, themselves the result of retrograde or disassimilative changes, in order to become assimilated again.

Nor do the tissues, in all likelihood retain all this large amount of sugar which the blood so liberally hands over to them, part of it at least is given back by the tissues to the blood, but in an altered condition altogether. The circulating matter and the normal constituents of the anatomical elements are the seat of constant mutations. Every particle of assimilable matter, as it courses through the capillaries is seized upon by the living cells, transformed, then ejected; but when it leaves the cells it is not as stale excrementitious material. It may be taken up by some other organ which makes it a business to elaborate nutritive matter and where it is regenerated and thence to sally forth ready to plunge again in the vortex of nutrition.

The cycle of nutritional mutations goes on uninterrupted. The liver is a great chemist. It is constantly at work taking up the residua of living cells, the floating mass of nondescrip organic débris, the many odds and ends resulting from incomplete or effete molecular changes; it hydrates or splits, or combines them afresh, hands over to circulation newfangled substances for the tissues to build upon, which after another series of avatars are again thrown into the blood and the cycle begins afresh. Some unfortunate molecules finally stumble into compounds that have to be eliminated; they get out of their orbit, so to speak, and can never enter it again. The principal role of alimentation is to replace those molecular outcasts, those pariahs of nutrition.

In the economy of nature, we see that the main function and *raison d'être* of the vegetable world is to pick up the residua of animal life, such as carbonic acid, ammonia, various salts, wherewith to build up substances from which fresh animal life will derive its substance.

In the animal economy the liver plays the part of a plant. A plant whose searching roots plunge into the remotest recesses of the digestive organs, and whose complex sap flows direct toward the centre of circulation.

It now remains for us to study how the sugar, in a state of disease accumulates in the blood (hyperglycomia); how it is forced through the renal barrier, carrying with it its water of dissolution (polyuria, glycosuria), and to explain why abnormal amounts of nitrogenous waste often accompany the renal flood (azoturia, albuminuria). Later on we shall have to look into the pathological alterations, so variable and so delusive, which diabetes brings in its train, but you will not fail to perceive that it is from the etiology and the morbid affinities of this insidious affection that we derive the most useful hints as to its real nature.

THE SURGICAL DISEASES OF WOMEN.

EXTRACTS FROM PROF. LUDLAM'S CLINIC IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO, SESSION 1894-95*.

REPORTED BY CORNELIA S. STETTLER, M. D.

INDICATIONS AND CONTRAINDICATIONS FOR THE PESSARY IN DISPLACED OVARIES.—Wednesday Nov. 21. Two cases of prolapsed ovaries were presented and discussed. The first of these patients (23,052) had been in this clinic Nov. 7. The examination detected a very tender ovary located in the Douglas pouch. She was placed in the knee-chest position, the ectopic organ repositioned and an Albert Smith pessary so placed as to keep it in situ. She now reports perfect relief thereby. In the second one (23,057) the symptoms were so obscure in certain respects that the patient had been through various clinics without relief. The case proved to be one of relapsing pelvi-peritonitis complicated with a dropping of the ovary behind the uterus. After awhile the pelvic inflammation and tenderness subsided so that Prof. L. thought possibly the retro-uterine ovary, sensitive as it was, might be lifted into place and kept there. The same kind of pessary was accordingly applied, but, after wearing it for one day, the patient could not endure the pain and it had to be removed.

An important point in prescribing any kind of mechanical support for a floating ovary is to decide, if you can, whether the organ is inflamed, anchored, strangulated, or only prolapsed and pinched between the uterus and the

*Continued from page 551.

rectum. If it is free and easily lifted by the finger, especially when the rectum is unloaded and the patient is in the prone position ; if there are few or no signs of metritis, or of relapsing peritonitis ; packing the posterior cul-de-sac or placing an appropriate pessary may be of the greatest service. But if the opposite conditions are found any kind of internal mechanical support will only crucify your patient without doing her the least good.

I have so often seen mischief result from a lack of care in this regard as to feel like placing particular emphasis upon these points of indication and of contraindication. And so also of the proposition and the practice of forcing or "tearing up the adhesions," as it is called, in cases of retro-deviation of the uterus, with or without ovarian prolapse. All such performances are rough, harmful, unnecessary and unwarrantable.

CHRONIC POST-PUERPERAL METRITIS WITH UNIVERSAL PELVIC ADHESIONS. VAGINAL HYSTERECTOMY. RECOVERY.—*Case 23,060.* Mrs.— æt. forty-four, sent to the hospital by Dr. G. E. Blackburn, of Montana, has been married 24 years ; has one child now 14 years old, but prior to its birth had several miscarriages. During her successful pregnancy she was in the care of Dr. J. H. Noble, of Eau Claire, Wis., who brought her to term with the greatest difficulty, and barely saved her life from puerperal inflammation afterward. She has not seen a well day since. The increased size and immobility of the uterus, and the constant pelvic aching, suffering and invalidism determined a resort to vaginal hysterectomy. First, however, a large caruncle was removed from the urethra, and an end put to the strangury and vaginal spasm which interfered with the proper and thorough examination of the case.

Operation. November 15 a vaginal hysterectomy was made before sub-class 6. The uterine inflammatory adhesions were almost universal, but were especially bad in the left pelvis.

December 6. Having made a prompt and perfect recovery the patient left the hospital in an excellent condition.

As the indications for this form of hysterectomy are multiplying we are learning to give it a wider clinical application. The slight cases of uterine anchorage that sometimes result from recent or remote attacks of puerperal

inflammation may be relieved, or cured, by milder means. Baths, electricity and massage are especially useful and should always be faithfully tried before the knife is called into requisition. But when that organ is hypertrophied and immobile, jammed down and fastened below the pelvic brim, with aching and distress and such constant suffering as sends an earnest, ambitious woman of forty years or more to her bed and keeps her there, it is time to find a more radical means of relief. And this imperative indication is all the more emphatic, and conservative too, in case there is an hereditary tendency to tuberculosis, or to malignant disease.

FATAL SECONDARY HÆMORRHAGE AFTER A DOUBLE VAGINAL OVARIOTOMY AND HYSTERECTOMY.—*Case 23,075.* Mrs. —, Eagle Grove, Iowa, was sent to the hospital by Dr. A. A. Goldsmith. She was *æt.* 45, the mother of four children. At Dr. G.'s first visit, five months ago, she was confined to the bed, suffering intensely from pain in all the pelvic region, with great tenderness to the vaginal touch. There was inability to take food, even of the blandest description, and a great accumulation of gas in the abdomen causing intense pain that radiated over the whole body; with extreme mental anxiety and apprehension. During the first week her temperature varied from 100° to 103°, and the pulse from 120 to 150. Diagnosis of general peritonitis, both pelvic and abdominal, was made. In about ten days a vaginal examination detected a large mass lying on the pelvic floor; and, as the inflammation subsided, the outline of a tumor lying behind the uterus could be readily distinguished. This tumor Dr. G. finally succeeded in lifting out of the pelvis, and for a short time only it was kept out by packing the posterior cul-de-sac with cotton.

Prior to this acute attack she had been in the care of a doctor in another town who had told her that her chronic ill health came from uterine adhesions, and who had accordingly attempted to break them up by very severe and painful manipulations.

Operation. December 6, a double vaginal hysterectomy and vaginal ovariectomy was made before class nine. The uterus was hypertrophied; the left ovary was decidedly cystic, and to the right one was attached a thick walled cyst larger than the foetal head at term. That cyst was behind the uterus and mostly below the brim of the pelvis. All of the tissues were unusually dark and venous. The

operation was carefully and speedily made; the vessels being secured by the usual small broad ligament forceps. The dressings were of iodoform gauze, and there was complete hæmostasis. No injury was done to the bladder or the rectum, and the patient was put to bed in good condition.

December 8, at the end of forty-six hours the dressings and the forceps were carefully removed, and the conditions being all right, a strip of the gauze was loosely applied. There was a free secretion of urine and flatus had passed from the bowels. An hour later she felt faint and weak and restoratives were given. Two hours later Prof L. exposed the wound in a strong light, flushed and cleansed it thoroughly, found the stumps and made certain that there was no active hæmorrhage from an open vessel. The wound was then packed most carefully and firmly with iodoform gauze. But the venous oozing evidently continued in a passive way in spite of everything possible, and she died from exhaustion induced by the loss of blood fifty-eight hours after the operation.

In all my experience I have but once before this lost a patient from hæmorrhage, and that did not follow a vaginal hysterectomy. You are entitled to the facts in this case, and I have no desire to withhold whatever would be of interest or profit to my clinical class. "Sure bind, sure find" is so decided a motto with me that, as you very well know, my habit in operating is to take especial pains to secure all bleeding vessels, and not to leave the possibility of hæmorrhage to chance. In this case, however, the venous circulation within and about the roof of the vagina and the uterus was peculiar; the vaginal mucous membrane was darkly venous, especially on the rectal side; and the hæmorrhagic diathesis was very pronounced. Indeed, the monthly flow was precipitated by her journey to the hospital, and we had to wait a fortnight for it to cease before we could examine her and arrange for the operation.

So long as the forceps and the first light packing were undisturbed there was absolute hæmostasis, and all the symptoms were favorable. But soon after the secondary hæmorrhage began the closest possible search failed to find any bleeding vessel, large or small, arterial or venous. There was no other local recourse but to pack the wound firmly and carefully and not to disturb it afterward. Unfortunately this expedient failed, as did everything else, and so we were all disappointed with the outcome of what

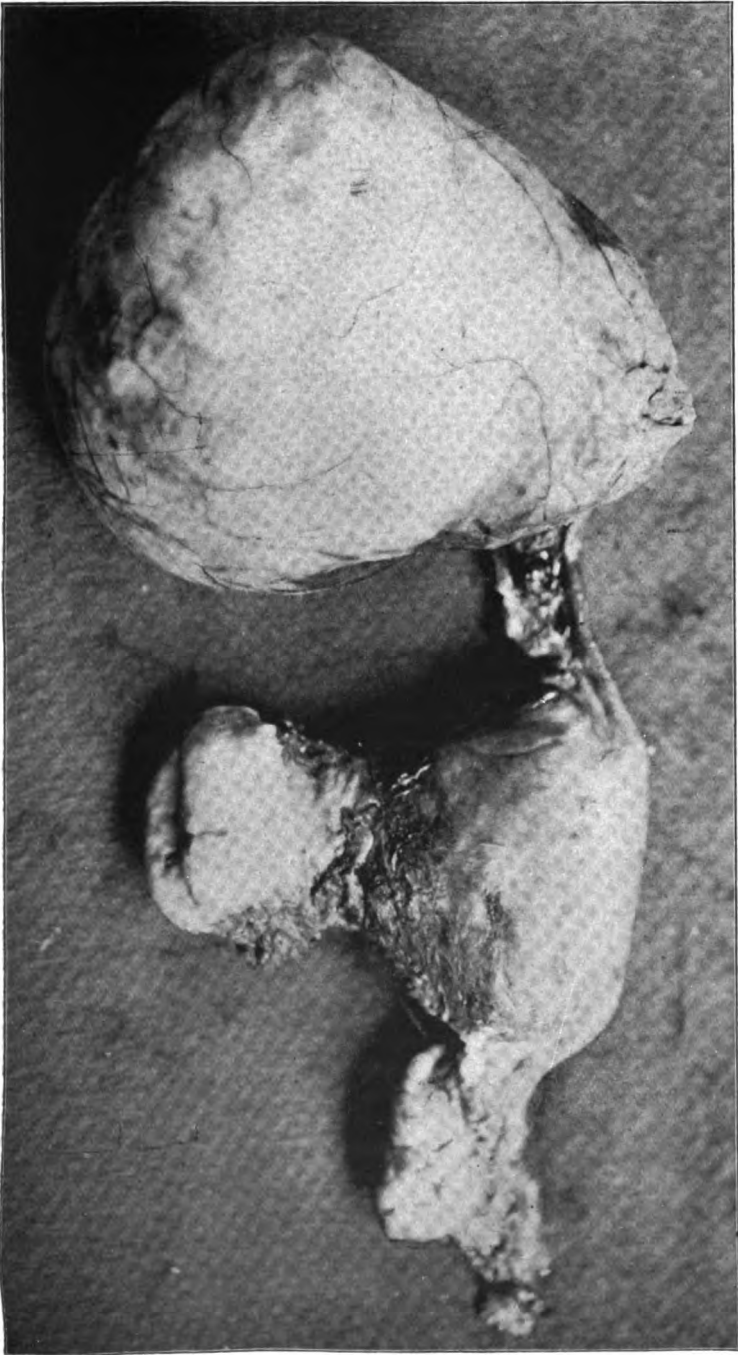


FIGURE 19.

during the first two days and nights after the operation was really a promising case.

If you will examine this specimen (see fig. 19) you will observe that the uterus and the right ovary are still united. The tumor is conoidal; its apex, which was uppermost, consists of the body of that ovary, while the cyst is attached to its lower margin. The veins on the cyst wall are very numerous and prominent.

HYDROCELE OF THE ROUND LIGAMENT AND OF THE LABIUM MAJUS.—*Case 23,062.*—Mrs. —, æt. thirty-three, married fifteen years, mother of one child of fourteen years. Eleven years ago she had a miscarriage at the seventh month, since which time she has had several others, one at the fifth month and two at the sixth week. Soon after the first of these what was thought to be a left labial abscess formed, was lanced and healed, but after a time she noticed a slight enlargement at the same point. This grew slowly until a year and a half ago, when it began rapidly to increase in size. Sometimes it is as large as an orange. Within the latter period it has developed a pedicle that now is nearly two inches long. The tumor is translucent except at its lower portion, where the integument has been scarred and tanned by local applications. The pain and swelling are most marked at the month, but sometimes this aggravation is lacking altogether. The uterine cervix is badly lacerated, and there is a troublesome leucorrhœa of an excoriating and purulent character.

Operation. November 7, in the presence of sub-class five, the pedicle of the labial cyst was severed by the Paquelin cautery, and a trachelorrhaphy was also made. The sac was afterward found to be lined with a smooth, shining tunica vaginalis, covered with its proper endothelium. The other tunics were dartoid and tegumentary.

Wednesday, Dec. 12. Examination before the general class showed only a slight cicatrix at the site of the labial wound; there was no enlargement or tenderness at the ring or along the inguinal canal; the cervix had healed, and the patient was discharged from the hospital cured.

Although the tumor in this case was labial, it was really a true hydrocele of the canal of Nuck. Contrary to the rule, which holds in these cases as in inguinal hernia, that it is most frequent on the right side, this tumor was on the left side. It happened to be a little flaccid, and therefore fluctuation was pronounced. The mouth of the sac had



FIGURE 20.

become adherent to the inguinal ring, and it was therefore irreducible. This impervious condition shut off all communication with the peritoneal cavity, and so converted the sac into a retention cyst. Its occasional enlargement and great tenderness at the month, as well as its imitation of the descent of the testicle, led me to think that possibly we might find an ovary within it, but such was not the case. Such a formation as this is extremely rare, especially when you remember its clinical history and observe the long pedicle upon which it was swung. I advise you, therefore, to examine this wet specimen very carefully.

Whether the tumor is still in the inguinal region, the mons veneris, or the labium, the hypodermic or a small aspirator needle may be relied upon to settle the diagnosis, for the fluid obtained will be thin and watery or serous. If the sac is emptied in this way it may then be injected as in case of hydrocele in the male. In some of these cases it is reported that there is a peculiar tendency to erysipelas from over-manipulation and rough surgery. Scanzoni found that the excision of a portion of the sac wall, as in the radical cure of common hydrocele, failed in this labial form of it. Whenever it is possible, either enucleation or excision as practiced in this case are preferable.

ABDOMINAL HYSTERECTOMY FOR DISSEMINATED UTERINE FIBROMATA. RECOVERY. Wednesday, November 29, Prof. L. called the attention of the class to a rare specimen of multiple fibroids, and passed it for inspection. He had operated for Dr. O. W. Carlson in St. Mary's Hospital, Milwaukee, three days before, and taken the uterus and these growths, of which there were *twenty-three* in all, by a ventral hysterectomy. Some of the fibroids were extra-uterine, others interstitial, and yet others intra-uterine. (See Fig. 20.)

Wednesday, December 12, Dr. Carlson writes that "the sutures were removed on the eighth and the eleventh days, the stump at the fourteenth day, and her temperature has not exceeded 100°. She is eating well, and has no disturbance of the bladder or the bowels, and there is nothing to retard her rapid recovery."

Clinical Society Transactions.

MARY H. LANDRETH, M. D., CORRESPONDING SECRETARY.

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NOVEMBER MEETING, 1894.

The regular monthly meeting was held in the large clinical amphitheatre of the Hahnemann Medical College, on Saturday evening, November 24. The very interesting programme offered in the following papers brought out an unusually large attendance and the keenest interest was manifest.

XXXVIII. ARTIFICIAL IMMUNITY AND THE DIPHTHERIA ANTITOXIN. By DR. A. C. CROFTAN.—Since Dr. Roux's remarkable communication to the Medical Congress at Buda Pesth some two months ago, the question of the diphtheria antitoxin, and incidentally the modern theories of artificial immunity and of preventive vaccination have sprung into sudden notoriety. Our worthy President, when he kindly asked me to deliver this paper to your society, requested me to speak "à la Française"; I will, in consequence, endeavor to avoid any tedious communication of facts and formulas, will try not to be didactic, especially in view of the fact that many of the points that will here be brought forward are undoubtedly familiar to a great majority of you. At the same time I beg your permission to recapitulate slightly for our mutual benefit and to recall some of the *facts* that confronted Louis Pasteur, when he formulated his theories and began the series of investigations and intelligent experiments that have given such positive results in the past, and that, in their last consequences, promise us everything for the future. It was long known that a child that had survived an attack of scarlet fever had an acquired immunity against the disease for some time; that, further, certain people were susceptible,

others *naturally immune* against a number of infectious diseases ; it had been conclusively demonstrated (after the discovery of the microbial origin of disease) that certain races, species, individuals "took" certain diseases when active virus was injected into their circulation, while others were wholly immune.

Thus it had been observed, for instance, that a *field* mouse was immune to glanders, while a *house* mouse infallibly took the disease ; that an Algerian sheep took anthrax, while a common domestic sheep was immune ; that man took certain diseases that no animal was susceptible to, and vice versa. Numerous theories were in vogue at the time to explain these phenomena, some of which survive to the present day, and justifiably so, as they are based on a rational foundation. The fact that carnivora are less susceptible to certain diseases was rationally explained from the law of natural selection and of survival of the most fitted, while some investigators adhered to a pretty theory of a temperature optimum that has been in many instances corroborated by experiments—its foundation is reasonable ; if a certain germ species cannot live above 35° C. for instance, and the temperature of an animal's blood is 37.5°, then this microbe has no possible chance of exercising the pernicious effects of its vitality in such an organism.

The same is true of cold-blooded animals and also microbes that need a higher degree of temperature for their development. A frog for instance is immune against a certain disease, but if he be heated in an incubator, he will be immediately affected and succumb. A chicken on the other hand is protected when in normal conditions, but is affected when placed in a refrigerator and cooled off. Some physicians actually attempted to make use of this idea to cure disease by raising the body temperature. As some of the infectious disease germs cannot exist at a temperature that is far above the normal temperature of our bodies, it was thought advisable to give an artificial fever, raise the body temperature and thus weaken the vitality and ultimately destroy the germ in the body.

These experiments, however, had negative results, firstly and principally because the patient usually succumbed to the artificial fever and then because the real source of the disease cannot be destroyed by the raise in temperature, as we shall learn later on. These facts, interesting as they were, only covered a very small number of phenomena and a few individual cases, that might just as well have been explained by the much used and abused idea of an "idiosyncrasy." Not until Pasteur by chance made his first *attenuated virus* was light thrown on the subject. Pasteur had been experimenting with the germ of chicken cholera and had cultivated the germ in sterilized neutral bouillon; the particular culture he was experimenting with had perchance remained in contact with the air for some three weeks and when he injected an ordinarily lethal dose into one of his chickens, he found that the animal did not die but recovered after a short attack. He thought quite correctly that the original virus had been "*spoilt*" and soon after the animal's recovery injected a very strong dose which he showed by a parallel experiment was sufficient to kill any other chicken in a short time. To his great surprise he found that this dose did not affect the animal in the least. He repeated his experiment several times, again injecting old virus previous to the strong injection and always with the same result; the first injection of weakened virus protected the animal against the strongest poison—he had practiced preventive vaccination and *for the first time consciously brought about artificial immunity*. Following up this line of research with an army of co-workers and disciples that immediately followed in his footsteps, carried away by the fascinating interest that the subject presented, the law was soon formulated and universally recognized, "*that artificial immunity can be brought about by subjecting pure virulent cultures to conditions unfavorable to the growth and the development of the microbial species, and injecting this weakened, attenuated virus into the circulation of the animal to be protected.*" The attenuation could be brought about in various ways, by cultivating the germs at a few de-

grees below the temperature maximum for their existence, by adding small amounts of antiseptics, by exposing to bright sunlight, by drying out the culture medium, and finally by passing through the body of a naturally unsusceptible animal and by electricity.

The interesting question now arose, what occurs in the animal body by the passage of the weakened virus that protects the animal from subsequent attacks of the same disease. This problem is not solved to-day, numerous highly intelligent theories have been advanced but none of these hypotheses singly explain a sufficient number of facts to even merit the name of theory. Light will undoubtedly be shed on the whole question suddenly; single rays seem to pierce the darkness now. Most great thoughts, great theories, seem to be evolved from an involution of many thoughts, until one mind (and not necessarily a master mind) discovers the key and can greet the world with an inspired "Eureka."

Bacteria apparently act by the special product of their vitality, ptomaines, leucomaines, toxalbumins. That this is the case in most infectious diseases can be easily demonstrated; an artificial culture medium is made containing most of the chemical substances that are found in the human body, heated and kept at a blood temperature. In this "homunculus" the germ is allowed to grow and to form the products of its vitality; these are then filtered off and the germ free filtrate injected into some susceptible animal. In every case an infection will be the result, identical in its course in every respect with the pathological changes that are brought about by the true germ. Those ptomaines then are undoubtedly formed in the living body, enter into the circulation and from a local infection cause a systemic trouble. Now theories have been advanced that after these ptomaines have been formed in the body once, the material from which they are originally elaborated by the specific microbe is exhausted, and hence a subsequent immunity. This, the so-called *exhaustion* theory has found little favor, and is in fact to say the least,

crude. The *retention* theory and the theory of *tolerance* that have been advanced by certain investigators, hardly merit a passing mention. They have a certain historical interest, but are no longer seriously considered. The two theories that are to-day prominent before the scientific world are the *phagocytosis* theory of Metschnikoff and the *antitoxin* theory first advanced by Behring and Kitasato. According to the most recent investigations, both theories can be, or rather *must* be combined, as it seems to have been demonstrated that antitoxines, if formed at all, are formed by the leucocytes. The phagocytosis theory is well known to all of you and is based on the hypothesis "that the body in the property of its amœboid cells to destroy microorganisms, possesses a formidable means of resistance and defense against infectious agents." We will not discuss this theory as it would lead us too far, but now proceed in medias res and attempt to demonstrate the probable validity of the antitoxine theory, by an example: the treatment of diphtheria, based on this theory exclusively. A priori, as Sternberg says, the theory appears to be the most improbable of all, and we must admit that it does seem highly hypothetical that some substance should be formed in the body of an immune animal which neutralizes the toxic products of the pathogenic microorganisms. *How* this antitoxine is formed, is a mystery; *that* it is formed is almost conclusively proven by numerous frequently repeated experiments. That the blood of an immunized animal contains some substance which destroys the activity of the original toxine, can be easily demonstrated by adding some of this blood to a virulent culture or to a filtrate containing an active toxine; a destruction or at least neutralization of the toxic product will be the result; what happens in the laboratory outside of the living body, holds good for the animal organism, and the blood of an immune animal is almost infallibly an efficient vaccine. This is not the place to give a detailed description of the numerous experiments that all point this way nor will we attempt to explain in what

part of the blood these antitoxins are formed ; the probabilities are that the serum is the chief source ; this is a complex substance and its chemistry is obscure. Let it suffice to emphasize that such substances are found in the living organism by the passage of the microbe and that they are ultimately found in the blood serum.

After this far-reaching introduction, a very few words will suffice to give you the full status quo of the diphtheria antitoxine treatment as it is now announced to the scientific world in general, and to the medical profession in particular. Diphtheria germs are cultivated in a liquid medium favorable to their development, preferably in sterilized nutrient bouillon, containing peptone and salt and made slightly alkaline. The living organisms are then separated from the toxine they have elaborated, and the virulent filtrate attenuated by any of the above methods, preferably by heat or by dilution ; this attenuated virus is injected into a horse, and the animal suffered to pass through a slight attack of the disease ; the injection is then repeated with stronger doses until the animal has acquired total immunity against the strongest, ordinarily lethal doses ; then some two or three pounds of blood are drawn off with the necessary bacteriological precautions, the clot allowed to separate, and the serum used as a vaccine. This serum contains the diphtheria antitoxine. That it has wonderful effects on patients is conclusively proven, as can be seen from a few statistical data that I gather from an article that recently appeared in the *London Times* : The treatment was carried on from February 1, to July 24, during which time 448 cases were admitted to the hospital. Of these 109 died, giving a mortality of 24.5 per cent. The average mortality of the previous four years in the same hospital was 51.7 per cent. Nothing was changed in the conditions except the introduction of the serum treatment, which is, therefore, credited with the lessened mortality, or in other words, with having *saved the lives of over one hundred children in a single hospital in six months.* The case is materially

strengthened by a comparison with the mortality occurring under ordinary treatment at the Trousseau Hospital during the same six months. Out of 520 cases there were 316 deaths, giving a mortality of 60 per cent. Noteworthy is also the experience of a private physician who treated forty cases of diphtheria ; of these ten were injected with the serum ; of the thirty noninoculated patients ten died, while the ten vaccinated ones survived. The last figures obtainable show that in the Berlin hospitals the mortality rose from 11.7 per cent to 60 per cent during October, owing to the fact that the antitoxine supply gave out suddenly, notwithstanding the fact that forty horses had been immunized to furnish vaccine. Injections of twenty cc. are made. This is usually sufficient ; if not, a second dose of ten to twenty cc. is injected. The treatment should begin as early as possible.

The preparation of the virus and its strength are still very uncertain. We are dealing with a very delicate chemico-biological substance of whose properties as a chemical individual we know virtually nothing. Our knowledge is exclusively empirical. The antitoxine serum cannot be prepared in a moment, or by everybody. It takes expert skill of a high order, and no little expense. A horse cannot be rendered immune in less than two months, and then the product must be properly tested before being used.

Dr. Roux, of the Pasteur Institute, shares the honor with Prof. Behring, of Berlin, of having made the first courageous experiment on man. What is now demonstrated for diphtheria in man is demonstrated for most infectious diseases in animals. Unfortunately, we are not enabled to experiment on man unless it be some enthusiastic, self-sacrificing young scientist—up to now science has demanded few martyrs from this cause, and the time is near when legislatures will license experiments on criminals condemned to death. A law to this effect is, I believe, at present before the French House of Representatives, and we may hope in the interest of humanity

that it will pass. If society must be avenged for crimes committed, and J. J. Rousseau and a few others dispute this, let it be avenged in a manner that will bring a profit, and will benefit future generations. But this is not here nor there ; let us rejoice that we are on the threshold of a new era in medicine ; that we are about to become disciples of an *exact* science, and that with the aid of chemistry and the natural sciences we may succeed in a short time in neutralizing the evils that befell humanity when a too inquisitive hand willfully opened Pandora's box.

XXXIX. THE INTERPRETATION OF CHEMICAL ANALYSES OF WATER. BY E. M. BRUCE, M. D.—You are accustomed in this society to hear of things clinical, but the President has asked me to give you something to-night upon things chemical. I suppose he desires to try an experiment, as in days gone by he used to worship at the alembic, and probably some trace of the old quest still remains.

Personally, I feel some trepidation in bringing analytical chemistry into clinical halls. I am not a realist, and you know it is only the realist who dares introduce science to art. But forewarned is forearmed and if you all go to sleep I promise you there shall be no rude awakening by explosions.

The analysis of drinking water has attracted the attention of chemists for a number of years. The results have in the past been and are now more or less unsatisfactory. This is not because there is any great difficulty in the technique of the analytical processes; there are indeed but few chemical determinations which are made with the same delicate accuracy as those of potable waters. Yet with all this it is only a few years ago that Prof. Huxly said: "A water may be as pure as can be as regards chemical analysis, and yet as regards the human body be as deadly as prussic acid, and on the other hand may be chemically gross and yet do no harm to any one." This is to a certain extent true to-day.

The condition of things is simply this : outside of the determination of poisonous minerals the things sought for in the sanitary examination of water are not in and of themselves harmful, but if they are derived from different sources have a vastly different significance.

In the analysis we usually determine what ; total solids,

chlorine, free ammonia, albuminoid ammonia, nitrates, nitrites; also the color, odor both hot and cold and the character of the sediment are carefully noted. The results instead of being expressed in the usual way are given either in grains per gallon or in parts per hundred thousand. Prof. Drown says: "The value of a sanitary analysis of water rests on its interpretation." Let us take the total solids first; if they are under thirty to thirty-five grains per gallon they do not excite much attention.

Chlorine.—This element is present to a certain extent in the form of a common salt in all waters and the significance of the amount depends upon the topographical factors. The amount of chlorine in this vicinity for instance is small but in the region of the salt bearing strata it would be very different. Waters on the coast of Massachusetts contain on the average about 0.55 parts per hundred thousand, while in the western part of the State it is only 0.10 parts. If the chlorine in a water is found to be much higher than the average water from which it comes it is very good evidence of sewage contamination. A water might have been highly polluted and by means of being filtered through the ground be rendered pure as far as nitrogenous products are concerned, but the chlorine would remain to tell the tale of the tainted ancestry.

Free ammonia.—(NH_3) The presence of this is always due to the decomposition of organic matter. In waters unpolluted by sewage it is seldom high, for it is taken up by the growing plants almost as soon as formed. In the nature of things the free ammonia is higher in the winter than in the summer when the plant life is active. If we could only determine whether the ammonia was from the decomposition of vegetable matter or from sewage, it would be a source of great satisfaction to the analyst, but this is not possible in the present state of our knowledge.

Waters from deep wells should contain no free ammonia and the presence of any amount is an indication of imperfect oxidation of impure water. In a drinking water of the first class the free ammonia will probably not exceed 0.005 parts per 100,000.

Albuminoid ammonia.—This stands for the nitrogen in organic matter that has not been affected by oxidation; in other words it represents the nitrogen in the form of albuminous substances. In brownish surface waters, the albuminoid ammonia may be high and be due altogether to vegetable matter. In good ground water, the albumi-

noid ammonia will rarely exceed 0.0025 parts per 100,000. Above 0.01 parts per 100,000 is very suspicious.

Nitrites.—Are derived from N_2O_3 , nitrous acid, and are the first oxidation products from ammonia. In unpolluted surface waters they are generally absent, but rarely exceeding 0.0002 parts per 100,000. In the first order of ground waters, nitrites are always absent. When one has the condition of the presence of free ammonia and high nitrites, it is a strong indication of pollution by sewage or house drainage.

Nitrates.—This stands for the completely oxidized form of nitrogen, N_2O_5 . In unpolluted ground waters, nitrates are very low. When they are present in any considerable amount, it is evidence of previous sewage or house drainage contamination, but is also evidence that the nitrogen has been oxidized to harmless mineral matter.

The odor of a water compared with itself is often of great importance. If, for instance, a water that has always been free from offensive odor suddenly became disagreeable, it is good evidence that it is being polluted.

The examination of a potable water cannot be considered complete without the aid of the bacteriologist. If he can detect any known disease germs, it would at once settle the question.

XL. HEREDITY IN TUBERCULOSIS. JOS. P. COBB, M. D., CHICAGO.*—The hereditary transmission of tuberculosis has for centuries been claimed as a fact, because of the frequent occurrence of the disease in childhood, and because of the large numbers of cases in the same families. The actual proof of heredity, however, has been recorded in less than a dozen cases, and its existence ought not to be presumed except in cases which occur at a very early period of life. Statistics show that tuberculosis is extremely rare at birth, very uncommon in the first three months of life, rapidly increases throughout the latter half of the first year and on through the second year, to reach its maximum in the third year of infancy.

It is agreed to-day by those best qualified to express an opinion that the one essential etiological factor of the disease is the bacillus tuberculosis of Koch. In their growth the bacilli form soluble poisons or toxins which are also capable of developing lesions, when introduced into the

*Read before the Southern Hom. Association at Chattanooga, Tenn., November 1894.

living body, similar to those developed by the bacillus itself. The bacilli are tenacious of life and retain their toxic virulence after freezing and desiccation ; they are said to have been found alive in subjects that have been buried two years. They retain their virulence after months of exposure to the air.

The bacilli are found in variable numbers in all tuberculous lesions, and are most numerous in rapidly growing tubercles and in old chronic pulmonary ulcerations. Millions of these little organisms are daily expectorated by each subject of pulmonary tuberculosis. In a neighborhood where there are several consumptives spitting around every where in the careless, nasty way they so frequently fall into, the atmosphere, dust and clothing all become saturated and every one in the vicinity receives and cares for his share of these ever ready tenants.

There are several routes by which these invaders may gain an entrance to living tissues. Inoculation is not a common method for man as the skin does not offer a favorable soil for their development. This mode of infection is possible among those who work over dead bodies and has been shown to have taken place in the performance of the rite of circumcision.

The frequency with which the disease is met with in the respiratory apparatus finds its explanation in the fact that a diseased mucous membrane furnishes a favorable soil for the lodgment and growth of the bacilli. The expired air of consumptives is not toxic, but the sputa when dried is readily disseminated through the atmosphere as dust and is continually coming in contact with the respiratory mucous membrane.

This membrane when in a healthy state is covered by ciliated epithelium, whose waving processes prevent the bacilli from gaining any lodgment, but any form of inflammation which causes a desquamation of the superficial epithelium removes this barrier and exposes a proper soil. Chronic catarrh, the disease *par excellence* of impaired nutrition, is therefore a most favorable condition for the transmission of the disease. Its influence as a preparatory factor in the induction of consumption was recognized long before the bacillus was known to be an essential element in the disease.

A third route by which the disease may gain entrance is through the alimentary tract. Experiments in the laboratory show that the ingestion of tuberculous milk may in-

duce tuberculosis; under normal conditions the bacilli are destroyed by the gastric juice, but any departure from a normal condition in the physiology of the stomach or its functions allows of their development; the same conditions exist in the intestinal tract.

When we consider that the bacilli may be present in milk even when tuberculous mastitis is not present in the cow, that the bacilli may retain their virulence in cream and butter, and remember that cows' milk forms so large a part of children's food, it is easy to understand why intestinal and mesenteric tuberculosis are so much more frequent in children than in adults. Here as well as in the respiratory tract the healthy organism has its own means of protection in the superficial covering of the mucous membrane and normal secretions free from adventitious forms of fermentation.

Direct hereditary transmission is a rare form of the disease; the hereditary influence as will be more fully stated later is rather in making favorable conditions for the development of the essential factor—the bacilli. Congenital tuberculosis has been definitely recorded in less than a dozen cases; in each instance it was direct maternal transmission. The mode of transmission was probably through the placenta though tuberculosis of the placenta is very rare. There is no evidence, either in recorded cases or experimental work, to show that a tuberculous father can directly transmit the disease.

Much of what has been considered evidence of hereditary transmission must in the light of modern knowledge be acknowledged as evidence of accidental ingrafting upon an acceptable soil, as the children of tuberculous parents are more directly and continuously exposed to the toxic matter.

In addition to the essential factor in the production of this disease there are, as in all other contagious diseases, other conditions which act as predisposing causes. In all localities where people are crowded together the disease is more common; in such places the dust not only contains more bacilli of this variety but also other toxic material which by inducing other forms of disease lowers the resistant power of the individual.

Climate affects the development of the disease mainly because in certain districts particularly of the temperate zone, people are congregated in thickly settled centres. They breathe air laden with infected dust; they live

closely crowded together often with utter neglect of all sanitary rules ; in thousands of tenements the sunshine never enters ; their food is poor and often insufficient, the parents are overworked and underfed ; malnutrition is the rule among the children ; diseases of all kinds are prevalent ; colds and catarrhal diseases are neglected and the ever present bacillus thrives amazingly.

On the other hand, high altitudes are, as a rule, sparsely inhabited ; the soil is dry, the air is also dry and pure, the every day life is more out in the open air and sunshine, disease of all kinds is at a minimum, catarrhal troubles much less frequent, and the bacilli much fewer in number. These conditions in a great measure explain the relative immunity of certain locations.

The invariable inheritance which tuberculous parents transmit to their offspring is a lowered tissue resistance, due in great part to malnutrition. This lowered tissue resistance favors the development of any disease, and especially of catarrhal forms of inflammation. Chronic catarrh predisposes an individual to tuberculous infection because it robs the mucous membrane of its safeguard—the superficial epithelium—and furnishes in addition a good nidus for the bacilli in the tenacious muco-purulent secretion.

It would seem from recent investigations that syphilis is just as powerful a predisponent to tuberculosis as tuberculosis itself, and that it acts in the same way, viz.: by entailing upon the offspring a lowered tissue resistance and a condition of malnutrition.

Some recently compiled statistics go to show that all races and people among whom syphilis has gained a foothold are decimated in the second and third generation by tuberculosis. Remondino*, in his "History of Circumcision," uses the same statistics as an argument in favor of circumcision, on the ground that because of circumcision syphilis is much less prevalent among the Jews, and that there is no other reason to which to assign the relative infrequency of tuberculosis among the Jews.

DISCUSSION: Dr. F. H. Orme remarked that he did not rise to criticize the paper, but to commend it as a model paper for a medical society, being replete with facts and sound doctrine, and up to date in its information. As confirmatory of some of the views expressed he would

* Remondino, Circumcision, page 161.

mention that the town of Thomasville, Ga., located in the healthy pine woods, has been for years a health resort for pulmonary invalids, and of late years has become so largely so that large and excellent hotels have been built there, to the delight of the citizens, for the accommodation of the large winter influx of invalids and their friends. Recently, however, there has been serious apprehension felt for the effect upon the general health, and consequently of the value of real estate, from the fact observed that there has been a considerable increase of tuberculosis among the chambermaids and other servants of the hotels, and even in the resident community. He has heard similar remarks concerning Aiken, S. C., another resort. Dr. O.'s point was that as invalids were commonly attended by accompanying friends it was not safe for the latter to go to these resorts, and that it would be better for the tuberculous invalids to be as widely scattered as possible instead of being huddled, as it were, at these famous resorts—there being many reasons for a preference of this latter course. A place whose soil and air are impregnated with germs of disease that are liable to be conveyed about is not so inviting as one which is free from the suspicion of such a condition.

XLI. APPENDECTOMY. By J. P. DAKE, M. D., OF NASHVILLE, TENN.—* * * With an increasing knowledge of human anatomy and the progress of surgery there has been a tendency on the part of many in the profession to resort to the knife, where formerly and generally medicines only were employed. Unquestionably the prolongation of human life and relief from the longest sufferings have resulted from the interposition of the surgeon with mechanical means in a large number of cases. But there is hardly a medical man of any experience or observation that may not tell of cases where the loss of a hand, or foot, or of life itself was due to hasty or unnecessary use of the surgeon's knife. However, it is not my object in appearing in the Bureau of Surgery at this time to discuss the ways and means for the removal

* Abstract of a paper from the Bureau of Surgery at the meeting of the Southern Hom. Medical Association, held at Chattanooga (probably the last paper written by Dr. Dake).

of the appendix vermiformis. I desire to state some facts in my own experience, and submit some questions thereby suggested.

It is somewhat more than forty years since I began medical practice, and I hardly need say to those who have known me that I have had my full share of cases, acute as well as chronic, to treat during that period. Among them I well remember the anxiety caused me by five or six of inflammation in the ileo-cæcal region. The remedies used were such as I have employed successfully in cases of inflammation in other parts of the intestinal tract. *I have never lost a patient with appendicitis, nor have I had one operated on surgically.*

* * * * I do not doubt the possibility of appendicitis nor the advisability of appendectomy in some cases, but I am sure the frequency of such a condition and necessity of a resort to the knife has been enormously exaggerated. To such an extent has the exaggeration gone by talkative surgeons in need of patients, and sensational newspaper articles, that many of the people no longer enjoy the eating of fruits that may possibly leave a seed in the appendix, and many upon the occasion of pain in the right iliac region, whether from some ilio-cæcal obstruction or irritation, flatulent distention or other cause, have been the willing subjects of the surgeon's knife. From my observation and reading I am convinced *that more people have been killed by appendectomy the past five years than have died from the want of it in the last hundred years.*

* * * * The loss or risking of human life by the removal of appendages, uterine or enteric, should have more safeguards put about it. The surgeon should not be allowed to operate except in the presence of two qualified consultants approved by the patient or the patient's friends, and some penalty should be attached for the removal of healthy organs not necessarily implicated by disease. There is altogether too much rash surgery in the world to-day.

Hospital Notes.

THE SURGICAL CLINIC.

SERVICE OF PROF. G. F. SHEARS.

ANGIOMA OF THE NECK. EXCISION.—*Case 19,759.* L. A., age six months. When this little child was two weeks old there appeared numerous dark red spots on the anterior surface of the neck, a little to the right of the median line. These spots were localized over an irregular space of about the size of a twenty-five cent piece. They increased rapidly in size, and finally united.

The tumor now has an area about the size of a silver dollar. It is irregular in outline, and of a purplish red color. At times a thin scab forms near the centre of the growth, and as it falls away it leaves a superficial ulceration. The growth is elevated above the surface of the integument about a quarter of an inch, and seems to have considerable thickness under the integument. It has a soft, doughy feel.

We have here what is known as a vascular tumor, or *nærus*, called *telangeectasis* by the German pathologists. It consists of closely arranged and minute blood vessels. The vessels which lie in the *papillæ* of the skin are dilated, tortuous and convoluted. These tumors are most common in the integument of the head, face and neck. They are probably in most instances congenital, at least a small spot is found at birth. The growth is especially quick in early childhood, a spot which is no larger than a pin-head at birth, reaching a large size in a few weeks. Sometimes they rest for a few weeks after birth and then grow quickly. There is no limit to the size which they may attain. I have seen patients with almost the whole face covered with one of these superficial *nævii*, which at birth was of minute size. Their vitality is poor, and as in the case before you ulcerate readily. The fact that those tumors are so liable to grow and to grow rapidly, should lead the surgeon to advise the removal of these growths at

a very early date. This is especially true when the growth is found on the face, for an operation which at an early date may be made without a deformity, may, if the tumor has reached a large size disfigure the patient for life.

Many plans of removal have been advised, namely, ligation, setons, vesicants, electro-puncture, coagulating injections, caustic applications, and excision. Of all these the latter is the preferable where it can be applied. Healing is prompt and the deformity is minimised. In little children, the extreme elasticity of the skin, enables one to remove tumors of large size and still be able to cover the raw surface. In this case we shall excise the growth, and, although the tension will be great, approximate the edges of the wound.

The operation was made as planned, and a prompt union resulted.

GUNSHOT WOUND OF THE RIGHT HIP; NECROSIS OF THE OS INNOMINATUM.—*Case 19,761.* Male, aged twenty-two. August 28, patient was shot in the upper gluteal region of right side.—The bullet from a 32-calibre revolver at close range entering at right angles to the tissue. The bullet was not extracted. Within a few days the part became very much swollen and painful, and the wound began to discharge pus.

On the ninth day an incision was made, and the bullet removed. This, however, did not control the suppuration. Examination shows a fistulous track extending to the right os. innominata, about one inch above, and a little above the acetabulum.

An incision was made down the bone, the outer plate of which was found fractured, the bullet evidently having imbedded itself in the bone. A cavity sufficiently large to admit the index finger existed, from which the bullet had been evidently extracted. The sinus was thoroughly curetted, the necrosed bone scraped away, and the wound dressed after the ordinary antiseptic method.

The wound that we have to treat to-day is an infected one, but whether that infection was due to the bullet itself, to some of the clothing pressed into the wound by the bullet, or to attempts at its extraction, I am not able to say.

In only a small proportion of cases is infection due to the bullet; every effort should therefore be made by the surgeon to protect the wound from without. If the surgeon has not at hand the necessary means to treat the wound aseptically, he had better leave it until such means can be secured, unless great urgency is demanded, as in the case of severe hæmorrhage. The temptation is often great when surrounded by anxious friends or officious onlookers, to do something at once. There is, however, more danger from the infection of the wound than from ordinary delay. Having conveyed the patient to some location where he can be satisfactorily treated, the parts should be cleansed with soap and water and sterilized with corrosive sublimate solution.

If the wound opening is small and no foreign substance has been carried into the tissue, the part may be dressed with an ordinary aseptic dressing, and the part immobilized if it is a limb, until sufficient time has elapsed for healing to take place. This is the plan known as primary occlusion, and is often followed by the happiest results. If the bullet subsequently becomes a source of irritation it may be removed. If the wound is too large to give hope of closure by primary occlusion, or if it has been infected by the clothing or by attempts at extraction, the patient had better be given an anæsthetic, and everything having been thoroughly cleansed, a thorough examination made. The best instrument for this examination is the finger, and free enlargement of the external wound be made without hesitation. The bullet having been found and extracted, every effort should then be made to make the wound aseptic.

If you have not the regulation antiseptic dressings at hand, linen or other substances which have been heated in an oven to a point just short of burning may be utilized. Immobilization is one of the most necessary features in the treatment, and many a wound thus treated will result in immediate union, although extensive in character.

TUBERCULOSIS OF CERVICAL GLANDS AND OF THE INTEGUMENT. EXCISION.—*Case 19,762.* October 22. Miss B., age thirty-six. Six months ago noticed a hard nodule about the size of a hazelnut on the left side of the neck just back of the sterno-mastoid muscle. This was followed by another below it, which enlarged rapidly. Evidence of suppuration being present, the swelling was lanced, and pus discharged. The wound has never healed, and a sinus now exists. Examination shows a chain of enlarged lymphatics, and just over the clavical and onto the chest an infiltration of the integument. The patient has a temperature of $100\frac{1}{4}^{\circ}$, pulse 110, shows evidence of poor nutrition, and is troubled with a distressing little cough. No positive evidence of involvement of lung tissue can be determined by auscultation or percussion. Two brothers and one sister have died from consumption.

A case of this kind naturally awakens some anxiety on the part of the physician or surgeon. The extension of the disease from the glands to the integument and the presence of the cough would seem to indicate that the disease had left its initial point and involved more distant organs.

Is one warranted in operating in a case of this kind? Is there some prospect of cure? I answer both these questions in the affirmative. The high temperature may be due to the process of suppuration in the gland. The integument affected is connected directly with the tubercular sinus, and may be considered a local trouble. As I said before, there is no positive evidence of involvement of the lung. It is quite probable that the removal of the local source of infection, with the subsidence of the temperature, may enable this patient to regain her strength and make it possible for her to successfully combat the susceptibility to tubercular infection, which is evidently her heritage. I remember distinctly a case of fistula in ano, accompanied by a persistent cough and great emaciation, which had been diagnosed as a case of tuberculosis, accompanied by the statement of the attending physician that he considered operation useless, that was promptly cured by the excision of the fistula and the removal of both the source of infection and irritation. I am hopeful of equally good results in this case.

The glands with the fistulous tract were excised, the tubercular skin excised, the region curetted, and the raw surfaces thoroughly rubbed with crystals of iodoform. The upper portion of the wound was covered with integuments; the lower portion, where the skin was excised, was allowed to heal by granulation. Three days after the operation the patient's temperature was normal. Two weeks later she had increased in flesh and the cough was materially lessened.

FIBROUS ANKYLOSIS OF THE LEFT KNEE, FOLLOWING PYEMIA. — *Brisment forcé.*—*Case 19,763.* Mrs. M., age 32. Nine months ago this patient had a miscarriage. This was followed by a severe pain in the right knee, so severe and constant as to deprive her from sleep and necessitate the use of constant opiates.

About this time she had high fever and chills, and was said to have had la grippe and pneumonia. The pain in the knee continued and the limb swelled enormously, the swelling extending from the hip to the toe. Six weeks later the limb was lanced, and one and one-half gallons of pus was removed. Drainage tubes were introduced on the side of the leg, but the cavities were evidently not drained, for a large accumulation was found in the popliteal space. This was opened and pus discharged. The patient was confined to the bed for four months, and upon the subsidence of the inflammation the knee was found firmly flexed at an angle of 90° , making all locomotion impossible.

The history of this case leads us to make several reflections. The trouble was evidently pyæmic infection from the products of conception. The fever, chills and other symptoms denominated as due to la grippe, are the symptoms of pyæmic infection. The pain in the knee was due to confined pus and should have been relieved at an early date by free incision. Had this been done, it is quite probable that much pain, a long illness, and an unfortunate deformity might have been averted. The ankylosis now present is due to the results of inflammation, and the formation of bands of adhesion between the different tissues surrounding and forming the knee joint.

There are two forms of ankylosis, the true and the false.

The first term is applied to that state of a joint in which it is absolutely motionless. False or fibrous ankylosis to that state of a joint in which there is some motion, however slight.

The case we have before us belongs to the latter class. It is a matter of great importance to ascertain to which of these classes a case belongs.

If to the latter it can be broken up by mechanical or manual force, aided, if necessary, by subcutaneous tenotomy or myotomy, whereas if it be true, or osseous, the deformity can only be relieved by section of the bone itself. In some cases of false or fibrous ankylosis, the adhesions are so firm that even under careful inspection it may be impossible to determine whether there is motion or not.

In such cases, if some little force be applied to the part, and on the following day if there is pain and tenderness, the probabilities are that you have a case of fibrous ankylosis, and that there is some motion although imperceptible; for were the union bony, and had no motion taken place, there would have been no strain on the soft tissues and no subsequent pain and inflammation.

Having determined then that this is a case of fibrous ankylosis we proceed to the question of treatment.

Extension with steaming and friction is often advised in these cases, and in those of lighter grade often prove serviceable, but even in these instances the length of time demanded, and the great pain which accompanies it results in its abandonment by the patient who prefers a distorted limb rather than continued pain. In this case the adhesions are so firm that any such plan would prove impracticable. I shall therefore forcibly break down the adhesions.

The patient having been thoroughly anæsthetised and the limb held firmly by my assistants, I throw my whole weight upon the lever furnished by the patient's leg. You hear the sharp cracks which accompany this procedure, and the leg is thoroughly flexed upon the thigh. Turning the patient over on his face, and placing a sandbag under the knee, I now forcibly extend it. You notice the "ham-

string" tendons give us but little trouble, but a firm ridge is felt through the middle of the popliteal space, showing adhesions of the popliteal vessels to the tissues surrounding them.

Danger of rupture of this artery can only be avoided by great care.

In making this operation one must not be content with moderate motion, intending at some time to complete the operation. Frequent attempts only sets up new inflammation, whereas thorough breaking up the adhesions and proper treatment often produces satisfactory results. The limb can now be flexed completely, and completely extended. I will put it up at once in an extended position in a plaster Paris cast, and apply extension by weight and pulley. I will keep it in this position until the inflammation subsides and the temperature becomes normal. It will then be taken out of the cast and flexed under anæsthesia. This plan will be continued until the inflammation has subsided and the motion of the joint is restored.

THE CHILDREN'S CLINIC.

BY DR. A. C. HALPHIDE, CLINICAL ASSISTANT.

SCROFULA.—*Case 843.* Frances A. (colored), æt. eight months, was brought to this clinic October 3, last past. There is a history of tuberculosis on the mother's side of the family. The mother's health is good but the father is not strong—has some nervous trouble. This child never nursed, but was fed on condensed milk. She has always had intestinal trouble with frequent attacks of colic. At present the bowels move three or four times per day and as many times at night. The stool is described as "dirty colored," and has a bad odor.

She has a dry, hacking cough, and is fretful and cross, worse at night; there is great enlargement of the cervical glands, with some enlargement of the occipital glands as well. Sulphur 6x was given to be taken four times daily.

There was an immediate and rapid improvement on this remedy and on November 7 the child was generally much improved. The cervical glands were but slightly if at all enlarged, and all of the other symptoms were removed.

The remedy was continued in the 30x potency, one dose daily.

We have here a typical case of scrofula, or struma, and by this we mean a constitutional condition hereditary or acquired—in this case the former. We do not use the term as the equivalent of phthisis, although it is often so used, for it may have other causes, such as old age, blood relation and syphilitic cachexia. It is a state of lowered vitality characterized by glandular swellings which are prone to suppurate and leave ulcers and other affections involving the skin, the mucous membranes, the bones and the viscera. Acquired scrofula results from various bad hygienic influences as crowding, vitiated air, poor food, insufficient clothing and overwork, and is followed by a like train of evil results.

While the family history in this case is bad, it is not likely that there are any tubercle bacilli present in these swollen glands, because the germs are not transmitted from mother to offspring prior to birth, and the child has never nursed, and again, because the result of our medication has been too pronounced. True tuberculosis does not yield so readily.

These children come into the world weakly, are as the mother says, "never well," and are only too apt to become infected and succumb to the family scourge or some other malady. It is probable that this child if removed from the danger of infection and placed in a favorable environment would never develop tuberculosis, while another child with no family taint under unfavorable conditions would develop the disease. We have a case illustrating this in the waiting room; will the clerk please call him in.

TUBERCULAR PULMONARY CONSUMPTION.—*Case 8.* Willie M., eight years of age, was brought to the clinic November 14. As far as can be learned the family history is very good. He is one of six children, the eldest being thirteen years and the youngest nine months old.

He has never been robust and has had, at various times, measles, whooping cough and chicken pox. He takes cold very easily.

One year ago he had a severe cold which settled on his lungs; at that time he coughed a great deal and has continued to cough more or less ever since. He raises a large amount of sputa in the morning and sometimes has night sweats, but not so frequently as formerly. He has aching all over the body and considerable pain in the chest and back. He complains of being always tired and does not care to work or do anything.

For two months past he has had looseness of the bowels with tenesmus. The stools are thin, watery and have a very bad odor. His appetite is good and he sleeps well, but he has a fever every afternoon. His temperature to-day at 4 P. M., is 102.6° F.

This is the first time the patient has been in this clinic and, although he comes with a very good family history, the probability is, judging by the present symptoms, that he has a very serious ailment. The cough, night sweats, pain in chest and back and the high temperature lead us to examine the lungs first, expecting to find the trouble there.

Upon inspection of the chest you notice slight depressions in each infra-clavicular region and the vocal fremitus is somewhat exaggerated over the superior lobes. You will find some dullness on both sides and also near the wavy (cogwheel) inspiration, followed by the prolonged expiratory murmur. There are subcrepitant and mucous râles heard over considerable areas of both lungs, and the respiration is superficial with diminished expansive power of the chest.

We lack but one thing to make it possible to give a positive diagnosis, namely the examination of the sputa for the presence or absence of tubercle bacilli. Doubtless in the large quantity of sputa raised by the boy, they are abundantly present, although in the early stage of pulmonary consumption it is often impossible to find them, for the reason that they are not liberated and raised so soon.

Pulmonary consumption, or phthisis pulmonalis, is of three types, 1, catarrhal; 2, fibroid; 3, tubercular. The two former are of pneumonic origin and are non-infectious, while the last, as the name indicates, is of germ origin and infectious. Phthisis of either type is studied in three stages:

1. A stage of incomplete consolidation of the lung tissue.
2. A stage of complete consolidation of the lung tissue, and
3. The stage of breaking down of the lung tissue and the formation of cavities.

Either or all of these several stages may be complicated by localized secondary bronchitis (capillary), lobular pneumonia, circumscribed pleurisy, or possibly all three; however, they are most likely to accompany the third stage.

In his report of the transactions of the congress for the study of tuberculosis, held in Paris in July, 1888, Page mentions the following conclusions which are well worth repetition:

1. True tubercle generally contains the bacillus that was first supposed to exist by Bouchard, of Paris, in 1880, but afterward discovered by Koch, of Berlin, in 1882.

2. Koch's tubercle bacillus is the cause, not the result, of tuberculosis, inherited or acquired, however. This fact may yet be doubted or disputed by some.

3. Tuberculosis is a contagious disease under certain conditions, especially those that tend to produce lowered vitality.

4. In early diagnosis of doubtful or suspected cases of pulmonary tuberculosis in man, Koch's tubercle bacillus should be sought for in the sputa.

5. No practical means of destroying the tubercle bacillus has yet been discovered.

6. The management of tuberculosis in man should therefore be directed toward two objects: 1, climatic and hygienic, including diet and exercise; and 2, treatment by medicine only as symptoms arise that require it."

Even in the face of these conclusions, we may confidently affirm that it is possible to greatly relieve, if not cure, some of these cases by homœopathic treatment. In the case before us it is not possible to make any considerable climatic change, but we will advise proper diet and exercise, and together with these, will give him four doses daily of arsenicum iod. 3x.

Subsequently the sputa was analyzed and showed tubercle bacilli present in great abundance. The patient has made two weekly reports since admission to the clinic and shows marked improvement.

CORRESPONDENCE.

The following communication was kindly furnished the CLINIQUE by Professors Bailey and Cobb, who had the good fortune to participate in the meeting of our near but far-away friends :

The Eleventh Annual Session of the Southern Homœopathic Medical Association was held at Chattanooga, Tenn., November, 14, 15, 16. While the attendance was smaller than at some of the previous meetings, the number of papers presented was more than sufficient to occupy the whole time of the meeting ; the character of the reports was of a very high order, and the discussion elected thereby, was interesting and instructive.

The Association decided this year to print all of its papers and proceedings ; very naturally the *Southern Journal of Homœopathy* was made its official organ, where the full text of the papers, discussions, and proceedings may be found. We cannot refrain, however, from mentioning some of the unusually good reports. Possibly the most interesting of all was the report of the Necrologist, which was presented by our courtly friend and veteran practitioner, Dr. F. H. Orme, of Atlanta, Ga. In this he gave a *resume* of the life work of two of the most noted Homœopathic physicians of the country, Dr. J. P. Dake, of Nashville, Tenn., and Dr. W. H. Holcombe, of New Orleans, both of whom he had known as friends and colleagues for many years.

This report sounded a responsive chord in the hearts of all present, and was accepted by a rising vote, following which a tribute of affection and reverence was paid to the departed such as has rarely been witnessed in a medical convention.

The bureau of *Materia Medica* furnished several excellent papers ; that offered by the chairman, Dr. A. L. Monroe, of Louisville, Ky., entitled " Sketches in Red " was a thoughtful study, while " Sketches in Blue," by Dr. L. C. McElwee, of St. Louis, was a clever and instructive comparison of the remedies homœopathic to threatened collapse. Both of these reports elicited an interesting discussion, which showed that our Southern friends are still standing upon the corner stone of our faith.

Passiflora Incanata received a set back from our friend Dr. C. R.

Mayer, of New Orleans, who recorded that for him she had not done what her friends claimed that she could do. A comparison of *belladonna* and *gelsemium*" by Dr. W. W. French, of Chattanooga, also deserves mention as not only an instructive but also a well prepared paper.

In the Bureau of Clinical Medicine the report by Dr. H. R. Stout, of Jacksonville, Fla., entitled "A Resurrection," was certainly startling. The Doctor detailed a case of morphine poisoning where both respiration and the heart's action had entirely ceased, and after all other efforts on the part of himself and two other physicians had proved futile, the action of the heart and respiratory muscles was elicited by the synchronous use of three twelve celled galvanic batteries. For hours they were used continuously, the cutting out of the circuit of even one of them being followed by a cessation of the heart's action. They were finally withdrawn one at a time and the patient was rescued.

The Bureau of Surgery was handicapped by the absence of the chairman, Dr. Thomas L. MacDonald, of Washington, D. C., who was reported sick from "vaccine incubation."

A posthumous article on "Appendectomy," by the late Dr. J. P. Dake, of Nashville (copious extracts of which appear elsewhere in this issue), received the most attention from the association.

In the Bureau of Gynecology two of the most practical reports were read by Dr. Sara J. Millsop, of Bowling Green, Ky., and Dr. Lizzie Gray Gutherz, of St. Louis, the one on "Membranous Dysmenorrhoea," and the other on "Diseases of the Vagina."

Much of the credit for the success of the meeting was due the very efficient work of its President and Secretary, Dr. Eldridge C. Price, of Baltimore, and Dr. C. R. Mayer, of New Orleans, while the physicians of Chattanooga, employed every opportunity to entertain their visitors and left them with no idle time on their hands.

The officers elected for next year include: Dr. Richardson, of St. Louis, President; Dr. French, of Chattanooga, and Dr. Millsop, of Bowling Green, Vice Presidents; Dr. Mayer, of New Orleans, and Dr. Gutherz, of St. Louis, Recording and Corresponding Secretaries; Dr. Duffield, of Huntsville, Treasurer, and Dr. Orme, of Atlanta, Necrologist.

The next meeting of the association will take place in November, 1895, at St. Louis.

The following chairmen of bureaus were appointed: Dr. James A. Young, Hopkinsville, Ky., materia medica; Dr. D. G. Curtis, of Chattanooga, clinical medicine; Dr. W. E. Green, of Little Rock, surgery; Dr. S. S. Stearns, Washington, pedology; Dr. George D. Troutman, Louisville, ophthalmology; Dr. A. L. Monroe, Louisville, official surgery; Dr. E. H. Price, Chattanooga, sanitary science; Dr. E. S. Bailey, Chicago, obstetrics; Dr. Susan Hicks, Atlanta, gynecology; Dr. H. R. Stout, Jacksonville, registration, statistics and history.

Miscellaneous Items.

The CLINIQUE brings greetings for Christmas and the New Year.—Compliments are heartily tendered the little list of good friends who have taken wedding vows since our last issue: Dr. Harry J. Macomber and Miss Marie Alice Polley, of Pasadena, Cal.; Dr. J. L. Alexander and Miss E. Blanche Greene, Denver, Col.; and Dr. Geo. L. LeFevre and Alice T. Ducey, Muskegon, Mich.—Dr. Ruth P. Bennett has removed to Santa Cruz, Cal., and Dr. Clara A. Hendy to Oak Park, Ill.—The comic opera, "Irma," given at the Schiller Theatre as a matinee, December 6, for the benefit of the medical department of the Hahnemann Hospital, was in every way a grand success.—Ergot is *the* new remedy for varicosis, and why not?—There are three clinics for the diseases of children each week in the "Old Hahnemann."—Our death list for the month includes that of Dr. C. S. Jones, of this city, November 17, of typhoid fever; Dr. Wm. H. Hart, at Pittsburgh, November 22, and that of our dear old friend, Dr. Ebenezer Howell, at Hillsboro, Ill., in his eighty-fifth year.—Now that the new Hahnemann Hospital building is finished and furnished, an earnest appeal is made to our friends everywhere to assist in its support.

VALEDICTORY FOR 1894.—In closing Volume XV. we have to thank our friends, and our excellent Publisher, Dr. Cobb especially, for the fact that the affairs of the CLINIQUE are in a better condition than ever before; to remind everybody that all of our editorial promises have once more been strictly and righteously kept, and to plead for the same clinical and substantial aid and appreciation in the future. Fifteen years of consecutive service and success have demonstrated the need and the desirability of such a publication, and it will therefore continue to be issued at the old time and rate. *Vive la Clinique!*

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DECEMBER 15th, 1894.

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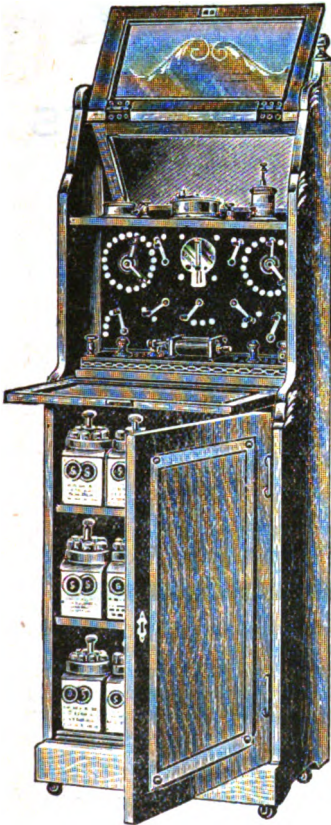
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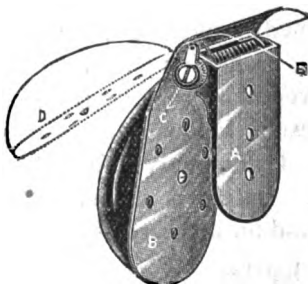
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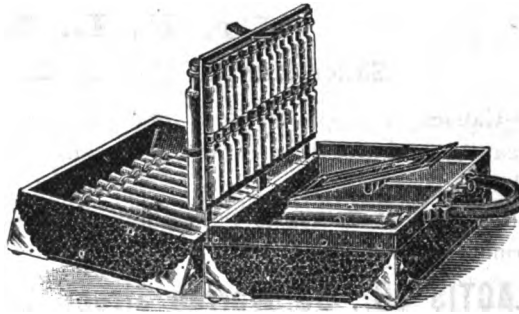
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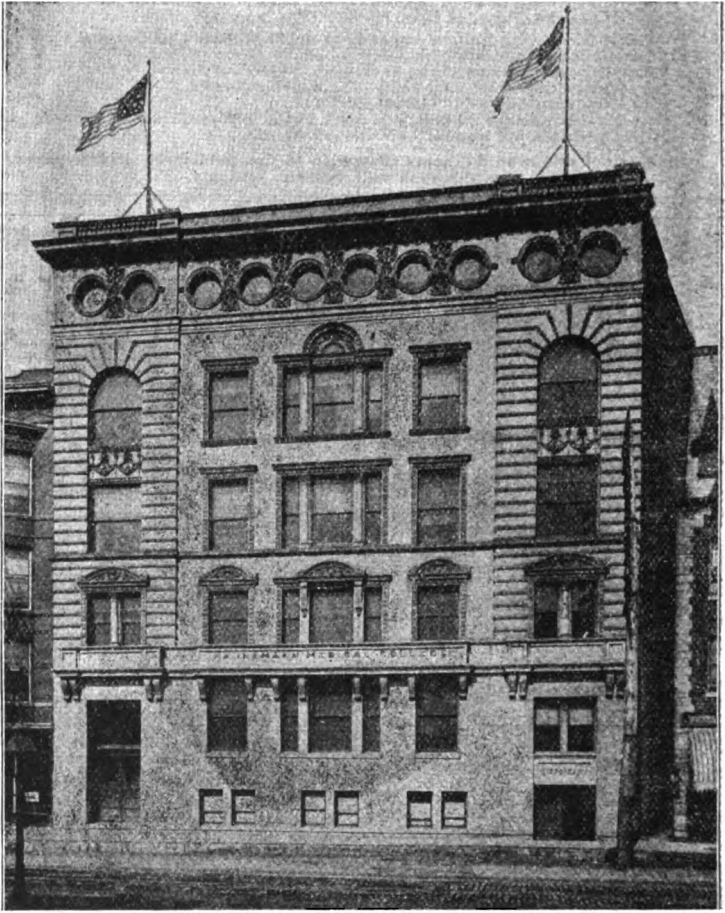
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