The Clinique

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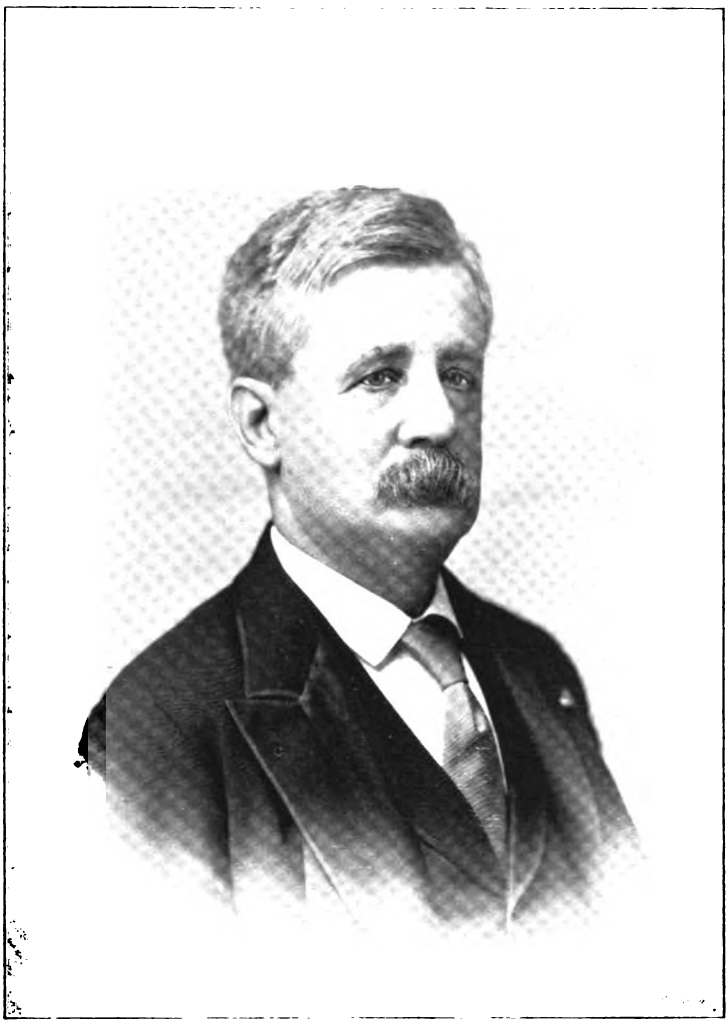

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THE CLINIQUE.

A MONTHLY ABSTRACT OF THE CLINICS AND OF THE PROCEEDINGS OF THE CLINICAL SOCIETY OF THE HAHNEMANN HOSPITAL OF CHICAGO, ETC., ETC.

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THE CLINIQUE.

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Original Lectures.

A UNIQUE CASE OF CHRONIC ŒDEMA OF THE LEFT LUNG, WITH PARTIAL ATELECTASIS, THE RESULT OF TRACHELO-BRONCHIAL ADENOPATHY OF TUBERCULAR ORIGIN.

A CLINICAL LECTURE DELIVERED AT THE HAHNEMANN HOSPITAL, CHICAGO, NOVEMBER, 1892, BY B. S. ARNULPHY, M. D., PROFESSOR OF THEORY AND PRACTICE..

A few days ago Prof. W. M. W. Davison wrote to me announcing that he would be on hand to-day with a case which presented, to use his own language, "an unusual number of interesting features." The Doctor is as good as his word, for here he is with his little patient. I take pleasure in introducing Dr. Davison to you; he is a hard worker and a careful practitioner. He tells us that upon examination of the boy, he found evidences of œdema of the left lung, and possibly of atelectasis; also signs of cardiac hypertrophy. He also states that Prof. Tucker, of Bennett College has made an examination and pronounces the case one of consolidation of the lung *only*, with augmented action of the heart in consequence.

Still feeling, I presume, that the case was sufficiently obscure to warrant further analysis, the Doctor kindly con-

cluded to bring it before the class for our consideration, for which we are one and all very thankful. And now let us go to work and endeavor, if possible to justify the Doctor's good opinion of our diagnostic ability. We will first look into the personal and family history.

Case. Albion is thirteen years of age. He was about six years old when he had the measles which left him with a cough that clings to him to this day, subject to occasional exacerbations when he would catch cold. His father tells us that he has never been a strong child and that his bodily growth has been rather slow, while his mind seems to have matured quite rapidly, as he is quite a student.

Ever since that attack of measles he has not been able to play with other children. In fact his father says he frequently saw him sit down and rest in the midst of a game.

Cough and shortness of breath are the only symptoms of which the child complains. The expectoration is slight and colorless. But of late the spells of cough and the dyspnœa have become more troublesome.

The family history shows that the father's eldest brother died at forty-five of heart trouble, though he was looked upon as a consumptive most of his life. The father's ancestors have been troubled with scrofulous manifestations in their old age. The boy's mother died of quick consumption, and his grandmother shared the same fate. His two younger brothers seem to enjoy fair health.

We shall now proceed to a careful examination of our little patient. *Inspection* first. The complexion is pale, the flesh rather flabby; the general character of his appearance betrays a lymphatic temperament. Look at his naked chest. One thing strikes you at first—the want of symmetry between the two sides. The left side of the chest is small, shrunk in as it were; the right side is large and seems distended. Now watch the respiratory movements. On the left side there is little general expansion during inspiration; nay, some of the intercostal spaces and the supra-clavicular region are rather inclined to show signs of sinking in, while on the opposite side the integument over the corresponding regions seems to bulge out, as in fact does the whole of the right chest.

What does *percussion* say? Over the left side we get a pretty uniform tone of sub-dullness, with here and there patches of clearer sound. No decided dullness anywhere. On the right side we elicit a clear quasi-tympanitic resonance all over the lung, the line of upper hepatic dullness being somewhat depressed.

Now the ground is well prepared for the test of *auscultation.* The left lung exhibits an abundance of sub-crepitant rales, heard both during inspiration and expiration; the bubbles are pretty uniform in size, though here and there I perceive patches of crepitation of a finer type. Of course the vesicular murmur is drowned by the prevalence of the bubbling rales, but the lowness of the pitch of the rales and the absence of bronchial respiration preclude the hypothesis of solidification of the lung tissue.

Over the right chest the breathing is puerile in character, the expiration being somewhat prolonged. No rale of any description is to be heard on this side.

As there might be some doubt yet, with regard to the possible consolidation of the left lung, let us apply the test of palpation. I lay my hands on either side of the chest and bid the boy count aloud from one to ten. Clearly not only is there no increased vocal vibration transmitted to the hand, but if anything the transmission is better effected on the right side than on the left.

Therefore one important point is gained. *There is no consolidation of the left lung*, Prof. T. to the contrary notwithstanding.

We have now to give some attention to the heart. You notice that there is a quivering motion of the integument under the left nipple, extending visibly to the epigastric region. The hand applied over the præcardium perceives a marked systolic impulse, more marked however toward the epigastrium than over the apex. Besides the apex is somewhat displaced to the left. Percussion shows that the area of superficial cardiac dullness is increased mainly toward its right margin. Upon auscultation I find the first sound slightly prolonged, louder over the tricuspid valve, but no murmur. The second pulmonic sound is reinforced.

All these signs point to one conclusion: hypertrophy of the *right ventricle.*

It is now time to examine the pulse, the temperature, and the frequency of the respiration. The pulse is 120; the blood-wave under the finger cannot be said to be small, but lacks resistance. It is a true febrile pulse, not only because the frequency of the pulse wave is increased, but because the nerve tone of the peripheral heart is impaired. What does the thermometer show? That the temperature of the body is 100⅗°, just at present. It would be interesting and important to know what the temperature is early in the morning and later in the day. The rate of the respiratory movements is twenty-five per minute.

Beyond this group of symptoms and signs we do not seem to be able to gather any further point of vantage from which to carry on systematic investigation. The appetite and digestion are good, and the boy sleeps well, his nervous system giving no sign of distress.

Now the question is in your mind: What ails the boy? Is there a scientific, satisfactory way to answer that question? Most certainly there is. The answer is already formulated in my mind, for while I was eliciting sign after sign in the work of this examination, an elaborate process of critical analysis, discrimination, comparison, and exclusion was going on, within myself, a process which habit and training has rendered easy and almost mechanical, the result of which was that a conclusion was arrived at, that seems to take in all the facts in the case and reconcile its apparently divergent elements.

I will now, for your benefit, go over the ground again and allow myself to think aloud before you.

Here we have a lung filled with subcrepitant rales, associated with a febrile temperature and dyspnœa. If we were to consider such a group of symptoms with reference to the present moment only, we might be warranted in concluding that an acute inflammatory condition existed in that lung, and we would first think of capillary bronchitis. But bronchial affections, acute as well as chronic, are bi-

lateral. Besides, all the facts in the history of the case point to a chronic, not to an acute condition. This cough and dyspnœa have existed for years; very likely then this abnormal temperature has been present for a long time, no doubt with periods of remission and exacerbation. Then it must have taken years to bring about such a shrinking of the affected lung, such a vicarious functional expansion of the opposite lung; and this inference is supported by the history of the case, which, in a nutshell, runs thus: Cough and dyspnœa since that attack of measles, five years ago.

Then also the presence of this hypertrophy of the right ventricle bespeaks some obstruction in the vascular area of the pulmonary artery, which we feel must be closely allied to the condition of the diseased lung.

We now begin to perceive that the shrinking of the left lung and the hypertrophy of the right ventricle are, in all likelihood, correlative phenomena, bearing both of them the stamp of chronicity.

We are getting on firmer ground. We know we are confronted by a chronic process, a process that has thrown out on the surface broad signs of its internal doings. It will rest with us, however, to explain how this chronic process, whatever it may be, manages to be coupled with a febrile condition, in the absence of hectic symptoms.

Now the Gordian knot of the whole question lies in this: *What is the pathological significance of those subcrepitant rales in the left lung?*

Subcrepitant rale means fine bubbling of air through a serous fluid, produced in the finer divisions and ultimate radicles of the bronchial tubes. Its distinctive feature from the crepitant proper is that it is perceived both at inspiration and expiration, the crepitant being heard only at inspiration.

Now the presence of such a rale in the lung means pulmonary œdema; associated as it is here with a chronic affection of the lung, it means chronic œdema. It stands to reason that if this œdema was dependent upon a general

disturbance of the pulmonary circulation, it would affect both lungs. Therefore the fact that it is strictly confined to the left lung shows that there must be back of it a local cause for its production, and in the premises a local cause *can only mean a mechanical one.*

At the present stage, our analysis becomes a question of anatomy. How can a local mechanical obstruction bring about a dropsical condition limited to one lung? Shall we conceive of that obstruction as bearing upon an important branch of the pulmonary artery, or of the pulmonary veins? There is nowhere to be found any clinical or experimental evidence in support of such a view. Clearly in mitral disease there is created an obstruction to the pulmonary circulation which is clinically exhibited in the guise of congestive symptoms in the lungs, such as dyspnœa, cough, hemoptysis, and ultimately œdema, but both lungs are invariably affected.

Being unable therefore to incriminate the pulmonary circulation we have to fall back on the bronchial circulation. You know that the lung is supplied with a circulation of its own; the bronchial arteries which are supplied to it directly from the aorta and its branches, finally resolving themselves into two venous trunks, the bronchial veins. These vessels shape their course toward the roots of the lungs and open the one on the right side into the vena azygos major, that on the left side into the superior intercostal vein. This is the nutrient circulation of the lung, and it is not unreasonable to suppose that it is to that circulation that the lung owes the faculty of developing a rythm of expansion and resistance independent of that of the systole and diastole of the heart.

Now suppose a permanent obstacle should be placed at the root of the lung, such as to obstruct the flow of blood in the bronchial vein, what is the consequence likely to be? A permanent venous stasis in the structures back of the obstacle, lung parenchyma and bronchial tubes, unavoidably resulting in œdema. We easily conceive that such dropsical condition of the lung might be fraught with serious

danger, if no relief were offered; but the passive congestion in the area of the bronchial vein finds vent through the communication established between the bronchial and pulmonary system of vessels, by means of the pulmonary veins. It is owing to this partial outlet no doubt that the serous fluid does not accumulate beyond a certain limit, compatible with a partial function of the air-cells. I say partial, because judging from the auscultatory signs, while the main portion of the exuded fluid seems to be gathered in the finer and terminal bronchioles, still the presence of an extremely minute moist crepitation here and there plainly indicates that a number of the alveoli are bathed in the fluid. Besides, it is only too evident from the shrinking up of the left chest, and from the sinking in of the intercostal spaces and supra-clavicular region, that a noticeable proportion of the lobuli are in a state of collapse or atelectasis, either from defective nutrition, or owing to the corresponding bronchioles having become obstructed.

Let us go a step farther. Granting that this supposed mechanical obstruction of the left bronchial vein satisfactorily accounts for the pathological condition of the affected lung, viz.: for a state of chronic œdema, partial atelectasis, without any evidence of consolidation or pleuritic effusion, would this same obstruction explain away all the remaining signs and symptoms, both objective and subjective? Undoubtedly it does, and in the most satisfactory way.

First as to the right lung. Its expanded dimensions, its tympanitic resonance, its loud, puerile breath-sounds all point to one conclusion, vicarious emphysema—the result of a salutary effort of nature trying to offset the deficient function of the crippled organ by supplementary work of the sound one.

How about the right cardiac hypertrophy? Here, also, we find evidence of an effort at compensation on the part of nature. If we bear in mind that the surface of distribution of the branches of the pulmonary artery is considerably reduced by the collapse of numerous tubuli, and

by the œdematous condition of the lung parenchyma at large; if we remember that the increased exertions of the right ventricle are still further taxed by its having to take care of the augmented collateral communication between the bronchial and pulmonary vessels, and also that the emphysematous condition of the right lung, the result of which is to put the capillaries on the stretch, thereby slackening the flow of blood in their network, constitutes an additional demand upon the driving power of said ventricle, we can no longer wonder why it should put on more steam, that is, more muscular force, in order to carry on its work.

As to the cough and dyspnœa, I hardly think, after what has been said, there is any further need of explanation.

The ground is now all cleared away, save for one important symptom, *the fever*.

Here the question arises: What is the nature of this fever? Is it dependent upon an obscure inflammatory action? Is it of a malarial nature? Is it of a septic, infectious character?

Being unable to ascertain the type of this fever in the absence of sufficient data, and lacking the aid of previous observations, I consider it safer to abstain from any further guessing until we can answer the final and decisive element of this clinical problem, viz.: *What is the nature of the supposed mechanical obstruction?*

Mark this: If the explanation I have to offer for the obstruction shall be consistent with the presence of fever, then the interpretation thrown upon the whole clinical drama stands a good many chances of being the correct one. If not, it can have no value whatever. Its a question of *sine qua non*.

Here we have to use the process of exclusion. Spinal deviation by exerting pressure upon the lung might have caused an affection pretty similar to the one under consideration, but our subject's spine, as you may see, is straight, and even if it were crooked, the fever would be unexplained.

At a stroke we can dismiss other causes of internal pressure, such as *aneurism, carcinoma, mediastinitis.* Likewise *adenia* and *leukemia* have to be dismissed since there is no outward glandular swelling. The idea of Hodgkin's disease cannot be entertained, as no signs of cachexia are present.

Finally, how about the possibility of a scrofulous or tuberculous glandular swelling?

A scrofulous swelling of the lymphatic glands that cluster around the bifurcation of the trachea is not a rare occurrence, but is hardly ever attended with fever. It is different, however, with a lymphatic glandular swelling of tuberculous nature; *in this case the fever becomes a characteristic feature.*

Here do we stand on the lowermost round of our analytical ladder. We have at last struck an hypothesis which seemingly accounts for all the elements of the problem. It certainly corresponds with admirable precision to the anatomical desiderata, as the bronchial glands are brought into intimate connection with the vessels issuing from the root of the lungs; and no stretch of imagination is required, for one familiar with the organic relationship of the parts, in order to conceive how a group of enlarged glands can press upon and obstruct, partly or totally any of the vessels of the region.

One more point to examine. Does this interpretation of the facts, however satisfactory, tally with the personal and family history of the case? Most consistently so. What does the family history show? That the mother and the grandmother of the boy died of quick consumption, while on the father's side we notice a decided scrofulous taint. The soil was well prepared for tuberculous infection. Then came the measles which left the boy with a cough or symptoms of pulmonary weakness from which he never rallied. What does that mean? That probably during the convalescence from the exanthema, which is well known to favor tuberculous invasion, the organic predisposition culminated into actual infection from the spe-

cific germs of the disease. The bacilli having seemingly failed to gain a foothold in the lung parenchyma traveled *via* the lymphatics toward the bronchial glands where they found lodgment.

Such is the conclusion we reach. We have been led to it by the unerring thread of a strict logical process through a maze of symptoms, physical signs, pathological, clinical and anamnestic inferences. No other hypothesis would offer the same harmonious and consistent view of all the facts in the case.

Therefore the final diagnosis reads thus: *Tuberculous infiltration of the bronchial glands; hence obstruction of the left bronchial vein, resulting in chronic œdema and partial atelectasis of the left lung, producing hypertrophy of the right ventricle.*

I say this is a unique case. I never saw anything like it before, nor read of any case that came near it. You may consider yourselves extremely fortunate in being able to examine such a case as this, and I am bound to once more express my gratitude to Dr. Davison for having provided for us such a rare clinical treat.

I do not want you to understand however that tubercular infiltration of the tracheo-bronchial glands is a rare occurrence. While it is not a common affection, it is far from being infrequent. But if you only bear in mind the various important structures which lie in close vicinity to and immediate contact with these glands, you may readily imagine that according to the number and location of the glands involved, as the case may be, and according to the structures that are pressed upon, as well as to the degree of pressure exerted, the outward symptoms and the physical signs thus generated are subject to considerable variation.

In some cases pressure symptoms are produced that remind one of thoracic aneurism; one case is on record in which pressure upon the vagus produced aphonia and slow rythm of the heart; I know of one case in which the phrenic nerve was irritated to such an extent as to produce irrepressible singultus ending in death.

In November, 1888, I was able to bring before the class an extremely remarkable case, unique also in its way, the full history of which will be found in the December number of the CLINIQUE, 1888. The lesion was exactly the same as in the present instance, *only the signs and symptoms were entirely different.* In that case the structure that was pressed upon was the right vena innominata. So that the resulting œdema appeared as swelling of the right side of the face, neck, and the right arm. There were a number of misleading symptoms about that patient, so much so that two expert diagnosticians of this city whose advice had been sought by the patient prior to his coming to us, had pronounced his case one of Grave's disease. I advise you to look up that case, to read it carefully and compare it with the present one. You will see that the case was one of tuberculous infection, from contagion, and since that time the patient's wife and the wife's mother have succumbed to tuberculosis. I have seen the patient a short time ago. His old symptoms of œdema and vertigo do not trouble him any more. But a capacious collateral circulation has been established by means of enlargement of the superficial veins of the trunk, which stand out in bold relief. He is now troubled with persistent œdema of the lower limbs, with occasional attacks of lymphangitis and peculiar dyspeptic symptoms, which lead me to think that the lymphatic circulation is interfered with, probably from pressure upon the thoracic duct. He used to have fever also, as our boy. It has now disappeared, the glands having subsided into quiescence.

The pathology of tuberculous adenitis is well known. When the localization occurs superficially, in the neck, the armpit, the groin, etc., it is easily recognized, and easily treated. It is different, however, with deep localizations, as in the case of trachelo-bronchial adenopathy. I have scanned for years our current medical literature without ever seeing a single case mentioned. Are we to conclude that this is a very rare affection? I do not think so. Why is it that in the space of a few years two most re-

markable instances of that affection have been found in this hospital, while the records of other hospitals and periodicals over this vast continent are silent on the subject? Are we to be suspected of having devised a "corner" in this particular trouble? The rational inference is that such cases are of daily occurrence, but are allowed to go by default, simply because they are not diagnosticated aright.

It is only fair to state that for almost all we know on the subject, clinically and otherwise, we are indebted to the researches of French pathologists, headed by Andral and Louis.

I suppose you are anxious to hear about the *prognosis* in the case at hand. From the left lung no immediate danger is to be apprehended. Of course it is badly handicapped in its work, but its mate seems to be equal to the occasion, and the obstruction created in the pulmonary circulation is met by the right cardiac hypertrophy.

The main danger arises from the fact that the affected glands might run into suppuration, break down and flood the system with baccilli, which means acute miliary tuberculosis and death in the course of a few days.

Still this may never occur, and the boy may live on for years and develop into manhood. At best, however, he will remain a lung cripple, and it is only too evident that any acute intercurrent thoracic affection which might befall him would easily become fatal.

We now come to the most important part of our task, namely, the *treatment*. Can we help the boy? Well, to a certain extent we can. At all events we are aware of the limits of our therapeutic intervention, and knowing the ground on which we tread we are not likely to deliver a prescription that might otherwise be fraught with danger.

The deepest axiom Hahnemann ever uttered is this:

"The physician should discover *what* is to be cured in disease, and what is curative in drugs, and adapt the latter to the former."

Now what is it *to discover what is to be cured in disease,*

unless it be to diagnosticate the organic lesion or the functional trouble that are at the root of the symptoms?

Take the present case. *What* is to be cured in it? Is it the cough, the dyspnœa, the fever, which are the symptoms appearing at the surface? Do you think that however closely you may study these symptoms and their modalities, however closely you would select your "similimum" in accordance thereto, do you think that your prescription would be correct and do any good?

It might be objected: Your prescription is not correct because you have not taken in the "*totality of the symptoms.*" All right. Let us gather more symptoms. First, the shrinking of the left lung, then, *if we know how*, we take in the sub-crepitant rales, the sub-dullness, the dilatation and increased function of the right lung, the increased function of the heart, and finding no further symptoms, we go to work and try to find a "simile" to this symptomatic picture in our materia medica.

Do you think such a prescription would answer? I leave it to your judgment to decide the question.

Again, it might be objected: You have not found *all* the symptoms yet; that is why your prescription is insufficient.

The objection is sound. We have to go deeper still; apparently we have not discovered yet *what is to be cured* in the disease. Then laying aside one by one impossible and improbable suppositions, we are driven to one conclusion, viz: that all the symptoms previously considered are created by a mechanical cause; that in the species that cause is a glandular swelling, and, finally, that the glandular swelling itself is of an infectious nature.

Here then we have the much-wanted "totality of the symptoms." Well and good. But how did we obtain it? By means of a thorough, conscientious, painstaking diagnostic process.

Diagnosis therefore is not the vainglorious, superfluous, some even say misleading achievement, that a few mistaken Hahnemannians would fain represent it to be. Di-

agnosis is a means of digging up the hidden symptoms, those that are really important, because they are causative; it is the only means that will yield the "*true totality of the symptoms*," and throw the necessary light on the hierarchy, the subordination, the filiation, the meaning of the symptoms.

It is odd indeed and worthy of remark, because it is intensely human, that the very ones whom we hear clamoring for the "totality of the symptoms," are precisely those who not having, or pretending to scoff at the ability to diagnosticate their cases, seldom if ever are able to get at it.

Reverting to the case at hand I claim that we now know *what is to be cured* in it. The question is: can we accomplish it? Of course the whole train of symptoms depending upon a mechanical obstruction of the bronchial veins, it were idle to hope to relieve, as long as the obstruction itself is not removed.

I claim that the only symptom of importance in the case is the presence of those tuberculous glands, the other symptoms and signs being secondary to that one, and of value only inasmuch as they throw light on the path leading up to the primary lesion.

If we could call surgery to our aid—a step which we would and should certainly take were the affected glands easily accessible—a decided gain would be obtained. We thus would at a stroke remove that Damocle's sword hanging over the head of the boy, namely the possible caseation and suppuration of the glands, and the scattering of the infectious germs broadcast into the system.

But even if that much were accomplished it is very doubtful whether the bronchial circulation would be materially improved; we must not forget that the lesion is one of a few years' standing, and that some permanent changes must have taken place in the coats of the vessel at the site of the pressure, resulting in all probability in complete closure of its lumen. All we can hope to do in the matter is to endeavor to bring about such modifications in the nutrition of the affected glands as will tend to reduce their

pathological activity, and furthermore to superinduce a slow intussusception of calcareous material, resulting in their final calcification.

In trying to accomplish this, we will only follow the hint which *natura medicatrix* gives us, and when we imitate nature there is little room for error. Cretification of the tubercular glands, of the tubercular deposits in the lungs and elsewhere, as well as of the tubercular cavities is a favorite mode of healing with nature in this dreaded disease, affirmed by clinical observation.

If the glandular swelling were of a purely scrofulous character, I would venture to say that *silicea* and possibly *iodium*, or *calcarea iodata* would sufficiently cover the ground. But while the above remedies may be useful in our case, *silicea* especially, I think the main work will have to be accomplished by the calcium salts, and more particularly by *calcarea carbonica*.

In my estimation *calc. carb.* is one of the greatest remedies of our materia medica, and stands second only to sulphur. But in this case *sulphur* would be dangerous, especially in the higher dilutions. It might precipitate the crisis we are anxious to avoid. Remember that *calc. carb.* is a powerful nutritious remedy. That its ultimate effects on the system are the production of a cachexia eminently favorable to the development of tuberculosis, a cachexia in which the alterations of the lymphatic system at large, glands and all, are a prominent feature. Remember that *calc. carb.*, like all nutrition remedies, acts by polarization, inducing the absorption of calcareous material in the tissues where it is needed, bringing about its elimination where it exists in excess. I have contrived to show you that double action in my lectures on general pathology.

It looks as though *calc. carb.* was eminently indicated in the present case, from the standpoint of the lesion at the root of the symptoms, as well as from that of special object referred to above. I would recommend its use from the 30th dilution upward.

It will be advisable, however, to support and amplify

its action by means of *calc. phosph.*, and even *calc. fluorata. Silicea*, as I said, may be useful. The climate influence is not to be disdained, and I think the Colorado climate quite suitable to the case. This treatment will have to be kept up until we have evidence from the gradual fall of the daily thermic ascensions that the glands have lost their specific activity, and that the colony of bacilli that they have harbored so long has found a calcic grave within their rigid walls.

In the meanwhile *arsenicum* will have to be given with a view to abate the feverish condition set up in the system by the toxin issuing from the affected glands.

THE SURGICAL CLINIC.

EXTRACTS FROM PROF. SHEARS' SURGICAL CLINIC IN THE HAHNEMANN HOSPITAL OF CHICAGO.

REPORTED BY L. A. SHULTZ, M. D.

ACUTE SYNOVITIS—ANCHYLOSIS—TENOTOMY—FORCIBLE EXTENSION.—Nov. 5. At my clinic three weeks ago I showed you a numher of cases of chronic disease of the knee joint, among them a case of chronic synovitis. To-day I want to call your attention to one of the unfortunate results that may follow an acute attack of synovitis.

Case. Mrs. K., age forty, sent to the clinic by Dr. Herkimer, Feb. 14, 1892. Almost nine months ago the patient fell, striking on the edge of a tub and injuring herself just below the left knee. For twenty-eight hours after the injury she felt no pain, but walked about and worked as usual.

At the end of this time the knee began to feel drawn and tense, the swelling increased above and below the knee and the pain became intense, the swelling increased until the knee measured nineteen and one-half inches. Various applications were made for its relief but without success. At the end of seventeen weeks the swelling subsided and the patient left her bed; soon after she fell and hurt the knee again, the pain and swelling returned and she has never since been able to leave her bed.

Upon examination the knee is found to be one and one-half inches greater in circumference than the right knee. The leg is flexed on the thigh and the thigh on the abdomen.

The least motion causes the most excruciating pain, and she lies on her back with the leg supported by pillows on each side. She sleeps but little, the slightest motion awakening her and causing pain.

The question may arise in this case; does this stiff and sensitive joint depend on progressive disease of the bone, or does it arise from the growth of fibrous bands or the contraction of tendons?

It is true that the ends of the femur appear to be enlarged, that the condyles are sensitive to touch and that the hamstring tendons are rigid, symptoms of common occurrence in bone disease. But it must be remembered that the history is not one of bone disease but of synovitis, and that actual enlargement of the part with pain on pressure may occur from induration of the tissues surrounding the bone, and that periarthritis is not an uncommon accompaniment of synovitis. The case, in my judgment, is clearly one of synovitis followed by the formation of bands of connective tissue between the femur and tibia, and also, probably, by a contraction of the tendons of the inner and outer hamstring muscles. The patient, I believe, will be much benefited by breaking down of these bands of adhesion and placing the limb in extension.

The patient was given an anæsthetic and the knee forcibly flexed and extended. On account of the contraction of the hamstring tendons the knee could not be entirely extended, although great force was employed, until the hamstring tendons were divided with a tenotome. It was found necessary also in order to completely extend the thigh to make a tenotomy on the sartorius.

On account of the great force necessarily employed and the swelling and echymosis which follow, it was thought best to put the limb at rest. Extension was maintained by weight and pulley, and an ice coil wrapped about the joint.

In reference to treatment Prof. Shears said:

There is always a certain amount of risk in interfering with a stiff joint, the result of synovitis. Inflammation may be reëxcited and irreparable mischief done. The risk however is reduced to the minimum if the temperature of the part is normal and a fair amount of motion exists in the joint.

One thing must be remembered, if after the operation is commenced it is found more difficult than anticipated that an incomplete operation is worse than no operation at all. It excites inflammation but does not relieve. All adhesions must be completely broken down.

In the case of children great care must be exercised because of the ease with which the epiphysis may be separated from the diaphysis. This is especially true when force is employed during extreme extension.

In ordinary cases after breaking down the adhesions and restoring the motion of the joint the limb may be used at once. If the patient has not the strength to use it passive motion must be employed and the part shampooed and massaged until strength is regained.

In the present case on account of the slightly increased temperature and the great effusion following the operation we will place the part at rest and apply cold until the inflammation subsides.

Notwithstanding the irritation produced by the operation the patient obtained great relief from the pain which she had suffered.

DOUBLE HARE-LIP—CLEFT PALATE.—November 15. A. B., age three years. Sent by Dr. J. A. Kirkpatrick. This little unfortunate has as you see the congenital deformity known as double hare-lip, complicated as it frequently is with cleft of the palate and failure of union on one side of

FIG. 1. DOUBLE HARE-LIP AND CLEFT PALATE.

the intermaxillary bone. (See Fig. 1.) This bone projects as you see considerably above the level of the left superior maxilla and is covered by a small portion of skin attached to the septum of the nose very near its tip.

The alæ of the nose droop, are flattened, the nostrils

elongated laterally, and the whole nose, depressed and flattened.

The condition you see here is due to an arrest of development. If the palate be examined at some time before birth there will be seen to be a cleft extending in the median line from the extremity of the soft palate anteriorly. A short distance from the alveolar ridge this cleft divides and from this point two clefts pass to the space between the lateral incisors and canines; between these is found a triangular piece of bone, the anterior portion of the superior maxillary, which contains the incisor teeth.

These clefts also extend through the soft tissues. The upper jaw with its appendages, the lips, is therefore in fœtal life separated into three divisions, the larger lateral portions and the smaller middle piece. Although this little fellow has developed in every other way, from some unknown cause there has been an arrest of development, and the jaw and lips remain almost in the same position in which they are found in early fœtal life. On the right side the intermaxillary bone has united with the right maxilla but at such an angle that its left border projects into the left cleft of the lip and is considerally above the left maxilla. In order that the lips may be brought together it will be necessary first to place the intermaxillary piece on a level with the left maxilla. To do this it will be necessary to break its connection with the right maxilla and then forcibly press it back in place. As a first step in the procedure I sever the labiomaxillary fold, freeing the little tab of skin over the intermaxillary triangle and separating the right and left upper lip from the jaw. I now pare the edges of the intermaxillary piece and the left jaw; extract the incisor teeth which are viciously placed and would grow into the cleft; and with my chisel divide the jaw at the union of the intermaxillary piece with the right maxilla. With considerable force the intermaxillary piece is now pushed back into place where it will easily be retained by the pressure which we shall put upon the restored lip.

My plan in the restoration of the lip is to pare the edges of the intermaxillary integument in such a manner as to form almost a square, to then make an oblique incision through the entire substance of the lip from a point very near the nostril, to a point one-half the distance to the lower border of the lip. By pulling down the flap thus formed and cutting off the sharp angle the right and left lips are made to surround the square and meet in the

median line below. The parts are held in place by means of hare lip pins and a figure of eight suture, and the approximation made more perfect by the application of superficial silk stitches to the skin and mucous membrane. The cleft palate will be operated upon at some subsequent time.

The after-treatment of this case is very simple. The pins will be removed upon the third day; the superficial stitches will be left for five days.

During the removal of the pins the cheeks will be pressed together by the thumb and finger so that no tension will be made upon the wound.

Upon the removal of the pins a firm piece of adhesive plaster will be placed over the lip. It would have been much to the interest of this patient, I believe, if the operation had been made at a much earlier date.

In simple hare-lip it may be made a few days after birth if the child is in good condition, and in double hare-lip as soon after the first two weeks as the condition of the child will permit.

The pressure exerted by the tightened lip favors, I believe, the closure of the bony aperture and thus exerts a favorable influence on the palate cleft.

TUBERCULOSIS OF THE SUBMAXILLARY AND CERVICAL GLANDS. REMOVAL. November 28th. M., aged nine years. This little child is not unknown to most of you. For more than six months she has been an attendant upon our clinics—either medical or surgical.

She has an enlarged submaxillary gland the size of a walnut and two enlargements of the cervical glands of about the same size. Recently several smaller enlargements have been noticed in the chain of cervical lymphatics. The cause of the trouble is obscure.

I can obtain no positive information as to the hereditary influences in this case, neither can I tell you the precise avenue through which the bacillus tuberculosis made its entrance into these glands (for I believe these glands to be tubercular).

It may have entered through an abrasion in the mouth, nose, or through an eczematous patch on the scalp. Inasmuch as the submaxillary gland was the first involved, it is possible it may have entered through a carious tooth. However, it made its entrance, and being taken up by the lymphatics, it would naturally lodge in one of the lymphatic glands on its way to the lymph centres.

When I first saw this child I hoped the enlargement was not tubercular, or if so, improvement of her general health might enable the gland to eventually dispose of its unwelcome intruder through a process of calcification. She was sent to the medical clinic, but notwithstanding the administration of the indicated remedy, attention to hygienic rules, so far as we could enforce them, and subsequently applications of electricity there has been no improvement; indeed other glands are apparently becoming infected. I shall therefore to-day remove them by the knife, believing that tubercular foci are always sources of danger, no matter if the disease remain latent for some time.

An incision was made over the submaxillary and the gland removed. Another incision was then made along the outer edge of the sterno-cleido-mastoid muscle, and the whole chain of lymphatics from the mastoid process almost to the clavicle removed. The wounds were dressed aseptically and united without suppuration.

Portions of the submaxillary were placed under the microscope, and reported by Prof. Lyon to contain the bacillus tuberculosis.

Clinical Society Transactions.

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

DECEMBER MEETING, 1892.

The monthly meeting of the Clinical Society was held in the Great Northern Hotel, Saturday evening, December 31st, the President, Dr. W. A. Dunn, in the chair.

REPORT ON THE MEDICAL DISEASES OF WOMEN.

BY DR. E. STILLMAN BAILEY.

It is a coincidence that, just at the close of my thirteenth year of membership in the Clinical Society, I should have my first regular appointment to present the report of the evening; and that on the summary of cases to present, they number thirteen. I hope none will have occasion to say anything about its being unlucky to be present under such circumstances.

Twice before, however, I have volunteered a report whenI have known that the essayist would not be present.

I. THE BACTERIOLOGY OF UTERINE DISCHARGES. PART I. My first thought was to take up the study of the various uterine discharges, and in an analysis, see what relation the bacteria stand to the cause, and the perpetuation of these abnormal discharges; and while my experiments now number in the hundreds of culture tube tests, and have extended over nearly two years, I find, that to make the subject entirely clear, and to strip it of the chances of error, that a few of the commoner forms of inoculations best subserve the purpose of illustration. I therefore present the following list of experiments, and the results you shall see for yourself.

I have one word of explanation to offer. The medium

used is the agar-agar, and was most carefully prepared for me by Dr. H. N. Lyon, and it bears the test of sterility and clearness; and secondly, the microscopical analysis of these growths has not been made, as I wished to avoid the errors sometimes caused by exposures. I beg leave to submit the microscopical test later.

No. 1. I offer you to examine this culture tube. The very brief history is that it was inoculated by taking the accumulations from under my finger nails, the circumstances being as follows: December 14th, I made my hands surgically clean and performed a laparotomy, finishing at two o'clock P. M., and at four o'clock, the same afternoon, I curetted the uterus in another patient, its contents being fragments of a decayed placenta. I cleaned my hands thoroughly after the operation, in fact, rendered them surgically clean again as I was to visit the laparotomy case and attend to the wound if it should require it. An hour after the return to my office I made this inoculation, observing the strictest technique of making the platinum wire first sterile by bringing to a white heat, and afterward using it to insert the particles upon the medium, the tube being inverted. In forty-eight hours a luxurious growth had appeared upon the surface of the medium, and in one week's time the growth had dipped into the medium or formed upon it to the depths of a sixteenth of an inch. Now it is a quarter of an inch and is still spreading.

There are mixed colonies of micro-organisms growing in this tube. It is instructive in many ways.

No. 2. These four tubes, the results of an experiment of December 16, are next presented for inspection. I announced to four members of subclinic class number twelve, please get your hands surgically clean for examination of the patients you may be assigned to treat. Immediately before making the examination I asked two students to let me critically examine their hands; this I did, by using the nail cleaner, and deposited the results of the scraping on the medium. One tube is sterile and one shows at least three colonies of bacteria, but the growth has not been a vigorous one by any means. Each examined the same patient, and I took on a platinum sound-sterilized, the little trace of a uterine or vaginal discharge that I found on the finger tips and you will see two distinct colonies of growths, of about the same size and character.

No. 3. In this experiment of December 23, I chanced to place the uterine sound upon the blanket covering the examining table in my subclinic room. Everything was ready to examine the patient in waiting. I called attention to the possibility of infecting the patient, if I should pass the sound into the cervical canal without washing it, and proposed to inoculate a tube with it before cleansing and use. You will see the wonderfully vigorous growth; it has the appearance of mould on bread, is greenish and feathery. It is the best I shall have to show you in the way of its resemblance to fungoids in the vegetable world.

I have fastened to it, by the adhesive strip, a tube labeled gonorrhœa; this tube was inoculated the same day, in my private practice, a drop of the discharge being taken from the meatus. There is a striking resemblance, the growths looking as though they had been originally from the same source, yet to my knowledge were widely different. This greenish color is not uncommon in these uterine discharges, and the germs are responsible for the color.

No. 4. This test tube contains the remnants of a former luxurious growth, caused by putting a bit of sponge, no larger than the head of a pin, on the media. I took a sponge out of its solution of five per cent of carbolic acid and supposed to be sterile, and picking off a speck dropped the same on the floor and immediately handling it with forceps, placed it in the tube It showed a number of colonies of bacteria during its time of growth, and the white line you see, resembling dust, contains numberless spores and dried bacteria. These germs can at any time be made to show life by transplanting them on nutrient media.

No. 5. This tube I exposed in my vest pocket December 26, removing the cotton stopper and carrying it as I did my lead pencil for six hours. There were present, three days afterward, forty-five distinct points of growth, showing that in this manner of expose the substances that happened to drop in the open tube are viable. A week later these colonies had united and covered the entire surface of the medium with a true fungus.

No. 6. This tube was exposed, minus its cork, Dec. 16th, for one-half hour in the subclinic room. The next day it showed evidences of having received some infection. It has a vigorous growth and shows two distinct colonies of bacteria, one showing red and the other yellow in color.

The air in this room cannot help being laden with pathogenic bacteria, as so many surgical cases are dressed here. This experiment and others like it that I have made show how totally unfit filthy rooms are for surgical work.

No. 7. These three tubes were exposed Dec. 23d in the amphitheater in the hospital. As you see two of them have evidences of having some germs deposited on the medium. The sterile one was hung as high as we could reach, the second one was suspended from the table, and the filthy one placed nearer the floor. With these three, I offer you three others that were exposed yesterday in the subclinic room. The tubes being inverted and suspended by adhesive strip. One was suspended from the gas bracket, mouth downward and cotton stopper removed; the second was suspended from the shelf, as was also the third, the latter however being much nearer the floor. Ten days afterward these tubes remain sterile, not a trace of infection showing.

No. 8. This tube was treated by putting in the medium a filthy uterine sound. I asked a physician to lend me a sound, saying please hand it to me the same as you would use it. There, said he, after wiping it on a common office towel, that's all right. You use it then this way? Certainly, he replied. Now I am going to use it in this tube, and I did, and together we watched a very vigorous growth of germs. Life showing itself within forty-eight hours, and continuing for six weeks or more, finally either consuming all the food or so liquefying it that it dried to a film. This was one of the most interesting of my experiments. The doctor told me that he did not know when his sound had been cleaned by boiling, in fact did not think it had for a year. Are there not other uterine sounds in the county in daily use in about the same filthy condition? Try them on a culture medium and be surprised and convinced.

No. 9. This tube was inoculated by single contact with a sponge tent. I asked at the instrument shop, for a sponge tent, not one that had been especially soiled by handling nor one that had been protected. I wanted just such a one as is sent when asked to supply the physician. Here it is, said the clerk, its just about the average. And I told him what use I would put it too. Let me see it if anything comes of it said he; and four weeks afterward I showed him a crop of microbes that had almost devoured the medium that had sprung from the filthy sponge tent. This was a year ago and at will I can reproduce a similar growth in fresh medium by "grafting" from this tube.

No. 10. This tube remained sterile. I purchased a laminaria tent with the above, but before using it I washed it in hot water. It never has shown a particle of life anywhere along the line of contact. It's surface was smooth, and its hot bath made it fit for use. It had been subject to about the same exposure as the sponge tent, so I was informed.

No. 11. This tube was treated to a bit of common, every day mud, just such as soils the linen by spattering, and such as often covers the busy practitioner during the season of storms when riding, or such as flies into the face when walking over a street crossing. It was only a pin point that carried it, but its growth of living matter is quite surprising, it being very marked and containing many colonies. This tube, literally, is as clear as mud. The filth of the hands and clothing is precisely of this character, and it shows it in the character of its growth and in its microscopical analysis.

No. 12. This tube I came into possession of through my friend, Dr. Lyon. He said he put two drops of water from the tap upon the gelatine, and you all see at least a half dozen colonies of living fungi. It was clear looking water, and might have been taken from any city water-pipe as well as from the "condensed" water supply of this city. It is no better nor worse than other taps supply.

No. 13. In my clinic, one day, a patient complained of suffering from a moist eczema of the vulva. There were patches, also, on the hands and wrists and back of ears. I inoculated from a drop taken from the wrist, and a greenish mould which soon became very dense resulted. I also took a test from the moisture from the eruption at the vulva, and also a drop of the leucorrhœal discharge. To the unaided eye the appearance of the growths are exactly similar and luxurious.

Cui bono?—While these experiments are interesting to make and to witness, what's to be the result? I really expect little, except the amusement, as these lessons seem quite impersonal. Yet, if in a careful resumè any benefit comes to any one, I shall be repaid. The experiments were all directed toward the surroundings of the gynæcologists, and show conclusively the existence and infected and infectuous possibilities. The fortunate thing is, that many of these germs are nonpathogenic; an unfortunate

thing is, that others are highly infectious and disease producing. Who is wise enough to discriminate? The argument that arises in the mind, just at this point, is not unlike that of the romantic and realistic in literature. The realistic seemingly having to beg a hearing. Here is a quotation from the critical pen of Howell's:

"Every true realist finds nothing insignificant; all tells for destiny and character; nothing that God has made is contemptible. He cannot look upon human life and declare this thing or that thing unworthy of notice, any more than the scientist can declare a fact of the material world beneath the dignity of his inquiry. He feels in every nerve the equality of things and the unity of men; his soul is exalted, not by vain shows and shadows and ideals, but by realities in which alone truth lives."

But an interesting part of my report is yet to be made, and I shall condense it.

The sterile culture-tubes have their lesson which we learn first. The animal and vegetable matters do not undergo putrefaction if all germs are excluded. Repeated experiments prove, also, the truth of this statement, that the normal fluids of the body will not undergo putrefaction if the germs are excluded. The truth of putrefaction was taught by Pasteur, and irrefutably puts a stop to the old question about the priority of the germs, whether they be cause or effect. They are preëminently the cause.

I have before me over one hundred inoculations from as many different patients. In every case where there has existed any kind of an abnormal uterine discharge, such as has sent the patient to a specialist for treatment, there has been shown upon the media a definite form of germ growth without exception.

It might weary you to hear of them all, so I select a few. 1. Here is one, the patient having had leucorrhœa for eleven years. Has always treated with a homœopathist, but never took local treatment as her physician said "he did not believe in it" and never used the vaginal douche. In forty-eight hours this culture tube teemed with living

germs. It is to look at as filthy as any that I have just shown you. At a later date under antiseptic douches, creoline three per cent solution, this abundant discharge was lessened to an extremely scanty one. 2. This one is a companion to the one reported above. It came from the patient whose clinical history is that of having been infected soon after marriage with gonorrhœa and has had several reinfections. The growth is the same as is shown in the inoculations of the students fingers after having made the examination. I have taken a dozen cultures from this patient during the year past and all are fertile with the gonococcus. 3. Is from a lady's maid, while she is being pitied because of "inherited weakness" the culture tubes reveal the gonococcus. 4. Case of sterlity, the cultured tubes showing mixed colonies of bacteria, the cervical canal being plugged by this jelly-like discharge. 5. This is from the cervical canal of a case of amenorrhœa with profuse whites. The amenorrhœa has been an almost constant factor since puberty, but the whites are of gonorehœal origin. 5. Taken from a patient fifty-six years old, passed the climactic ten years ago, leucorrhœa for a year past, mixed germs present but this case improved with douching. 7. Case of cervical cancer germs found before useing bichloride, one to five thousand, douching none since and the patient improving after a most thorough curetting. She positively declines any surgical interference. 8. Case of endometritis, profuse discharge daily. There are several colonies of bacteria. In this case I have every reason to believe the patient was inoculated with a filthy uterine sound. The patient was not married at the time it was first used, but distinctly remembers that she never had any leucorrhœa until after the sound was used. After curettage and packing, now six months ago she has not had any leucorrhœa. This tube shows an abundance of dried germs, and I can reproduce them at will by implanting on fresh media. 9. This tube was inoculated from a patient who had been flowing almost every day since a miscarriage eight months ago. The stinking odor alone

driving her to a physician for relief. The growths applied in less than twenty-four hours and have destroyed by liquefaction all of the media. Washing out the uterus thoroughly only once has practically cured this patient. Creoline three per cent solution was used. 10. Endometritis case, present three years ever since an absorption. The colonies of bacteria present to the eye several variety of color and characteristic growths. 11. Discharge taken from a little girl three years old, called whites, but on analysis was gonorrhœal. 12. Discharge taken from the child's mother, as I was treating the father, an engineer, who confessed to having contracted gonorrhœa. It was not difficult to explain the appearance of the culture tubes. The child contracted the disease by filthy cloths. 13. Hemorrhagic discharge, including a blood clot. This growth was very feeble and never advanced any after the second day; practically sterile, notwithstanding the great surface of the blood clots. It has not been infected and hence no growths from it.

I might multiply cases but they would simply be confirmatory. I have taken, with all the care of the most exacting technique, a little portion of the discharge from over fifty different cases of endometritis and there has invariably been a growth of bacteria according to the severity of the case, as indicated by the quantity and quality of the discharge. Mild cases have shown a feeble growth, and the severer types vigorous growths. I am not yet willing to go so far as to assert that all these cases are of gonorrhœal origin, but I am prepared to say they have all been caused by some kind of infection. As the doctrine of autoinfection in the puerperal state has been relegated to the past and proven untrue, so it will be concerning these cases of uterine infection. The cause is always from without and the variety and virulency alone are determined by the source of infection. In the study of the causes of abnormal uterine discharges the truth seems to lie in the fact that infectious material is carried to the endometrium, then it thrives. The peculiarities of the structure of the female

organs of generation render them especially liable to septic infection. I cannot go extensively into this discussion, but to illustrate the point, I submit two micro-photographs, of different cases of endometritis. The preparations are from the laboratory of Mr. Taite, and were loaned to me for study by my friend, Dr. Fred. B. Robinson, of this city, and excellently photographed by Mr. Charles H. Trego.

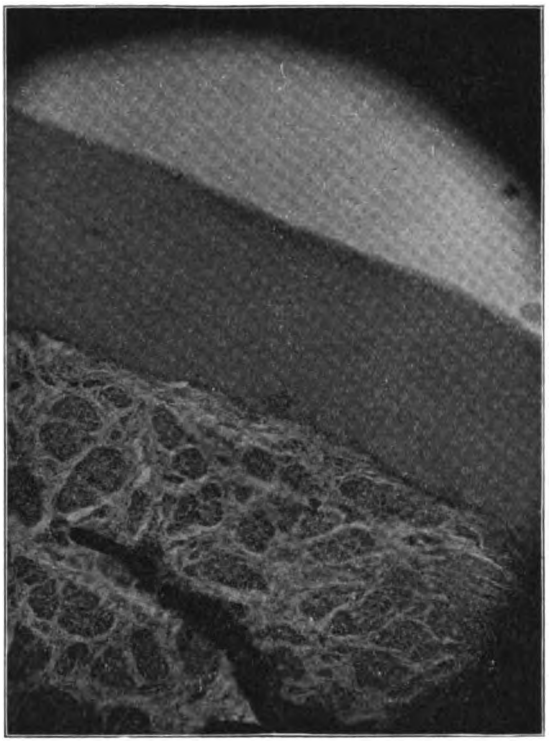

FIG. 2.

Fig. 2 shows the endometrium thickened, but an unbroken surface, the epithelial covering protecting the deeper structures. This is a chronic endometritis, and acute septic symptoms may not be met with.

Fig. 3 represents the endometrium where the epithelical layer, as shown in the above one, has been broken

down and discharged so that the lymphatics and blood channels are exposed to direct action of septic matter that may be brought to and imposed upon them.

With these conditions before us it seems that those who have undertaken to treat the diseased endometrium have often been the very ones to carry to it the very elements of disease upon which it thrives most. The filthy sound, or dilators, the unclean specula or fingers are responsible for the infection.

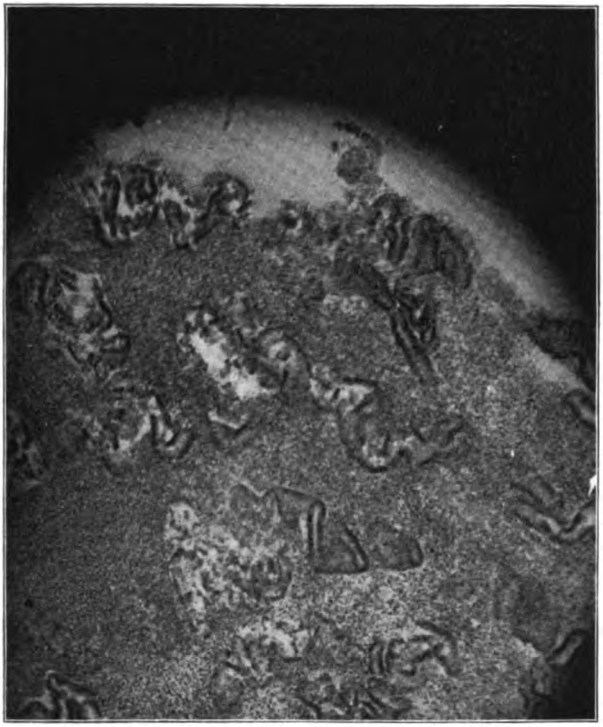

FIG. 8.

I shall have to close this already too lengthy report. The blessings of antisepsis, and the comforts of asepsis are nowhere more marked than in distinctly uterine cases; and in my experience, the rapidity of cure comes in exact

proportion to the thoroughness of combating the infection by cleanliness and perfect drainage.

II. ANCHORED, RETROFLEXED UTERUS FROM PELVIC HÆMATOCELE, WITH ADHESIONS, CURED BY BRANDT'S METHOD OF UTERINE MASSAGE. *Case*, Clinic No. ——. Miss ——, age thirty years, gave the following history: Never has been well since puberty. Very early in life was treated for a leucorrhœa, by caustic, and she suffered greatly in consequence. Four years ago, 1888, the menses began to be scanty, and from November until the following February she suffered from amenorrhœa. Without provocation in February, she menstruated very freely; the first day of the flow was extremely cold, and as she was obliged to go into the city, she ventured, though at the time the flow was scarcely less than a hæmorrhage. Returning at night as best she could she had internal hæmorrhage, described fully under pelvic hæmatocele with all the symptoms diagnostic thereof. Two months in bed. The next July she had a repetition of the same clinical kind. The tumor disappeared very slowly. Since this time the uterus has been retroflexed and anchored. She had all sorts of medical treatment, and becoming an invalid, with loss of business and property, applied for relief at the clinic.

Becoming familiar with the case I suggested uterine massage and it was faithfully carried out by Miss Batelle, one of the hospital nurses. Result after receiving forty treatments, the uterus became freely movable, and was restored to its normal position. December 1st, she called at my office and volunteered the information that she firmly believed the method would cure her, and that for the past six months she had been constantly gaining, and that she had returned to her work again. She asked to have the treatments continued to keep the parts in their present condition of health.

III. UTERINE SUBINVOLUTION, WITH ADHESIONS, MAKING THE UTERUS FIRMLY ADHERENT TO THE LEFT PELVIC BRIM. UTERINE MASSAGE CURATIVE.—*Case.*—Mrs. ——, age, thirty-five years, referred to me by Dr. Martin, synopsis of case, on local examination of the uterus it was found very much enlarged in all its diameters and firmly adherent to pelvic viscera and left pelvic bone. On inspection, the

tumor was oblong extending almost to the umbilicus, abdomen sensitive and tympanitic, excessive muco-purulent discharge from the bowels.

For ten weeks the patient had daily uterine massage and steadily improved in all her symptoms, the uterus becoming normal in size and freely movable, and remains in situ. The discharge from the bowel is quite free. The patient is positive that the massage has greatly improved her local and general condition.

IV. ASCARIS LUMBRICOIDES, female, with several small worms issuing from the reproductive orifice.

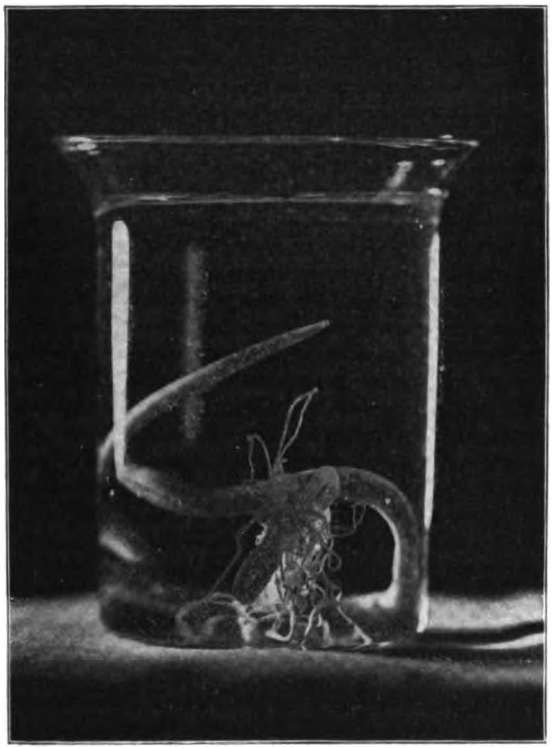

FIG. 4.

Case.—Mrs. ——, age, twenty-five years. This unique case is presented to call attention to a lot of abdominal symptoms that seem to have been greatly aggravated, if not

wholly due to the presence of this parasite. The worm was twelve inches long when it was vomited. The patient has been wonderfully better since getting rid of the worm. My connection with the case was as a consultant. (See Fig. 4.)

In July last, my associate, Dr. Smith, while attending this patient had frequently to prescribe for a very troublesome diarrhœa, remedies sometimes seemed to check immediately, subsequently an obstinate constipation would follow, then the abdomen would become tympanitic, and the rolling of gases was very distressing. One afternoon we were summoned in haste; there were symptoms, and they were very marked, of intestinal obstruction. These suddenly gave way, and for a while the patient was greatly relieved. Relapses would follow and the patient became greatly emaciated. Two months ago I was informed that the patient was again very ill, and that it might be necessary to operate for the relief of appendicitis, as the symptoms pointed to that condition very markedly —these symptoms yielded when they did yield, suddenly, and the patient experienced nausea to a great and alarming degree, and was thoroughly wretched until the worm was expelled from the stomach.

To those who do abdominal surgical work there are a number of curious facts that should be kept in mind concerning the clinical conditions that may come from the presence of this parasite. Its proper habitat is the upper and middle part of the small intestine. But it often wanders into the stomach and sometimes gains access to the outer world by the natural passages of the mouth, nostrils and anus—occasionally by perforating the intestinal and abdominal walls. Many cases are on record where the lumbrici have passed into the abdominal cavity, and when they find their way within the abdominal viscera they give rise to the formation of abscesses, requiring surgical interference.

The characteristic symptoms are colic, and shooting pains about the abdomen, nausea, vomiting, and even diarrhœa, restlessness and convulsive twitchings. It may be of some interest to see how these little ones are born; but the cause of the parents being found in the intestine or how they got there still remains an undecided question.

VOLUNTEER PAPERS. V. CASES FROM PRACTICE. BY MARY C. SHIBLEY, M. D. *Case I.* Miss G., æt. nineteen, was always well until fourteen years of age when she was

ill with what was diagnosed as typhoid fever. Vomiting and diarrhœa were persistent and prominent. The child recovered nicely and the catamenia appeared at about fifteen, with moderate amount of pain and a rather scanty flow lasting two or three days.

During the Spring of '91 had another attack of fever, again "typhoid", keeping her in bed four weeks. Vomiting and diarrhœa were again prominent and persistent. Convalescence was slow, and abdominal pain continuous.

In April '92, complained of malaise, anorexia, with chilly sensations in the evening followed by fever and sweating. The abdomen during this time was enlarged and tender. This condition was present for a couple of weeks, when vomiting and diarrhœa commenced and a physician was called. The tenderness and pain in the abdomen had been increasing; the pain was located in the median area, and extended from the niphoid appendix to the pubes. During the entire illness the pain was rarely absent from that locality and at times would radiate over the whole abdomen.

For the first month vomited from two to six times daily, with about the same number of stools. The retching was always severe and long lasting. At the end of this time the temperature dropped to the normal, the vomiting and diarrhœa ceased, marked constipation supervening. The patient remained in this condition about two weeks when the first series of symptoms reappeared, and again continued for about four weeks, the emaciation and general weakness becoming extreme.

The fever, vomiting, and diarrhœa again abated, the appetite improved, and constipation again appeared. Enemas were of no avail, cathartics being necessary to produce a motion of the bowels, which would then be accomplished with great pain and followed by temperature, for six to eight hours.

When the case came into my care, August 4th, from Dr. Cora Taylor, who had had charge of it for about a month and was leaving town, the result of the physical examination was as follows:

Appearance. Patient emaciated to an extreme degree. The skin dry, harsh and brownish, and although patient had had daily baths with inunctions of cocoa butter, the skin had such an appearance as though it had not been bathed for weeks.

Abdomen. Ilia very prominent; abdomen rather flat

but *tense;* brownish color very marked. On palpation very tender, with tense thickened feeling later, a tumor, not well defined in right lower portion of umbilical region. On percussion tympanitic over usual area. Heart's action very rapid and weak but valvular sounds normal.

Pulmonary resonance and respiratory murmur good. The constipation continued four days longer, when vomiting and diarrhœa again returned, defecation and micturition becoming involuntary; the temperature remaining at about 97°. The patient died at 2 A. M. August 14th. Post-mortem examination fourteen hours later—by Drs. Emma Butman and Mary Shibley.

On attempting to enter the peritoneal cavity, after section of the parietes above the umbilicus, the intestines, omentum, and parietal peritoneum were found so tightly adherent that only after much working and tearing was it possible to separate them. The entire peritoneal surface was involved, there being adhesion wherever possible, and scattered throughout were cheesy deposits with irregular outlines, about the size of a kernel of wheat. The mesenteric glands were enlarged, varying in size from that of a pea to that of a Lima bean—caseous on section.

Below the umbilicus we come down—not to the peritoneum—but to a thick, "sunset red" membrane containing similar cheesy deposits to those in the peritoneum, and only after tearing through this membrane could the pelvis be entered. It was found to be reflected over the pelvic viscera like the peritoneum, and to extend from the ant. surface of the sacrum forward and upward, the intestines being tightly adherent to the upper and post-surface of this layer, which held them above the pelvic cavity.

After removal of the uterine appendages this membrane could be peeled from them, leaving what was apparently a peritoneal surface. The tubes were found about the size of a lead pencil, convoluted, and filled with a cheesy material. There was no fluid in the abdominal or pelvic cavities. In the parenchyma of the left apex and in the visceral pleura of the right lung were a few solid gray tubercles, nearly the size of a pinhead. The heart was small, dark, soft and flabby.

Case 2. Amelia D., colored. æt. five, admitted to the Home for the Friendless, May 21st, was well until the latter part of June, when with swelling of the parotid glands, the care taker noticed a yellowish discharge from the vulva. Child was listless; appetite poor.

On the evening of July 4th, a considerable bloody discharge from the vagina was noticed.

July 5th. Examination.

Tongue has furry white coating, breath fetid. Swelling of the parotid and submaxillary glands; also of the cervical lymphatics.

Bloody discharge continues.

Temp. 99.4. P. 110. R. 30.

Child continued about the same until July 7th, the discharge lessening and becoming brownish, when she complained of pain in the inguinal regions and tenderness on pressure. This continued until July 12th, discharge now muco-purulent, pain and swelling of glands gradually diminishing. Temperature varying from 98° to 102.5°.

Child was listless and did not regain her usual health for about a month, but at present is well.

VI. DERMATITIS EXFOLIATIVA PERIODICUS. By B. BELL ANDREWS, M. D., Stella, Neb. During the session of the Nebraska State Society, 1892, I exhibited to my friend, Prof. E. Stillman Bailey, a photograph of the subject of the following sketch, as a *rara avis* that I had come across in practice, and he requested that I prepare a history of the same for the CLINIQUE at my earliest convenience.

The parties having moved away from this neighborhood, I wrote and obtained a history from the mother, which I submit, in part, to the profession, as something of a prodigy—as not more than a dozen similar cases have been reported, wherein the periodical shedding of the skin is noted.

Case. John H. P., æt. thirty-six years, offspring of healthy parents—there being no knowledge that would lead to the belief that heredity plays any part in the production of this queer phenomenon.

The mother states that "when John was eight months old, we lived in Kansas. He had an attack of ague which lasted a few days. We gave him quinine and Smith's tonic, which broke up the chills. Immediately, his flesh turned red all over, and he had a high fever a few days. When this went down he began peeling off. We called in a doctor who said it was the ague in his blood. He had two spells like this that fall—of peeling off.

We moved to Colorado the July following, and remained

there seven years. While in Colorado there were no symptoms of the disease. We then moved to St. DeRoin, Neb., on the Missouri river bottom. In July of that year, 1862, he had a few chills, and peeled off as before. We called in a doctor who gave quinine.

The next year, 1863, in the month of July, he had a spell of ague and peeled off again. We then moved to Barada, Neb., where he had good health, with no symptoms of shedding his skin.

He went to Montana sixteen years ago; after three years residence there, he began to shed his skin regularly every July, between the 14th and 20th of the month. This has occurred regularly for the past twelve years without a single intermission. Wherever he is, the spells come on in July.

The symptoms are a little different from those when a child. It begins with a chilly sensation, vomiting and intense fever. After a few days of this fever, he begins shedding his skin, great flakes a foot or more square hanging from him. His entire skin peels off, and not a single part of his body escapes. He remains in perfect health up to the time when the spell comes on, then he is perfectly helpless. These spells are growing worse as he grows older.

The father thinks I was frightened at a snake shedding its skin; but I have no remembrance of such a fright. It was during the Kansas trouble that I was pregnant, and the contending armies kept me in mortal dread by skirmishing around our place. But I do not believe this or the snake had anything to do with it."

I quote the last paragraph of the mother's statement in full, to show that she is fairly cognizant of the fact that no prænatal influence is sufficient to account for the cause.

This man has been in the hands of many physicians, and has submitted himself to various processes with an attempt to gain a cure.

The fever and other symptoms are typical of arsenical poisoning, and I was at first almost persuaded that his vomiting and water aggravation was accidental poisoning.

The photograph from which the accompanying illustration was made, was taken after an attack, July 25th, 1891.

There is no angina, and the desquamation takes place without itching and burning.

I have neither space nor the inclination to enter into an etiological description of the disease, as this can be

found in most of the modern treatises on skin diseases. But I will advance the opinion, that if the cases now known to exist, together with a careful perusal of the history of those that have been recorded from time to time in the journals be compared, they will be found to exemplify in their instruction to the student of medicine a relationship to the law of similiars, if they do not come wholly within the great law of cure.

The history and evidence attained, leads me to believe that the diseased condition of this man's skin is the symptomatic effect of arsenic poisoning administered to him for other ailments, and continued and aggravated since then by taking this drug to cure the skin disease. And this with all other recorded cases has no evidence of idiopathic origin.

VII. MASTITIS AND PARTURITION DURING TYPHOID FEVER, BY SARAH J. MILLSOP, M. D., BOWLING GREEN, KY.—*Case.*—I was engaged to attend a healthy woman of twenty-six in her first confinement. The date of labor was put down for October 3d. The first of September the family moved into a recently purchased house. Both house and back yard were in a filthy condition, but the expectant mother, desirous of getting settled in her new home, assisted her servant in cleaning up the premises after moving.

On the 15th of the month the husband came for me, saying his wife thought labor must be coming on, as she was suffering a good deal of pain. He added that she had been having fever for two or three days. I found her with a heavily furred, moist tongue, edges red; anorexia marked, headache severe, aching and soreness all over the body, bowels constipated, which had been their condition for some time. There was so much tenderness all over the tense abdomen that I could not locate it in any one point. I found increase in temperature and pulse rate, both increasing daily, with evening exacerbations.

The second or third day she complained of pain in the mammæ. She said they "felt as if engorged with milk." They became swollen, hot, tense, "caked," and purplish in color; and so painful that she could not lie on either side. I feared they would go on to suppuration in spite of all my efforts. The patient admitted getting chilled dur-

ing a cold, rainy change in the weather soon after the fever developed, and I thought the condition of the mammæ must be due to the combined causes of "catching cold," and the high temperature, as I could find no record of mastitis preceding labor, or as a complication of typhoid fever. I was undecided whether to dry up the milk, or to try to promote it. Thinking labor still two weeks off, I pursued the former course, using in addition to phytolacca, internally and as a cerate, camphorated oil. I also bandaged the breasts, which gave marked relief.

At noon, on the 21st of the month, and the ninth day of the fever, I was hastily summoned to the patient by the announcement that "the waters had broken." I found her the most cheerful member of an anxious household. She knew she had a fever, but never having been told the nature of it, she fancied the birth of her babe would terminate all her sufferings, especially the great suffering with her breasts. The labor was normal and she went through with it remarkably well, considering her condition. A rigid perinæum was the only obstacle to what would have been a quick labor. In spite of Dr. Winterburn's specific, "plenty of lard" aided with hot fomentations, there was a pretty bad laceration.

Before labor the temperature was ranging at 102° A. M., 103° P. M. An hour after the completion of labor the temperature had dropped to 101°. It was the same late that night; but next A. M. it was back at 102°, and by night was 104°. Up to that time the bowels had been constipated, but soon after labor the characteristic typhoid diarrhœa set it. There was well-marked tenderness in the right iliac region, and successive crops of the rose-colored eruption appeared on chest and abdomen. The abdomen became greatly disturbed from tympanitis. The babe seemed to be in a stupefied condition. He made no attempt to nurse, on repeated applications to the breast, although his mother had perfectly developed nipples and the glands seemed full to bursting. He was not fed, and after twenty-four hours nursed an aunt with regularity. He slept all the time when not disturbed by the feeding process. He had a brilliant reddish orange complexion, with a squamous condition of the epidermis.

A second time we thought mammary abscesses inevitable. The nurse tried to draw the milk with her mouth; then, after steaming the glands, using in hot water carbonate of ammonia, different pumps were used; but only a

few drops of a thick, yellowish substance appeared. The pain was intense. A pup was secured and he succeeded in drawing the milk; but the supply far exceeded the demand and a second pup was procured. Both had an ample supply. The breasts were being emptied; but, in spite of all precautions, the nipples became excoriated, and bled freely at every suckling of the vigorous pups. The agonizing pain of this condition was greater than anything that had preceded it; and the patient declared she would let her milk dry up rather than be so tortured. I couldn't risk suppuration threatening again; so managed with the aid of the pup, and less frequent suckling by the pups, to keep the glands emptied of the lessening quantity of milk.

All this time, in my medication, I was trying to steer between the Scylla of the typhoid state, and the Charybdis of mastitis, while looking out for shoals in the shape of puerperal septicæmia. For the ten days succeeding parturition I had an anxious time of it. I was unselfish enough to wish the case might have fallen to the lot of the old school doctor, who had done the family practice heretofore. He, considerately, comforted the anxious relatives by assuring them that the patient would die. That was the universal verdict of the other doctors in town; and I was not over sanguine of her recovery myself. However, I worked faithfully with that end in view. I gave a vaginal douche, containing creolin, peroxide of hydrogen, or hamamelis—the latter because of the reappearance of a sanguineous flow after the lochia alba had become established. At no time was there marked tenderness over the pelvic organs. I did not give intra-uterine injections. Indeed, I could not give the vaginal douches with any regularity, at a time when the patient was having frequent diarrhœic stools, and was suffering so much with her breasts. But I managed to keep the genitalia clean, attending to that matter myself, using antiseptic care.

After parturition I had the temperature of the body reduced by frequent alcohol baths, and, as is my custom in these fevers, gave frequent inunctions of sweet oil.

The fourth week of the fever the temperature began to decline, the tongue to clean, and the patient went on to convalescence, with the usual ravenous appetite, and falling out of the hair. When the fever declined I allowed her to suckle her babe once in the twenty-four hours, then twice, and so on as the milk and her strength increased. For several weeks past she has furnished more than half the

food for a healthy, vigorous child—truly a remarkable child, as he bears my surname.

I report this case, not only by request, but because of the scarcity of literature on the subject. The most that I could learn from numerous text-books consulted, was that pregnancy was an unfavorable complication of typhoid fever, and so it is. One case is quite enough for me.

Prof. Richard Lea Macdonnell, of McGill University, Montreal, in reporting a case in "International Clinics," says; "the complication of pregnancy with typhoid fever is not extremely uncommon, though I have met with but one case and in that case the patient died in the acute stage of the disease."

We have had another case in our little city during the the past autumn. The patient was convalescing from fever; but aborted at the seventh month, of her second pregnancy, and died in a few days afterward. It is possible the result might have been different could she have had the good nursing and cheerful influences that surrounded my patient. At no time did my patient realize the gravity of her condition, nor did she know that her case was unusual or caused as anxiety, so there was no depressing element of fear to combat.

Hospital Notes.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

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

SUPPURATIVE PAROTITIS AFTER OVARIOTOMY FOR AN INTRA-LIGAMENTOUS CYST. RECOVERY.—*Case 20,900.* Miss ——, æt. twenty-three, was brought to the clinic by Dr. D. L. Deyoe, of St. Louis. Puberty was established at thirteen, and for the first year the menses were normal, but since then until a year ago they have been very painful. The pain preceded the flow for a day or so, then suddenly ceased, and afterward came again with renewed violence and continuing while the flow lasted. The discharge was quite profuse. For the past year, however, the dysmenorrhœa has been less pronounced and the flow less free. The general health is good, barring some indigestion. One year ago a lump was noticed in the left iliac region. Dr. Deyoe writes: "Eight months ago, when I first saw the case, this growth was about the size of an orange and appeared to be very firm and solid. Her attending physician had been treating her with internal remedies, and continued to do so until two months ago, but without result. When she came to me eight weeks ago the tumor had enlarged to the size of the fœtal head at term, and I resolved to try the effect of electricity. This was continued for six weeks but without benefit. I therefore advised an operation, and have accordingly sent her to the hospital."

Operation.—November 30 an ovariotomy was made before sub-class No. 13, Dr. Deyoe being present. An ovarian cyst with three compartments, the lower third of which was deeply imbedded in the left broad ligament, was removed. Three pints of fluid contained in the parent sac were carefully taken; but the two smaller cysts were unavoidably ruptured in the attempted enucleation of the lower segment of the tumor. The fluid in all the

*Continued from Vol. XIII., page 577.

cysts was of a dark, chocolate color and consisted chiefly of decomposed blood. The abdomen and pelvis were flushed and carefully cleansed and a drainage tube inserted.

The after-treatment.—The drainage tube was removed on the third day and a strip of iodoform gauze put in its place. The sutures were taken on the eighth day, the wound having closed by the first intention. Until the morning of the ninth day her temperature had not exceeded 99°, nor had the pulse been above 106. There had been no symptoms whatever. But in the afternoon of that day she began to complain of pain in the region of the right parotid, and soon that whole side of the face and neck became very much swollen and disfigured. She could not protrude the tongue, and because of extreme dryness of the mouth and tongue, could scarcely swallow anything. Her temperature rose from 99 to 101°, and finally, two days later, to 102⅘°, and the pulse to 128. There was no chill; no pain or soreness in the abdomen; no change in the appearance of the wound, and no critical discharge. But on the morning of the thirteenth day her temperature fell from 102° on the previous evening to 99°, and with it came a subsidence of the local pain and swelling in the face and neck, and an increased ability to take food. For the first time, however, the distal end of the gauze drain was covered with pus. Two days later the local pain returned, the swelling about the angle of the jaw became very hard, and it finally suppurated and was lanced on the eighteenth day with very great relief. Except where the drain had been, the wound was firmly closed.

Those of you who were here at our last winter session will recall a case (No. 20,774) in which at the thirteenth day of convalescence from an ovariotomy for a large suppurating cyst, our patient was siezed with parotitis.* Prior to that date she had been doing well in every particular, when the "parotid bubo" began to develop rapidly. The local symptoms, which were very painful and distressing, continued for four days when they disappeared simultaneously with a free discharge of pus by the rectum. The patient afterward made a speedy and complete recovery, and is now, one year later quite well.

Apropos of the present case you should note the exemp-

*The CLINIQUE, Vol. XIII, 1892, page 72.

tion of the patient from the septic mischief that would have been certain to follow such an ovariotomy without the safeguards of flushing and drainage. But for these expedients the contact of that vicious fluid with the peritoneum would have so infected it that in all probability the poor girl would not have lived long enough to have had the parotitis which now makes so interesting a feature in the clinical history of her case. For the unmixed and unmistakable sepsis that follows abdominal operations, like that of childbed, usually comes within the first week. After that, although there are exceptions from avoidable causes, the drift is toward pyæmia, and pus is the outcome.

This explains the risk from parotitis as a sequel of ovariotomy when it occurs after the first week of a promising and uneventful convalescence. It may be sympathetic and self-limited, passing off in a few days by resolution; or it may give evidence that the suppurative process is going on either within the gland itself, within the pelvis or the abdomen, or somewhere else, and culminate in a critical discharge that shall relieve or destroy the patient. In this case the first appearance of pus on the drain at the angle of the wound seemed to mark the turning point and explained the decided improvement in the symptoms; but there was a relapse, the gland swelled again and suppurated with a free discharge of pus.

How shall we determine whether a case of post-operative parotitis is septic or not? If all the conditions of the operation, and of the interval between it and the first dressing of the wound, say at the sixth day, have been thoroughly aseptic, such a mishap is neither probable nor possible. Later on the risks of putrid infection multiply, especially where drainage has been necessary. Then you would apply the more common tests of septicæmia, such as examining for enlargement of the spleen and albuminuria, and noting carefully the hyperthermic as well as the exalted mental condition. If there is parotitis without these symptoms it must be either sympathetic, epidemic, or suppurative.

In both of our cases the gland involved was on the opposite side of the body from which the diseased ovary and tumor had been taken. Neither of them had been exposed to the "mumps," nor did any one contract the disease from being with them. When such a sequel follows any gynæcological operation I know of no better treatment than moist heat and emollient applications to the parotid region, and to the side of the face and neck; stimulating soups and fluids, and such remedies as are given in an ordinary case of benign, idiopathic or infectious parotitis.

December 29. The abdominal wound is firmly united; the parotid lesion is nearly well, and the patient has gone home.

ASPIRATION IN ABDOMINAL DIAGNOSIS.—*Case 20,902.*—Mrs.———, æt. fifty-one, mother of four children, began to menstruate at fifteen and passed the climacteric at forty-three. Her periods were always normal. She has had a hacking cough for years, but six months ago her stomach became very irritable and would not retain food. Four months ago she began to have severe pains with a sense of bloating in the abdomen, but as the distension increased the pains diminished. Meanwhile the bowels have been loose and bound by turns; and for a time there was some trouble with the bladder, but now that has ceased. The pain has always been more severe in the right hypochondrium extending to the iliac region and around into the small of the back. For the past six weeks she has been confined to her bed. The abdomen is so distended that for three weeks she has been very much troubled with shortness of breath and with occasional fainting spells in which the heart threatens to stop.

Wednesday, December 7th. In presenting this case the following remarks were made by Prof. L.: In one of my special lectures on minor gynæcological surgery we have already discussed the propriety of tapping as a means of diagnosis, and decided that, while with aseptic precautions it is safe enough, yet it is not always nor often quite satisfactory. In the hands of the prudent and experienced gynæcologist a careful exploratory incision, all things consid-

ered, is far better. But here is an exceptional case in which we are justified in resorting to tapping by aspiration.

You have heard this woman's clinical history. Observe her pallor and emaciation; the expression of her countenance, which bears a close resemblance to the *facies ovariana* that was once supposed to be diagnostic of ovarian dropsy; the prominence of the abdomen, the skin over which shines through distension and shows such a network of superficial veins as you perhaps have never before seen. She is not a fit subject for anæsthesia, neither for any surgical operation; but she has been brought a long way for relief and we must do what we can for her.

Now tapping by aspiration will enable us to draw off the fluid, whether it is free in the abdomen or contained within a smaller cyst or compartment; it will bring relief to the pressure upon the diaphragm and the neighboring viscera; will give a correct notion of the kind of fluid that has accumulated through some morbid process, and will afterward afford an opportunity to examine the abdomen as to the existence of a possible tumor lying behind this collection and beyond our reach at this moment. The top of the abdomen is resonant on percussion, but laterally the fluctuation is so pronouced that we can be pretty certain the fluid is thin and not thick, which is quite a consideration when we are about to use the needle of the aspirator instead of a larger trocar.

Remembering that the evacuation of large cavities sometimes causes syncope, we take the precaution to give her a little whisky and water beforehand, and to begin while she is lying down. After awhile her head and shoulders can be gradually raised until she is in a sitting posture, so that the fluid can all be drawn off. I select a point on the mesian line high enough to avoid the fundus of the bladder, and low enough to drain the abdominal cavity; and now, to save suffering, inject a four per cent solution of cocaine beneath the skin at the site of the proposed puncture.

[Seventeen pints of ascitic fluid were drawn off, the patient was sent back to the ward and a careful diagnosis was reserved for the next clinic day.]

Wednesday, December 14th. This patient was brought before the class again and a careful physical examination showed that the ascites had depended not upon an abdominal or pelvic tumor but upon a disease of the liver. She was accordingly referred to Prof. Arnulphy's care.

VAGINAL HYSTERECTOMY FOR UTERINE FIBROMATA, INTRA-UTERINE, INTERSTITIAL AND EXTRA-UTERINE.—RECOVERY.—*Case 20,903.*—Mrs. —— æt. 44, is the mother of two children,

FIG. 5.

the youngest of which is twenty years old. She menstruated normally until seven years ago, when the flow became

hæmorrhagic. Sometimes it recurred every fortnight, and then she would be confined to her bed for six or eight weeks. From the age of nineteen she had an obstinate constipation which yielded to no treatment whatsoever. This was followed by uterine displacement, terrible back ache and neurasthenia. The menorrhagia finally became so severe and exhausting that a few months ago she applied to a surgeon who removed two fibrous polypi from the os-uteri. Since that time the flow has been very much

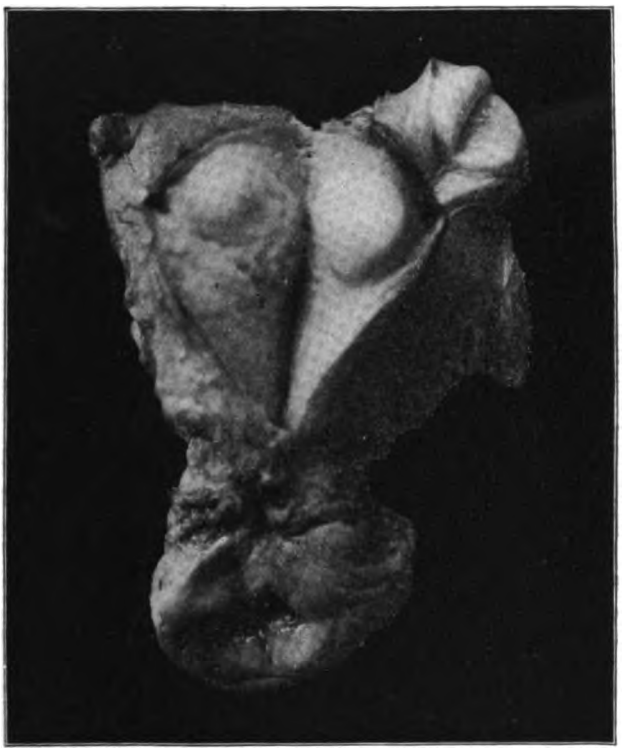

FIG. 6.

lessened, but the other symptoms are no better. Local examination disclosed the existence of other uterine tumors, which, as they were possibly sarcomatous, furnished a strong indication for vaginal hysterectomy.

Operation.—December 10th a vaginal hysterectomy was made before sub-class 2, the different steps of the operation being carefully demonstrated to those who were present.

Wednesday, December 14th. We are now at the close of the fourth day, and this case has gone on exceedingly well. She has had little pain, no fever, a slight inoffensive discharge, passes the urine naturally, is being nourished with milk and water, turned upon her side occasionally and has nothing to complain of.

Here is the tumor, which I commend to your careful inspection. Observe that there are seven of these fibroids which are disseminated throughout the uterine tissues. Some of them are external, others are interstitial, and still others within the cavity of the organ. (See Figures 5 and 6). Manifestly nothing could have been gained by leaving all these growths to develop within the pelvis, and finally to destroy her life through their deterioration and through the inevitable drain upon an organism that was a physical wreck already.

Wednesday, December 21st, the eleventh day. The patient is passing along with a convalescence like that from a perfectly natural labor.

Wednesday, December 28th. She eats and sleeps well, and feels well enough to sit up again.

AN EXPLORATIVE LAPAROTOMY. FUNDAL AND CERVICAL FIBROIDS, WITH A CYST OF THE BROAD LIGAMENT. — *Case 20,865.*—Mrs. ——— æt. 27, was in this clinic three months ago, for advice concerning a præ-cervical fibroid. Her menses were not excessive but were accompanied with great pain and distress, with inveterate nausea and vomiting.* The irritability of the stomach is constant and unyielding, and so, also, is the pelvic pressure and distress. For a time the latter symptoms were mitigated by electricity, but now they have returned, and she is so wretched as to demand relief through an operation of some sort.

Operation, December 13th. An explorative laparotomy

* THE CLINIQUE, vol. xiii., 1892, page 430.

was made before sub-class 4. The abdominal section revealed a small interstitial fibroid in the uterine fundus, and confirmed the existence of a præ-cervical fibroid lying behind the bladder. There was also an intra-ligamentous cyst as large as a big orange, which was aspirated and the thin cyst wall broken up. Both ovaries were so bound down by adhesions, that it was thought best not to remove them. Flushing, and drainage by the Mikulicz method.

Wednesday, December 14th. Our patient is doing well in all respects. Her temperature this morning is 99° and the pulse 72, and her only complaint is that she is being starved. In a true, conservative spirit, and following the line of advice which I gave to her and to the class when she was here before, I decided not to make a supra-pubic hysterectomy, neither to tear out the ovaries in this case, but to stop with having disposed of a cyst in the left broad ligament, which must have been the chief source of her constant pain and suffering.

Wednesday, December 21st. The ninth day and her temperature has not reached 100°. The drain was removed on the fourth day, and its place supplied by another strip of gauze.

Wednesday, December 28th. She ate a good Christmas dinner, and feels better than for many months past.

Wednesday, January 4th. Discharged yesterday.

EXTRA-UTERINE PREGNANCY. OPERATION. RECOVERY. Wednesday December 22. *Case 20,905.* Mrs. —— æt. 22, has been married ten years but has had no children. The menses were regular but somewhat profuse until two years ago when they became tardy. Five months since they stopped for three months, when she had the usual subjective symptoms of pregnancy. Two months ago she had a severe attack of pain, began to flow, and it being supposed that she was threatened with an abortion, she was kept in bed for a fortnight. After that she went about her work as usual for a week, when she was again seized with severe abdominal pains and flowing which sent her to bed for three weeks more. There is still a slight sanguineous discharge which has at times been shreddy, but no deciduous cast of the uterus has been thrown off. With the first return of the flow and the pain, she observed a swelling in

the right iliac region, which became quite prominent and very tender, but which is not quite so large or sensitive now as it was then. This growth interfered with the action of the bowels and also occasioned strangury.

A number of excellent and experienced physicians have pronounced this right-sided enlargement, upon which I place my hand, to be due to an extra-uterine pregnancy. And, as it does not often happen that such a case is brought before a medical class for examination, I must beg your attention to the details of its clinical history and to our deductions concerning it.

The complete arrest of the menses for the three months, with the occurrence of the usual signs of pregnancy was misleading. But when she began to flow, failed to abort, and came down with an evident peritonitis; when the discharge continued while the tumor grew, the possibility of a tubal conception with rupture and a consequent hæmatocele suggested itself. The location of the pain and the position of the growth, which is easily felt at the right side of the uterus, indicate the formation of the gestation sac within the broad ligament. And the fact that this tumor is circumscribed explains the exemption from the striking and dangerous symptoms of an intra-peritoneal hæmatocele. The shrinkage in the size of this tumor and its increased hardness correspond with the changes in a hæmatoma, and might easily lead the ignorant to suppose that it would ultimately disappear if left to itself. But you should not forget the possibility of a secondary rupture and of suppuration in an old sac of this sort; and that such an accident is almost always fatal because in that case its contents would be emptied into the peritoneal cavity.

The usual rupture of the tube at or before the third month naturally divides ectopic pregnancy into two clinical periods, one of which precedes and the other follows that event. In the first the diagnosis is most difficult and is seldom established with clearness and certainty; while in the second, especially after the acute risks that are incident to the rupture are passed and a month or more has

intervened, a larger share of cases can be properly differentiated. This state of things has led some authorities to claim that the fœtus can be destroyed and the development arrested by electricity, the injection of morphine and other means, at a period when the impossibility of an accurate diagnosis invalidates their testimony altogether. It also explains the fact that those who have watched such a case as this from first to last can usually form a better idea of the actual conditions later on than those who examine it early or in a more casual way.

But, while the diagnosis of this case is somewhat easier now than it was two months ago, the prognosis is less favorable. For, whether the fœtus and its attachments have been absorbed and altogether destroyed since its moorings were damaged; or if it is still in the sac, or free in the abdomen, the risks attending its removal have greatly increased.

Operation.—Dec. 24, '92, a laparotomy was made for the removal of the tumor before sub-class No. 5. The diagnosis of extra-uterine pregnancy was confirmed. The gestation sac involved the right broad ligament and contained a quart or more of bronzed blood-clots, a disorganized placental mass, and some fœtal relics, the latter having been almost entirely removed by absorption.

Wednesday, Jan. 11, the eighteenth day. The drainage is diminishing and the patient is making an excellent recovery. She menstruated normally two days after the operation and since the flow ceased, her temperature has not exceeded 99⅘°

The New College & Hospital.

At 2:30 P. M. of January 14th, 1893, a large crowd of students and friends of Homœopathy assembled at the laying of the corner stone of the new wing of the Hahnemann Hospital of this City. On account of the cold weather the exercises were held in the amphitheater of the old hospital, directly across the street from the new structure. The President of the Board of Trustees took the chair supported by Vice President Phelps and the College Faculty on the right. Prof. Shears was Master of Ceremonies. Excellent music of an appropriate character was interspersed by the Class quartette.

After the invocation by the Rev. L. P. Mercer and a jolly good song by the quartette, MAJOR H. A. RUST, member of the Board of Trustees and Chairman of the Building Committee, said :

Mr. President, Ladies and Gentlemen: The occasion which has brought us together is a midway point in the building enterprise in which the Board of Trustees of the Hahnemann Medical College is now engaged. Five months have passed since, with appropriate ceremonies, the corner stone of the College building was laid, and now its completed walls invite criticism. To-day we repeat the ceremony and thus formally commence the new home of the Hospital department of the institution. It is not certain that you would hereafter be called upon semi-annually to participate in similar proceedings, even though our grounds had wider boundaries.

I am courteously permitted, for the time, to here represent the laymen upon the Board of Trustees, as also its Building Committee. I will not at this time recite details incident to the building enterprise, contenting myself with the statement that it is the purpose of the Board to continuously prosecute the work upon both buildings to completion at the earliest practicable date, trusting that such date

may be that early period in the spring which the necessities of the Institution, coupled with the World's Fair ingathering, cause both the faculty and trustees to earnestly desire. When this time shall have arrived, it will be appropriate that the committee review in detail the events of the building period, and concurrently therewith "put off the armor."

I may be permitted to briefly traverse the history of this corporation, touching upon its salient points from the layman's business point of view.

The charter of the institution became a law February 14th, 1855. My arrival in Chicago preceded this date by about one year, and it would be a matter of pride to me could I establish any relation between the two events. There is none—the fact, however, of my residence in Chicago during the entire period covered by the history of this corporation, beginning when the population numbered less than 60,000, has made it possible that I should personally know many of the noble men who have been its counsellors and administrative officers.

The initial step in the creation of its hospital department by Hahnemann College, was taken by the Board of Trustees, April 25th, 1855, in assumption of the control of a nucleus of a Homœopathic Hospital, the existence of which was due to the heart and purse of Mrs. H. Wright. Dr. George E. Shipman, known to many of us as the "beloved physician"—one who, during a long life has daily demonstrated that he is "one who loves his fellow-men"—had been selected by Mrs. Wright to coöperate with her in the establishment of this philanthropy; and it was through Dr. Shipman, that this enterprise was brought to the attention of the Board, and at a time when the feeble life of the Hospital hung in the balance with the probability that the benevolent intention of Mrs. Wright would fail of accomplishment. The Trustees accepted the trust in so far as related to Mrs. Wright, and in so doing founded this department of its Institution. It is noteworthy that at this meeting among the six physicians and surgeons who were then constituted a Medical Board, entrusted with the management of the Hospital, is found the name of Reuben Ludlam, M. D., who from that date, thirty-eight years ago, has continuously occupied a Chair in the Faculty of this College, and since May 6, 1891, has been the President of the Board of Trustees. Dr. Ludlam is present and by virtue of his official position, presides

over this meeting. Dr. Shipman was also a member of the said Board. We will not delay until the hour when their ears shall be dulled to all earthly sounds, to bring the tribute of our appreciation and respectful regard to these men, whose lives have been a sustained recognition of the obligations of individual being in relation to the human brotherhood. The other members of that Board have been "gathered to their fathers," and now dwell in that better land from whence comes the inspiration that crystallizes into institutions like unto our own.

Next in order to the *birth* of this Hospital, as marking an epoch in its career, I should name the advent upon its Board in 1870, of the late Hon. J. Young Scammon, whose devotion of time, donations of money, and gift of land, must ever give to this noble-hearted and sagacious man a large place in the hearts of the friends of the Hahnemann College and Hospital. His relation to this institution, however, constituted but a segment of his well-rounded life. To Mr. Scammon and men of his type is Chicago indebted for the distinctive and virile characteristics that the consensus of the world's opinion accords to this municipality.

The Hospital Department was not born "with a silver spoon in its mouth," and would seem to have had the regulation number of infantile diseases; but through good nursing, it has survived successive periods of the hardest of "hard times," visitations of pestilence, and the heroic treatment by fire, and now with hardened muscle and undaunted spirit, it may be regarded as having the assurance of a prolonged life of usefulness. This assurance is rendered doubly sure through benefactions bestowed upon it within the past few months, chief among which is to be named the gift of fifty thousand dollars ($50,000), by Mrs. Caroline E. Haskell, through the agency of her physician, Dr. George F. Shears. Of this sum ten thousand ($10,000) was by the donor apportioned to the building fund, and forty thousand dollars ($40,000) to the endowment of the hospital and maintenance of free surgical beds, in terms specified. This gift, large and grand in itself, has a significance even beyond its money value, in that it furnishes a substantial foundation for the belief that it will stimulate others to follow the magnificent example, and so increase the revenue of the hospital, that it may ere long, greatly enlarge its sphere of usefulness, through its ability to offer all of its resources to the suffering poor.

The splendid contribution of five thousand dollars ($5,000) to the building fund, made by the late Mr. Hugh Riddle, marked his confidence in his physician, Dr. H. B. Fellows, and at the same time enrolls the donor as a most timely benefactor to our institution. Other contributions in smaller amounts to the building fund have been opportune, and will receive due recognition.

In reflecting upon the history of the Hospital Department of the Hahnemann College, I have been especially impressed with two features, one of which is the prominence of woman as a factor at and from its birth until the present hour. This impression does not startle me, coming, as it does, simply as additional evidence in support of the already well-established fact, that nearly all the grace and much of the strength in human character is resident in our mothers, sisters, wives and daughters.

The other feature to which I allude is, that "other men labor, and we enter into their labors." A perusal of the records of the Board of Trustees is graphically illustrative of this fact. One may note the incoming of a member of the Board, or Staff, and trace his absorbing interest and guiding hand for a time, and then, for him Death closes the record; but Time does not tarry, the gap is filled and the work continues. In this fact of continuity and cumulative force of organized philanthropic effort, is found both incentive and reward for all that any individual may have the disposition to attempt and the ability to accomplish.

In the past the Board and the Faculty have counted its members from among Chicago's most stalwart and unselfish citizens. Men who were wise in counsel gave of their time without stint, and who had the courage of their convictions; of whom Hon. Thomas Hoyne, Hon. Norman B. Judd, Edwin H. Sheldon, Presidents Small and Smith, are representative. These men now "rest from their labors and their works do follow them."

The President and Secretary of the present Board, Drs. Ludlam and Shears, are so unceasing in efficient service in the furtherance of the interests of the Institution that the citing of any single act of service upon their part would only be typical. The simple mention of the names of Messrs. Phelps, North, Higinbotham, Cable and MacFarland, affords a guaranty that the lay element in the Board will not prove recreant to its trust, but as in the past, will continue to coöperate with the learned men of the faculty in enlarging the capacity and extending the bene-

fits of this time-honored institution. The Board has constituted Vice President Phelps, Dr. Leavitt and myself a committee charged with the conduct of its building enterprise, for which mark of confidence our grateful appreciation is due and can be best evinced by intelligent devotion to the task.

Corner-stones of buildings devoted to education and philanthropy are not inanimate material; they are instinct with the highest aspirations and most noble purposes of man. They are mile-stones registering progress along the royal highway of Christian civilization. Looking further back than our own century these mile-stones are hardly found, but the eye of faith sees a future bright with these and kindred evidences of a full-voiced affirmative response to the query "Am I my brother's keeper?"

At the conclusion of his remarks Major Rust presented the sealed box to Mr. W. W. Boyington, the architect, who was deputed to deposit it in the corner stone of the new building while the in-door ceremonies were progressing.

Dr. E. M. Bruce then read the following Address by the Rev. Dr. M. Crandall, of the Memorial Baptist Church, the author being unable to be present on account of illness:

I bring to this board of trustees, and to those whose benefactions have made possible the building of this hospital, my heartiest felicitations. We do well to rejoice together this hour over that which already has been accomplished, and to view with profound satisfaction the promise of future results to be secured through the erection of this building. We rejoice because another and large addition is made to those institutions which are the crowning glory of our land and time. But full as are our hearts of rejoicing, our joy is made serious and thoughtful by consideration of the vastly important purposes to be subserved by this building. I see in this structure incarnate ministry. Here will be brought the diseased and maimed. Here will gather those whose lives are dedicated to the prevention and cure of disease. Here will be waged hand to hand battles with death. From this place some will go out with restored health to new activities; some will be carried hence to rest under "that low green tent whose curtain never outward swings." What hopes and fears will center here. What joys and sorrows will find their beginnings in

this place! Because of this it becomes us to thoughtfully consider the significance of this enterprise. Of what does it speak? It is an expression of the highest and finest civilization. True civilization is not compassed by perfected art, by elegant literature, by colossal wealth, nor by a combination of all these; but by attention to the interests and welfare of man.

And we are not to confound the appreciation of the results accrued by man, with the appreciation of man himself. It is quite possible to be greatly interested in a statue, and wholly indifferent to the welfare of him who created it. It is easy to forget the soldiers whose courage made victory possible, while lost in admiration of the victory itself. We need to drive back of all the products of man's toil to man himself, and to realize that in him we have the worthiest object of our care and endeavor.

This hospital is for man; for his welfare and happiness. Its existence is due neither to selfishness nor pride. Its founders do not seek through it to gain to themselves wealth. It has come into being because of the recognition of the importance of man. This institution takes its place alongside the school and the church, and these three agencies round up and make complete the effort of civilized and christianized man to benefit his fellowman.

It may not be wise to attempt any comparison between the members of this trinity, in an endeavor to determine which is entitled to the highest place. But certain it is that the work of the physician conditions the work of the teacher and of the preacher. Certain it is that the health of the physical man is a condition to the best activity of the intellectual and spiritual man. The fact that some, in pain and sickness of body, have yet wrought splendidly for the moral and mental quickening of the world, only shows the power of the human will. It proves not at all that in brain and soul work, physicial health is a matter of comparative unimportance. Neither mental nor spiritual life has any other medium of expression—in the present—than the body. It is time then, that we cease underrating the importance of health in this organ of expression, and realize that its well-being conditions the normal and fullest manifestation of those powers of man which are less tangible, even if no less real.

The time has largely passed when man seeks to secure greater spirituality by mutilating his body, when piety expresses itself through hair-shirts and self-flagellation, and

semi-starvation. The time has largely passed when men talk about the "vile body," and fancy that they are quoting scripture. Novalis said "we touch heaven when we lay our hand upon a human body." The body is sacred. He that deals with it, has to do in a real way, with the most vital experiences of life. The agency that promotes its well-being is among the most potent forces for good that any community or any time may know. So then, this hospital, dedicated to ministry to the body, shall stand as the expression of that which is wisest and noblest in our christian civilization.

This hospital is incarnate opportunity. There can be little significance in walls, and roof and building, except for the purpose which lies back of all. If the purpose be unimportant, the building has no meaning. This hospital, let us trust, is erected that it may be a constant suggestion; that through many years to come it may furnish opportunity. And I do not have in mind only the opportunity which it shall offer to the sick to be healed of their maladies. This, no doubt, is the thought in the minds of the founders, and a most high and holy purpose it is. Here shall be found all the aid that human skill can furnish to those who are diseased. Multiplied agencies for alleviating pain and restoring health shall find their home in this place. Those who come hither for treatment shall increase their chances for recovery. But there has been in my mind a thought as to the opportunities which this institution will furnish for the exercise of the noblest traits of character on the part of those who serve here. In no other place on earth is there greater demand for the exhibition of tenderness and strength than in such institutions. Men, and women, and children will come hither, who will stand in greatest need of sympathy and love. I do not plead for maudlin sentimentality or gushing platitudes, but for the exhibition of that thoughtful interest and sincere kindness which serve to lighten heavy burdens and cheer despondent hearts. This tenderness, coupled with the firmness which springs from conscious knowledge, should find abiding expression here. The opportunity will be present, and, no doubt, it will be turned into reality by nurses and physicians and all who labor here.

Again, this institution will furnish opportunity for the wisest beneficence. From lack of knowledge I cannot speak intelligently concerning the regulations which shall govern this hospital, but I have dared to hope that the

number of "free beds" here will be limited only by the limitation of endowment for that purpose. Is there any wiser, more helpful form through which interest in our fellows may manifest itself? What an opportunity is here for those to whom wealth has been entrusted. Goethe has said, "Nobody should be rich but those who understand it." To understand being rich is to understand how to so invest our riches that the greatest good shall come to the greatest number. It would be easy to cite numberless cases which have come under my personal observation, showing the necessity of providing for the free treatment of the poor, but I must content myself with a single instance. The little sister of our servant girl was suffering from a disease of the eyes which rendered her almost blind. She had been treated by local physicians, but "grew nothing the better but rather the worse." I succeeded, after some persuasion, in gaining from her parents permission to take her to New York City for treatment. Through a friend we were able to secure for her the use of a free bed in one of the best hospitals there, and within two months she was home again, entirely restored. Blessings upon the man who endowed that bed. Surely if he could have witnessed the gratitude of this child and her mother, he would have been amply recompensed.

And is there not in this opportunity for beneficence an involved opportunity for solving, in part, the class problem? The air is filled with clamorous voices declaiming concerning existing social conditions. The heart of the civilized world is full of unrest. Great contests are waged between capital and labor. Not a few seem to be bent upon arraying the poor against the rich, and the rich against the poor. We talk of the "submerged truth" and the "lapsed masses," and countless theories are put forward as to the true solution of social problems. Right here in this hospital will be opportunity for helping to settle social problems. When the poor understand that wealth is to be dedicated to beneficent purposes, that those who accumulate do so that they may pour out their wealth in streams of blessing, the antagonism now existing will have received its death blow. One such institution as this, as a solvent of class difficulties, may be of more value than many treatises on social science. Again I congratulate you, friends of Hahnemann Hospital, and will trespass upon your patience only long enough to express the hope that the future of this institu-

tion may realize the hopes and expectations of its founders —greater success we could not wish for it.

REV. MR. MERCER said: The time-honored custom of laying the corner stone of public buildings with becoming formality is a half unconscious but real recognition that the institutions they are to house are themselves founded on fundamental principles. Homœopathic theory and practice is a superstructure which rests on the foundation of natural, immutable and indestructible fact, the law of *similia* being the firm and true corner stone. It is not a rule, nor a dogma; it is a law; and like the corner stone of the Temple of old, not made with axe or hammer, but formed in the order of things. All theory and all rules are built upon it, and measured by it, and held in place if true to it. On that corner stone the Hahnemann Hospital is built; and those who believe in the law will believe in the hospital as a demonstrator of the law, and contribute of their means to erect its building and endow it, if common charity should build other hospitals resting on other foundation on every corner.

Referring to the effect of the physician and the humanity of practice on the minds of the patients, he said, resting on its own corner stone, the law of *similia*, the Hahnemann Hospital should become not only the demonstration of the only law of medical cure, but a witness by contrast to the prevailing evils of so-called regular medicine as an original cause of disease and active propagator of epidemics.

PROF. G. A. HALL spoke as follows: It affords me great pleasure and satisfaction to be present on this occasion, but I am somewhat surprised at the presumption on the part of Dr. Shears in calling upon me to make a speech after two such able addresses as those to which you have just listened, especially as he well knows my retiring nature and native modesty.

You have listened to the prospective, and I trust I shall be excused for indulging in some reminiscences of this institution. I do not know what the future may be, although I trust it may prove as eventful and prosperous as the word-pictures would make it. But I do know of the past and what it has been. As I stand here I seem to hear the spirit voices of our late lamented colleagues, Professor A. E. Small and Dr. D. S. Smith. The latter received the

appellation of the Nestor of Homœopathy in the northwest. It was due to his indefatigable energy that a charter was obtained for the Hahnemann College and Hospital, and it was at his instance that the first faculty was formed. Prof. A. E. Small came to this city in the spring of 1856. He was a host in himself. His professional ability was as broad as the land and his reputation extended beyond the seas. It was largely due to his influence that the Hon. J. Y. Scammon was induced to donate the land on which the College and Hospital now stand, and that an old two-story wooden building was drawn upon the hospital lot and dedicated as the Hahnemann Hospital.

Those two noble characters, together with their worthy colleague, Prof. Ludlam, were the pioneers in hospital, clinical teaching. That wooden building was the only representation of a hospital up to the winter of '72 and '73. Oct. 9, '72, the great fire came to purify and benefit our city. To care for the homeless and suffering the Relief and Aid Society was re-organized. By this society fifteen thousand dollars was donated to build the long brick structure which now constitutes our ward departments. A Siamese connection united the old wooden building and this new structure.

It was difficult to find a competent person to take charge of such a dilapidated concern. If we could have been fortunate enough to have secured the services of such a person as our present matron, the old buildings would have had the merit of being clean at least; for you all know how much she has accomplished in the appearance of our present hospital. In fact, I believe it is owing to her economy and thrift, united with the energy and push of our worthy colleague, Prof. Shears, that we are enabled to-day to lay the corner stone of our new building.

I do not wish to ignore the backing which has been given this institution by its present honorable Board of Trustees. They have given not only their influence, but freely of their wealth and individual personal effort to promote this glorious and noble undertaking.

Fortunately, or unfortunately, in the spring of '76, dissensions crept into the Faculty and ten of the professors seceded to form a new college. There remained only three of the original faculty, the college building which has recently been replaced, and the hospital just described. What little furniture, or rather *débris*, there was, was removed. Having been honored with the position of busi-

ness manager of the college, and superintendent of the hospital, with the aid of my colleagues, Profs. Ludlam and Hoyne, we proceeded to organize a new faculty, to secure a matron and to organize a hospital staff. Ranges, furnaces, stoves and other findings of the hospital were secured, and our hospital work moved on interruptedly. We were given *carte blanche* to purchase anything the hospital required, provided we would pay the bills ourselves.

The college class increased, the duties of the faculty were multiplied, and our hospital clinics steadily grew to be the largest in the city. Subsequently the old amphitheatre, which was very small and unsatisfactory, and a new front were built at a cost of twelve thousand dollars. Within two years this new structure was destroyed by fire at the very beginning of the winter session. Our clinics were continued, however, in the college building, and we immediately with the assistance of the trustees, rebuilt the structure which contains this amphitheater and the rostrum upon which I now stand.

Thus I might continue for hours, rehearsing these reminiscences, and so interest myself exceedingly. But fearing that you have already more than you can digest, I will close by quoting Carleton's poem (modified).

Out of the old hospital Colleagues—moved up into the new,
All the hurry and worry is just as good as through,
Only a bounden duty remains for you and I,
And that's to stand on the doorstep here, and bid the old house good bye.

What a shell we've lived in these nineteen or twenty years—
Wonder it hadn't smashed in, and tumbled about our ears.
Wonder it's stuck together and answered 'till to-day,
But every individual brick was put up here to stay.

Things looked rather new though, when this old hospital was built,
And things that only worried us would have made *some* men wilt,
And every other day then, something was sure to break,
And all the pryin' neighbors watched to see us quit or make.

Look at the old hospital now, how little it appears,
But it's never gone back on us, for nineteen or twenty years—
And we won't go back on it now, or go to pokin' fun,
There's such a thing as prasin' a thing for the good that it has done.

Probably you remember how rich we was that night,
When we was fairly settled, and had things snug and tight,
We feel as proud as you please, over our hospital new,
But we felt as proud under this old roof and a good deal prouder too.

Yes, a deal has happened to make this old hospital dear,
Christnins, funerals, weddins—what havn't we had here!
Not a nook in this buildin' but it's memories has got,
And not a nail in this floor but touches a tender spot.

Out of the old hospital colleagues, moved up into the new,
All the hurry and worry is just as good as through,
But I tell you a thing right here, that I aint ashamed to say,
There's precious things in this old house we never can take away.

HON. ERSKINE M. PHELPS, Treasurer of the institution, congratulated everybody concerned upon its progress and prosperity. Both the college and hospital buildings would soon be ready for occupancy and then we shall have well-merited quarters for teachers and pupils, as well as for patients. Mr. Phelps' remarks were eloquent and hearty.

After a grateful acknowledgment to the Board of Trustees and to the friends of the Hospital who had made this occasion possible, Prof. Ludlam said:

At the meeting of our national society in June last it was voted to erect a monument to Hahnemann, and that it should be located in Washington, the Capital of this great commonwealth. There was the right sort of enthusiasm, and plenty of it, and the machinery for raising subscriptions was set in motion at once. The physicians of Chicago have already interested themselves in that enterprise and will doubtless do what they can to further its completion. It is in every way commendable, and in accord with the fitness of things that the old hero should have a statue that is grand and glorious in proportion with the issues of his life-work, and with his untiring labors in the cause of humanity. By all means let us have it, and right away, too.

But 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 to mankind. With my Quaker proclivities I insist that this is the *very best kind of a monument.* For it is a monu-

ment 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. We should strive for its upbuilding and extension, not only because it already glorifies its illustrious progenitor, and will continue to do so, but also because of its charitable and clinical, its social and scientific relations to the public and to the profession at large.

Prof. Hall has spoken kindly of this old building, in which we are working like beavers until the better one is ready. We shall not leave it without regret, but we will enjoy the new one all the more because of its improved and increased facilities, its greater capacity, and its thorough fitness for the work that is before us.

CORRESPONDENCE.

The dry antiseptic treatment for persistent sinus after an operation for a fatty tumor.—In March, '92, Mrs. D——— came to consult me concerning a discharging sinus, the result of an operation two years before for the removal of a fatty tumor located at the upper and inner part of the right clavicle.

The operation was made without an anæsthetic, an elliptical piece of integument three inches long by one and one half inches wide being removed, and the tumor taken out whole. The incision was closed with catgut and dressed with iodoform, and the patient told to return for redressing in three days, which she did, when the lower portion was found not healed and gaping. It was again dressed as before, and on the following visit the whole length of the wound was open. A change was made in the dressing but there was no permanent good from any of the applications, and at the end of a year there was still a large suppurating surface. Directions had been given to remove the dressing every day, and with it each time the crust which had formed was always torn off, so that there was a raw surface left upon which the new dressing was applied.

At this time the surgeon in charge left the city and another was called in who suggested a second operation, which was made, and the incision closed with silk sutures; but the strain was so great that these soon pulled out leaving a gaping wound larger than before.

To this the doctor made applications of calendula, hamamelis, boracic acid, iodoform and other things which seemed indicated, but as before the dressing was removed every day and the crust which had formed *was torn off with it;* and at the end of another year the patient found herself no nearer being cured than at the first. At this stage she came to me. My first application was of iodoform gauze in a pad sufficiently large and thick to fill the cavity left by the removal of the tumor. This was strapped firmly in place and left there, and she was told to come back when she felt in the least uncomfortable from the pad. This she did in a week, but finding that the gauze was firmly adhered to the crust and both to the wound, I determined to let it remain until it was ready to *drop off*, which was in two weeks. I then applied another similar compress, which one remained five weeks when it *dropped off*, leaving a healthy ganulating surface, to which I applied the tar-plaster. There was no more suppuration, the surface grew smaller each day and at the end of three weeks was as smooth as the palm of my hand, and after nearly two months there is no return to the old condition.

The only internal medication was graphites 3.

DR. BELLE L. REYNOLDS.

Miscellaneous Items.

For a frontispiece to Vol. XIV. of the CLINIQUE we offer an excellent portrait of Major Rust, the very efficient Chairman of the Building Committee of the New College and Hospital.—Thanks to everybody the laying of the hospital corner-stone, as reported at page 54 of this issue, was an event that was suited to the opening of the Columbian year.—Dr. J. E. Hughes, '90, was elected coroner at Moscow, Idaho, at the recent election.—*On dit* that Prof. Hall will publish a work on the Surgery of the Rectum.—The issue of No. 3 of the *Hahnemann Pulse* is imminent and all the boys, and girls too, are glad of it. —We are greatly pained to note the sudden death, September 22, of our old friend Dr. George Bollen, '73, of Port Adelaide, S. Australia, in his 67th year; and also the recent death by drowning of a member of the present college class, concerning which the following paper has been presented us for publication:

IN MEMORIAM.

Through the death of our fellow-student, J. M. Martin, this class has lost one of its most respected members, therefore do we, the members of the class of '94, assemble to express our high esteem for his excellent qualities as a student and a companion. His pleasant nature and gentlemanly conduct while with us will always endear him to our memory. And we desire that our expresion of sorrow at his early death be recorded in the annals of this class, and that a transcript of the same be made and sent to his parents with our heart-felt sympathy.

THE CLINIQUE.

VOL. XIV.] CHICAGO, FEBRUARY 15, 1898. [No. 2.

Original Lectures.

CEREBRAL APOPLEXY.

A CLINICAL LECTURE DELIVERED IN THE HAHNEMANN HOSPITAL OF CHICAGO, BY H. B. FELLOWS, M. D., PROFESSOR OF THEORY AND PRACTICE.

REPORTED by EMMA A. CASWELL, M. S.

Case. Mrs.——, æt. 40, passed the climacteric six months ago. She has always had some pain in the cardiac region. One day last June she felt "very drowsy," which she attributed to the intense heat. This lasted two hours, when suddenly she fell, retaining consciousness, deprived of sensation. The left arm was paralyzed, the tongue turned to the right side, the mouth was drawn to the right and there was marked aphonia. She avers that she had perfect control of the left leg. This condition of affairs lasted some ten days when gradually she began to recover first the use of the arm, then of the mouth and tongue. She was very weak for a long time. Now she talks perfectly well, the tongue comes out straight, there is no perceptible difference in the strength of the hands; that of the left is perhaps slightly decreased. Since the attack she complains of cramps in the left leg. Prior to the fall she had some gastric difficulty which has been aggravated to such an extent that she now vomits almost everything ingested. The bowels are badly constipated. Especially at night she complains of seeing bright colored lights and all sorts of things. The heart sounds are normal, except that they are

pretty loud; the first sound is accentuated as if there might be ventricular hypertrophy, which may be due to the excitement of coming into the clinic.

In analyzing the symptoms in this case, Prof. Fellows said: This case is of considerable interest inasmuch as it is a somewhat peculiar one. It does not follow the model. You will remember that during one of the hottest days of last June we had an unusually severe storm. This attack then came on under the influence of extreme heat and fear. This will, perhaps, account for the premonitory symptoms, but looking further, there was another active factor in the production of these major symptoms. She tells us that the leg was not paralyzed, but I mistrust that had there been a careful examination made at the time her statement would have been disproved. It would have been very singular to have had such extreme paralysis of the arm and face without involving the leg.* Now we do not know the condition of the eyes, whether or not there was any conjugate deviation, but you have one side of the face paralyzed and the same side of the body, as far as it goes.

Of course the attack is in the nature of hemiplegia. With this one-sided condition coming on as quickly as it did, we must locate the trouble in the brain, and without any previous history of a known cause for the paralysis we must conclude that there was a rupture of a blood vessel. There is no cardiac disease here which could cause embolism, and in fact the age of the patient is against that. You will observe that we have the motor and not the sensory nerves affected. Now, beginning in the cortex, these motor fibres pass down through the internal capsule, crus and pons into the medulla, where they cross and continue downward in the crossed pyramidal tract of the lateral columns of the cord. If we trace this we shall be able to locate the difficulty. It occurred before the facial fibres crossed, or

*The husband informs me that the leg was paralyzed, and that its improvement accompanied that of the other injured members. So reported two weeks later.

else the paralysis would have occurred on the right side of the face, so we must go to some point above the place where the fibres cross above the pons. If we strike anywhere into the region of the internal capsule in front of the posterior one-third, we shall strike motor fibres. This must be the region affected by the hæmorrhage, for here we get fibres for the opposite side of the face and the opposite side of the body including the face. If the injury was located in the cortex it would have to strike a larger area and the attack would have been initiated by convulsions, the hæmorrhage occurring from a meningeal artery. Therefore, it probably was not in that region to any extent, but mainly in or just outside of the internal capsule, in its anterior two-thirds. The recovery from the paralysis was so rapid that there could not have been great destruction, therefore no great hæmorrhage, but it was sufficient to produce paralysis. If the hæmorrhage was small it might affect more the fibres of the upper part than the lower part of the body. There is a facial symptom to which I wish to direct your attention, and it is this: that she could close the eyes perfectly. If we had facial paralysis (Bell's palsy) she could not have closed the eye on the paralyzed side, while in apoplexy this is not true. In this case it seems to have affected the lower branches of the facial nerve only, so that we are able to locate the hæmorrhage from that point.

This patient says she had some fever. If the fever goes very high the outlook is not very encouraging. If it fluctuates and finally goes down in a few days there is a strong probability of the case improving and going on to recovery. Immediately following a cerebral hæmorrhage the temperature is generally subnormal, but if after reaction has set in, it should a second time become subnormal, you have a dangerous case in your care. In most of these cases there is a period of unconsciousness the duration of which is variable; however, should it last from twenty-four to forty-eight hours there is less chance of recovery. The less the unconsciousness and the fever, the more hope.

Now you will often find the mentality of the patient involved ; they become emotional. One case which I had was quite typical, that of an old physician who came to me from the Southern part of the State. He told me he had run away; I asked him why, and he said he was tired of making a fool of himself, that when he met any of his old friends on the street and when they congratulated him on being out again he would burst out crying, and so he had actually ran away, skipped out in the night to consult me. He never entirely recovered and finally died of apoplexy. In this case you see it has disturbed the brain. She sees imaginary things, almost a hallucination, verging on a delusion. You will also find in this case an aggravation of the vomiting and gastric irritation. Now vomiting is a brain symptom, and I have no doubt but that the brain disturbance has aggravated these symptoms.

She also is constipated. This may irritate the system in a reflex way; and of the fœcal matter lying in the colon, the fluid part is absorbed, causing a form of toxæmia which will contribute toward keeping up the ill health.

There is one more symptom to which I wish to call your attention ; and that is the way in which the tongue came out. She says it turned to the right side.

The muscles atttached to the tongue, in their contractions, draw the tongue out, and, in hemiplegia, to the palsied side. Rarely there is an exception to this, the rule being so general that you are safe in remembering it.

We will continue nux vomica, as the case has improved since she was here last week. The patient looks much better. These mental symptoms, which are very prone to follow an attack of this kind, I think we will be able to get rid of.

In these cases first ascertain the nature of the difficulty, the location and the extent and adding to this a close study of the individuality of the case, you are prepared to go on with your treatment and prescription.

THE PTOMAINES IN INFECTIOUS DISEASES.

BY E. M. BRUCE, M. D., PROFESSOR OF CHEMISTRY AND TOXICOLOGY IN THE HAHNEMANN MEDICAL COLLEGE OF CHICAGO.

LECTURE II.*

We said at the close of our last lecture that to-day we would take up the real chemistry of the *ptomaines*. It is by no means certain, however, that any one at the present time is fully aware as to just what the real chemistry of these compounds is; so before giving you any of the credited formula or methods by which these organic bases are isolated, we wish to tell you something further of the experiments with the bacterial proteids. And in order that we may clearly understand each other, let us, in as far as the subject will permit have a definite idea of what the various proteids are.

It is well known to most of you that we are not much given to those "tombstones of ideas," called definitions, yet they are to a certain extent necessary evils. Now what is comprehended in the term proteid? The department of physiology has, we have no doubt, ably discussed the subject, but it will do no harm to freshen up on the matter a little by some explanations from our point of view. While not by any means desiring to assume the mantle of Carlyle and coin new words, we will suggest the neolgism *chons* for the proteids as a means of aid to the memory *i. e.*, they are those compounds which play such an important role in physiological chemistry and are made up of various proportion of C, H, O, N, and S. They turn yellow under the action of HNO_3, and their NaHO solutions give a violet color under the action of $CuSO_4$. Please look over the following outline in order that we may understand more clearly the experiments that have been and are being made :

*See Vol. XIII, page 445.

Proteids.

- **Albumin Native.** — Occur in natural condition of tissues and fluids of the body. Are soluble in distilled water at ordinary temperature. but are precipitated by strong acids and heat.
- **Albuminates Syntonine.**
  - **Acid.** — Formed by action of dilute HCl. Not precipitated by heat, but by careful neutralization. Insoluble in water and Na Cl solutions. Contain Sulphur.
  - **Alkaline.** — Formed by action of dilute alkalies. Not precipitated by heat, but by careful neutralization. Insoluble in water and NaCl solutions. Contain no sulphur.
- **Albumoses.** — Anti-Albumose, Hemi-Albumose. Effects of pepsin or trypsin.
- **Albumate.** — Formed by imperfectly acting pepsin or insufficient action, or by dilute H Cl at 40°. Cannot be changed by pepsin into peptones, but can by trypsin.
- **Peptones.** — Formed by action of gastric juice. Freely soluble in water. Not precipitated by heat or acids or alkalies. Precipitated by alkaline tannates. Rose color with trace of $CuSO_4$.
- **Casein.** — Albuminate of cheese.

This outline may seem long and unnecessarily complicated to you, but it really is not so, and we are sure a little careful study of it will aid you in understanding the chemical study of the poisonous proteids and the chemistry of suppuration. Let me glance now at the chemical aspect of suppuration. Along about 1882 Leber demonstrated that pus free from germs was formed after the introduction subcutaneously of mercury and copper. It was some two or three years later that the same investigator boiled for hours cultures of the staphylococcus pyogenes aurens and produced suppuration by the injection of them after that sterilizing. In 1888 he found that the alcoholic extract of the dried staphylococcus would produce pyogenic effects. From this extract he separated a crystalline sub-

stance which he called phlogosin. These crystals were soluble in alcohol and ether but sparingly so in water.

Leber found that certain chemical bodies had this power of attracting leucocytes and termed this peculiarity the chemotatic action (*chemotatische Wirkung.*)

We have already explained the manner in which Büchner prepared the proteids for his experiments and so need not describe it again. The chemotatic power of this substance was tried in the following way: The proteid was dissolved and placed in small spindle shaped glass tubes which had previously been thoroughly sterilized by boiling. The tubes were introduced with antiseptic precautions under the skin on the backs of rabbits and subcutaneously broken off. After a lapse of two or three days the tubes were removed, and contained several millimeters of fibrinous pus. This pus was most carefully examined by means of the microscope and by preparations of cultures but it remained sterile.

Experiments were carried on in the same manner, using solutions of the butyrate and valerinate of ammonia, trimethylamine, ammonium hydroxide, leucin, tyrosin, urea, urate of ammonium, glycocol (amido-acetic acid and skatol. But only glycocal and leucin were found to possess chemotatic action; and these in a very mild way as compared with the bacterial proteids. Now the bacterial cellular proteids have a close analogy with the vegetable casein, and experiments conducted in the same manner were tried with a proteid prepared from wheat gluten and from peas. They were found to possess chemotatic properties and produced suppuration. Solutions of starch and hydrodisodic phosphate were tried but the results were negative. Peptone gave no effect, but gelatin had a decided chemotatic action.

Alkaline albuminates from muscle, kidneys, lungs and liver were injected and all produced pus. That from the liver being particularly active. Experiments from blood and yolk of egg produced pus, those from fibrin and white of egg none.

Hemialbumose was found to be chemotatic, note that peptone was negative. Please note this interesting experiment: before the injection of the bacterial proteid the ratio of the white to the red corpuscles was 1:318, on the second day after the injection it was 1:126, on the third 1:102, on the morning of the fourth 1:73, in the afternoon 1:38. The red corpuscles were not affected as to number, but the white ones were increased seven times in number. A general leucocytosis was set up by a similar employment of vegetable casein, and by an alkaline albuminate prepared from the muscles of the calf.

Büchner finally tested the effect of the proteid upon himself. One cubic centimetre of a solution containing 3.5 milligrams of the solid proteid was introduced antiseptically under the skin of the forearm. In two hours' time there was pain along the lymphatics localized at the elbow and axilla, the temperature not markedly raised, 37.8° C, (100° Fr.). On the next day there was decided erysipelatous redness and swelling extending for some inches above the point of injection, and attended by great pain. The area of redness was hot to the touch, and projected above the surrounding surface. The lymphatics of the arm were greatly swollen and very red. On the third day the redness extended from the wrist to the elbow. By the fourth day the symptoms began to lessen. Similar, but less marked symptoms were induced by using a dilute solution of vegetable casein. Now, could this clinically typical erysipelas, having all the essentials (heat, redness and swelling) of inflammation be induced without involving the solid tissues? Büchner says, No! The same author says that the bacteria will not cause inflammation unless they be broken down. That is to say, that the pyogenetic substance within the bacterial cell can exert no chemotatic power until the cell disintegrates.

Along with these experiments of the bases and proteids there has been performed some most interesting work on the "immunity giving substances." Ogata and Jasuhara, found that anthrax bacilli grown in the blood serum of

animals not susceptible to the disease, will not upon inoculation induce anthrax in animals naturally susceptible. Anthrax germs grown in frog blood make mice sick but do not kill them. The germs grown in the blood serum of white rats or dogs have a similar effect upon rabbits, but the germs grown in the blood of animals susceptible to anthrax kill both mice and rabbits.

They found also that if one drop of frog blood serum or one-half drop of that of the dog was injected into a mouse, any time between the limits of seventy-two hours before or five hours after the inoculation with anthrax, that it prevents the mouse from the disease.

Fränkel found that if from 10 to 20 c. c. of the culture of the baccilus of diphtheria three weeks old, after having been exposed to a temperature of 60°-70° C. for an hour, be injected under the skin on the abdomen of guinea-pigs give protection against the inoculation of the live culture, provided the inoculation is not made until fourteen days have passed. In Fränkel's opinion the cultures contain two specific albumius, one of which is poisonous, the other giving immunity. He says that the modified cultures which gives immunity is of no therapeutic value, and that if the animal be treated with it immediately after the inoculation with the germ death is not retarded but actually hastened. His idea in a word is that the so-called immunity giving albumin at first lessens the power of resistance but that subsequently it increases it.

The results of some of these experiments, together with the seeming contradiction of terms is almost discouraging at the first glance, and indeed is not very satisfactory on careful study. One thing seems clear to us in midst of the chaos, and that is the chemical nature of the bacteria poison, and that it is not the bacteria in and of themselves that do the evil, but the chemical which they elaborate or is elaborated by the breaking of the bacterial cell.

The thing most earnestly desired by the medical man is some therapeutic agent which will rid the infectious disease

of its baneful effects. To us it seems that there is a starting point in the so-called "immunity giving substances." This part of the subject should we think most especially attract the student of the homœopathic creed. We trust it may be the privilege of some of you to find the "open sesame" of all this hopeless task and thereby rid infectious disease of its terrors.

CLINICAL CHIPS.—A case was recently presented at the Academy of Medicine of Paris in a man æt. 31 had undergone a symphysiotomy for resection of the bladder and the removal of a sessile tumor contained within that organ. He made a good recovery.——Dr. Hugenschmidt holds that tropacocaine has the following advantages over the ordinary cocaine: (1) In a dose that is sufficient to induce anæsthesia it is much less poisonous and has a less marked action upon the vital functions; (2) it causes a local anæsthesia that is more rapid, more profound, and of equal duration; (3) because of its antiseptic nature, its solution can be kept for months, while that of cocaine spoils after four or five days.——The old expedient of cold applications for the relief of gall-stone colic is coming into vogue again. ——Dr. Schede, of Berlin, had occasion to suture the inferior rena cava for hæmorrhage following the removal of a cancerous kidney. The patient died a month later and the wound of the vessel was found to be firmly closed and cicatrized.——The treatment of myxœdema by the hypodermic injection of the thyroidean liquor is declared to be a pronounced success.——Antispasmine, composed of one part of sodic narceine and two parts of the salicylate of soda, contains about fifty per cent of pure narceine, is very soluble in water, and is the popular fad in infantile therapeutics especially.

Clinical Society Transactions.

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

JANUARY MEETING, 1892.

The regular monthly meeting of the Clinical Society was held in the Great Northern Hotel, on Saturday evening, January 28th, Dr. W. A. Dunn, President, in the chair.

REPORT OF THE BUREAU OF OBSTETRICS.

S. LEAVITT, M. D., CHAIRMAN.

VIII. THE USE OF THE HAND IN THE DIAGNOSIS OF PREGNANCY. BY SHELDON LEAVITT, M. D. The physical conditions in pregnancy are so diversified, and they change in so progressive a manner, that it will be advisable for us, in this consideration of the subject of diagnosis, to divide the period into three parts, the first extending to and including the sixth week, the second extending thence to the eighteenth week, and the third being the subsequent part of the pregnant term.

During the first six weeks of pregnancy the megascopic changes are but slight. The organ in which a most astonishing evolution is about to take place does not augment much in volume, nor do any contiguous or related organs undergo any pronounced change. At the close of this first term the uterus has added somewhat to its weight, partly by accretion of structural elements, but mainly from the unusual quantity of blood circulating in its walls. The impregnated ovum itself has not attained a size greater than that of a sparrow's egg. A noticeable change is found in the position of the uterus in the pelvic cavity, consisting of a slight prolapsus, very likely due to increased weight; but this prolapsus is by no means diagnostic, since

a corresponding descent of the organ is found in many non-pregnant women.

It follows that, with these comparatively insignificant data before us, manual diagnosis of pregnancy during the first six weeks can be given little more strength than that which attaches to a mere probability.

During the term extending from the sixth to the eighteenth week, marked changes take place in various parts of the body, and especially in the womb itself. During this time enlargement is progressive, so that at the close of the eighteenth week it may measure five or six inches in length, instead of three inches as does the non-pregnant organ. *The increased size of the uterus is of more value as an indication of pregnancy than any other single sign that it is possible for us to recognize, and ought first and most prominently to be consulted.*

It is by careful examination that we are able to determine, even approximately, the size of the organ, inasmuch as we are not at liberty to introduce the sound, and yet, in most instances, it may be ascertained by conjoint touch, the fingers of one hand being in the vagina, while those of the other depress the abdominal walls until the fundus can be felt.

What other conditions could cause so uniform enlargement? In a woman who has borne children the organ is often left in a state of subinvolution, and, if no previous examination has rendered one familiar with the condition of it in a given case, one may easily be led into error. In a multipara, considerable hypertrophy of the body of the uterus, without a long history of pelvic disease, is rarely, or never, found. Carcinoma of the uterine body, with no indications of cervical involvement, is so rare as scarcely to merit attention; and even if present the clinical history of the case would disprove possible pregnancy. Intrauterine growths of sufficient size decidedly to enlarge the organ are most frequently fibrous, and are accompanied with menorrhagia and metrorrhagia, symptoms contraindicating pregnancy. Neoplasms of the uterine wall cause unequal

enlargement, as a rule, and present the hemorrhagic symptoms just mentioned. Furthermore, the feel of the uterine walls is, in nearly all pathological states, indicative of greater density of structure than we find in pregnancy.

This leads me to consider at this point a sign of great value for diagnostic purposes in early pregnancy, a sign which by some is considered positive, namely that known as Hegar's. Those most expert in its detection claim that it can be made out with satisfaction as early as the fifth or sixth week, but less practiced fingers would search for it in vain at that early period. By the seventh or eighth week it becomes quite distinct in most cases, and should always be sought where it is desirable to make the diagnosis as strongly presumptive as possible.

Hegar's sign consists in a softening of the uterine strucures at the isthmus, that is to say, at the junction of the body and cervix, with a ballooning of the uterine walls immediately above this point. In order to make it available the uterus has to be pressed downward into the pelvic cavity, so that the organ can be brought within the grasp of the hand, the fingers being passed into the rectum and the thumb into the vagina. If this cannot easily be done, a fair result can be obtained from the usual conjoint manipulation, the fingers of one hand being in the vagina, and the other hand repressing the hypogastrium.

When the abdominal walls are loaded with adipose tissue, conjoint manipulation of the uterus is attended with unusual difficulty. The results of examination in such cases are most unsatisfying. Still much can be learned concerning the size and shape of the womb from a vaginal examination alone. The ballooning wall is quite characteristic of pregnancy, and, when associated with cervical softening, should be regarded as highly presumptive evidence of pregnancy.

Now a word with respect to the situation and position of the uterus during pregnancy. In the early weeks, as I have previously said, the uterus sinks in the pelvic cavity; but after the eighth week it begins to rise till at or near

the close of the third month the bulk of it lies above the pelvic brim, in a situation where there is ample room for development. It is a clinical fact to be borne in mind that, in both sinking and rising in the pelvic cavity, the uterine longitudinal axis is usually made to conform to the pelvic axis, and hence the direction in which it points is correspondingly changed. Therefore when the organ lies low in the pelvis the cervix is turned forward within easy touch, while it can scarcely be reached after ascent, owing not alone to height, but also to the remotely posterior direction of the part. When the uterus is at its greatest height, with the cervix thus situated, the vaginal *cul de sac* lying anteriorly to the cervix is put upon the stretch, constituting a valuable sign of pregnancy.

After ascent of the uterus begins, softening of the cervix, which, at the sixth week is scarcely noticeable, becomes more distinct and progressively increases so that at the close of the fourth lunar month nearly the lower half of the vaginal portion is reduced to a state of exceeding pliability.

During the fourth lunar month that sign, very valuable when elicited by an expert, known as *ballottement*, can be utilized. This consists, as the members of the society well know, of tossing the fœtus as it floats within the *liquor amnii* in such a way as to make the movement sensible to the fingers applied to the lower uterine segment. At an early period in pregnancy it can be practiced with satisfaction only by the internal method, the fingers resting against the lower uterine wall, or the cervix. In order to get the best results the woman should be placed in the semi-recumbent posture, with the thighs somewhat flexed. Two, even four, fingers of one hand should be placed against the lower part of the uterus, within the vagina, and the other hand upon the fundus of the uterus as felt through the abdominal walls. With the woman in the position indicated the long axis of the uterus is nearly vertical, and the force of gravity is thus given better effect.

By a sudden movement of the fingers as they rest against

the uterus the fœtus can easily be impelled upward with some force only to return with a delicate, and not easily recognized, gravity impulse, to the place from which it was dislodged. As I have before indicated, great delicacy of touch is required to detect this movement.

Throughout the greater part of pregnancy there is a rhythmical action of the uterus going on, first described by Braxton Hicks, and which becomes distinguishable on prolonged palpation before the close of the sixteen week. It constitutes one of the most important signs of pregnancy, and should always be consulted for diagnostic purposes.

When the case has progressed beyond the sixteenth week the evidences of pregnancy become more conclusive, and manual examination needs little confirmation from other diagnostic means. Here again the uterine changes furnish the most important data. At that period the enlarged uterus can easily be felt, and the height of the fundus readily determined. To be sure mere enlargement of the organ, even to a considerable degree cannot be accepted as conclusive evidence; but, taken in connection with other presumptive signs, to say nothing of positive ones, diagnosis becomes unquestionable. At the eighteenth week the fundus rises but a short distance into the hypogastrium, but by the twenty-fourth week it is usually found at the umbilicus.

Normal pregnancy may be confounded with molar pregnancy, especially that of the hydatidiform variety; but there are characters by which it may usually be distinguished. True molar pregnancy is always based on real pregnancy, and, in the case of the carneous mole, it may be impossible to differentiate between it and normal pregnancy until expulsion of the uterine contents makes the case plain. When once hydatidiform degeneration begins in the villi of chorion, the bulk of the mole increases very rapidly, so that this very rapidity of development constitutes a diagnostic feature of the greatest value. There is also a uniform resistance and a peculiar boggy feel under

abdominal palpitation. The escape of some of the smaller vesicles along with a watery fluid, at infrequent intervals, clinchés the diagnosis.

Without entering into a consideration of differential features, it may be enough to say that an experienced observer can scarcely mistake uterine fibromata or ovarian cystomata for pregnancy.

Discussion. Dr. W. A. Smith: The ground has been so thoroughly covered by the essayist that there is nothing left to discuss. It tells you in the plainest possible manner the methods you should pursue in undertaking to make a diagnosis of pregnancy and also enable one to avoid making a mistake in diagnosis. I remember one case of hydatid pregnancy where the symptom of the boggy feeling mentioned by Prof. Leavitt was present. On making the examination you will notice that there is not the resilient feeling to which you are accustomed in normal pregnancy. I did not know what it was until it was expelled, but supposed it was a dead fœtus. The mass reminded me of a huge bunch of white grapes.

There is one sign that I did not notice in the paper that is also a sign of pregnancy and that is a darkening of the areolar tissue around the nipples. I wish to say, however, that the making of a positive diagnosis of pregnancy is one of the most difficult things to do, and I doubt that it can be made. If you wish to save your reputation as a physician, never tell a lady that she is or is not pregnant for you are liable to make a mistake.

Dr. Morrison: I have nothing to add, but in the general practice of medicine we are often called upon to make a diagnosis of pregnancy. My experience has taught me to be very cautious in the diagnosis. While these signs of pregnancy have been given very frequently I find that all cases of suppressed menses, from any cause, produces almost all of these symptoms. For that reason I simply advise the patient to be very careful and consider that it is a pregnancy.

Dr. SMITH: About making this balottement that Prof. Leavitt spoke about, I have tried making it with the woman in a semirecumbent position and would be unable to get the gentle tap of the fœtus on its return. It is made by introducing two fingers into the vagina and giving a sudden push against the lower segment of the uterus. Lusk says that this is a positive sign, as no other condition is present in which a solid body is floating in the uterus. I have never been able to get the sensation of the return of the fœtus when the patient was prone, but have been able to do so when the patient was standing up. Do not know whether my tough has not been delicate enough, or why, but you do not want to make a prophesy of pregnancy unless you are a prophet.

I noticed some time ago that some writer in a journal said there was a difference in the color of the mucous membrane in the vagina after eight weeks of pregnancy. It became darker. I do not know anything about it, but have often wondered if any one did.

Dr. WISNER: It is quite a constant sign.

Dr. W. A. DUNN: While I am not especially interested in the diagnostic points of this paper, I am especially interested in the scientific side of the frequently mentioned symptom of pigmentation.

We so often see certain symptoms which become everyday experience with us and yet we do not appreciate their cause, their value or their relation to other organs. So it is with pigment spots. It is the custom of physicians when such symptoms appear to say pregnancy or the liver are the conditions. This is not always true; besides, if it be true, what is the relation of the uterus or the liver to the skin of the face, the areolar tissue of the nipple or other portions of the body.

In the first place we must remember a pigment is the result of the breaking up and metamorphosis of the red corpuscles in the spleen and perhaps to a slight degree in the liver. In the normal state there is the required amount of pigment produced to supply the body with its

proper coloring material, but like the other functions of the body perverted nerve supply changes this to an abnormal condition.

Pigmentation depends for its changes on abnormal conditions of the blood, such as ague, syphilis, various cachectic conditions, etc., on violent emotions and on reflex irritation from the abdominal and pelvic viscera.

It is only to the latter condition that we have reference in pregnancy and similar conditions producing pigment changes.

Increased pigment material is produced by hæmatic stasis in the spleen so that any condition producing paresis of the splenic vessels will produce excessive pigment production.

The splenic arteries terminate in large sinuses instead of small capilaries which decrease the flow of blood through the splenic tissue and favor decomposition of the red corpuscles and the formation of pigment material, therefore, any condition impeding the circulation through the spleen favors the manufacture of pigment.

Now let us see how this is brought about from uterine irritation, whether from pregnancy, a uterine tumor, cervicitis or any other disease of the uterine appendix.

The irritation is transmitted through the uterine plexus to the abdominal portion of the sympathetic to the solar plexus where the force is reorganized and transmitted through the splenic plexus governing the circulation in the spleen, causing paresis, stasis and decomposition of blood corpuscles.

At the same time another portion of the sympathetic system is perverted; the irritation transmitted through the upper portion of the vasomotors, together with the psysiological relation with the nipples cause a paralysis and stasis in the areolar tissue of the breast.

Sometimes this perverted force is conveyed to the trophic filaments of the facial sympathetic governing the circulation through the skin or to the trophic filaments of other portions of the cutaneous surface, especially the chest and arms.

With this description of the cause, course and deposit we can readily appreciate that any reflex irritation transmitted to the solar plexus, from whatever point, is capable of producing extensive pigmentation in any part of the body.

Pigmentation from indigestion and perverted action of the liver I believe to be frequently observed. I do not mean by this the usual deposit of bilirubin so frequently observed.

Emotional pigmentation is similar to the reflex type, except the cause is psychological, instead of from reflex local irritation.

This is an especially interesting subject, and like all reflex irritations shows the necessity of appreciating the psychological and pathological changes that are taking place continually, and that what we see is but the tail of a series of changes which we must appreciate in order to estimate their value as diagnostic symptoms.

Dr. LEAVITT: I wish to call the attention of the gentlemen who have done me the honor to discuss this paper to the notable fact that they have wandered from the subject, which was, the use of the *hand* in the diagnosis of pregnancy. It would be very interesting to consider the use fo the eye in the diagnosis of pregnancy, and I may do so on another occasion, when the remarks of our President, so well given on this occasion concerning the causes of pigmentation, would be very appropriate.

Dr. Smith has alluded to his unsatisfactory experience in the practice of ballottement, and I may add that my own experience has been of a somewhat similar nature. I have never obtained very satisfactory results from my attempts to elicit the sign in question, and nowadays rarely consult it.

With regard, however, to a positive diagnosis of pregnancy, I may say that after the fourth month, and many times immediately after the third month, such a diagnosis can be made.

In closing, I wish to call special attention to the great value of the one sign of characteristic uterine enlargement, under the impression that this sign, which is unquestionably the most valuable of all, is not always attentively considered.

Hospital Notes.

CLINIC FOR THE MEDICAL DISEASES OF WOMEN.

SERVICE OF PROF. E. STILLMAN BAILEY, M. D.

THIRD SERIES.

Being a Report of Five Hundred Cases Treated in this Clinic, Comprising Numbers from 20,300 to 20,800 inclusive.

Having previously submitted two reports of one hundred and fifty cases each, for the sake of the summary, I take the liberty of incorporating some portions of the former reports in connection with the two hundred cases that come into the third series at this time. I have compiled from the clinic records the data, with great care and believe the accuracy quite in proportion to the answers that have been given by the patients. The details as to the variety of cases are purposely admitted in this report as a more extended table will be submitted at a future date.

The cases reported are taken from the general record book of the clinic, and comprise the different ones that have come before the general or some of the sub-clinics. In the general average of the five hundred cases, puberty was established at fourteen years. The American girls arrive at this clinical epoch on an average of a year earlier than the foreigners. One patient, born in Chicago and always living here, gave a history of her first menstruation at the date of nine years and six months. She was at the time an inmate at this hospital. She had a sister menstruating on her ninth birthday; her mother was but ten years and her grandmother but nine years and a half old when menstruation was established. One patient of twenty-four years had never menstruated. There was some malformation described, but the patient did not return so that the cause of delayed menstruation is still unknown. In over three hundred cases the date of the first menstruation was a considerable over fifteen years, this was particularly noticeable in Danes and Swedes. A

fraction over sixty per cent had always menstruated normally every four weeks.

The majority of those whose menstrual period was not normal, had the anticipating type, averaging nearest the time of twenty-one days. Only one case is recorded where the flow seemed normal and expected at intervals of eighty or ninety days. Sterility existed in the patient.

In the record of the last two hundred cases, very few had reported that they had passed the climacteric. The figures are not exactly accurate, but the percentage gives a fraction over seven. One of the fourteen whose history I have, had passed the menopause over ten years ago, but was again menstruating normally, or at least this was her history while attending this clinic.

The average length of menstrual life is thirty-three years. In the three hundred cases reported the figures are thirty-two and three-tenths years. The average duration of menstruation is a fraction over four days. In the previous three hundred it was a fraction less than four days. Over fifteen per cent menstruated not less than seven days. Four per cent were sick for one day only. Five per cent exceeded ten days, and one patient was unwell exactly one-half of the month, and suffered nothing.

Thirty-five per cent had dysmenorrhœa. In the last series four had convulsions at the approach of the period. Eight per cent suffered excruciating pain. The larger proportion of dysmenorrhœa cases, the pain anticipated the flow, and as half of the cases were relieved as soon as the period was established. Only five cases in all are reported to have suffered great pain during the entire time of the period. One-fifth of the patients of the entire number were unmarried. Of the eighty per cent who had married thirty per cent were childless. Twenty years seems to be about the average age of marriage. The three hundred and twenty women became mothers, giving birth to the aggregate of over twelve hundred children. The average number of children being four for each family. One mother had nineteen children. The thirty-one married and childless mothers had suffered from miscarriages or intentional abortion. Quite a number sought relief from the condition of sterility, per centage not obtainable.

In the first one hundred cases the greatest number of any one form of disease treated was perverted menstruation, either amenorrhœa or dysmenorrhœa. The second

hundred had a larger per centage of pelvic disorders, such as ovaralgia, effects of labors or abortions and uterine displacements. In the third hundred the greatest per centage of disease was uterine displacements. In this enumeration thirty-five per cent had prolapsus uteri, ten cases of anterior displacement and fourteen of retro displacement. In the 500 cases there were but six cases of complete procidentia, one was of recent date and four had existed for several years—one as long as twenty years. Cystocele and rectocele have averaged about as frequently as anterior displacements. In the summary of disease in the third series the cases have been more of the inflammatory type, endometritis leading, uterine discharge being very frequently present.

In respect to specific causes for disease as syphilis or gonorrhœal, the former has been conspicuous by its absence quite as much as the latter by its presence. Less than a dozen cases in the entire series could be traced to the primary lesions of chancre or chancroid, or to the secondary or tertiary forms, although there were typical cases of each presented for treatment.

Gonorrhœa has doubtless been a very marked factor in creating disease, but the numbr of acute cases have been very few, not to exceed those of acute syphilis. Latent gonorrhœa has been traced in a good many cases, but there being other diseases quite as marked it has been entered up as a complication. I am not sure as to the percentage and so pass it here.

Taking the clinical history, such as the patients express at their first visit, I know I am warranted in saying that the greatest cause of chronic ailments has been the evil effects of abortions and willful miscarriages. This truth does not come out without repeated questioning, but it comes. Many patients saying "I have never been well since my baby was born." I have learned that this by no means refers to the confinement at full term, the loss of the fœtus causing the idea to prevail that the effect was the same as the disorders produced by labors at term.

The second great cause for the chronic ailments are the effects of child-birth and the accidents attending the lying-in period. The third cause is one not so easily traced, but it is infection and possibly is a greater cause than the two preceding.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

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

TUBO-OVARIAN DISEASE SIMULATING APPENDICITIS. OPERATION. RECOVERY.—Wednesday, Jan. 11. *Case 20,911*, æt. 35 was sent to the clinic by Dr. Turner, of Elkhart, Ind. She has been married 14 years and has two children, the youngest being 11 years old. She had normal labors with each and has had no miscarriages. Puberty was established without difficulty at 15. Of late she has often suffered with dysmenorrhœa, although the periods have been as regular as formerly. She says that she has never felt well since her first child was born, 13 years ago. The perineum was lacerated at the time but was repaired two years ago. For one year following the operation she expresses herself as having felt very well. Then she began to suffer with severe pain in the right side, in the region of the appendix vermiformis. At such times a swelling would appear in that locality and gurgling would be quite pronounced. She has had four distinct attacks of this kind which were diagnosticated as appendicitis, and she has a great dread of a repetition of them.

Operation. January 13 an abdominal section was made before sub-class 9. The operation will partake of the nature of an exploratory incision because this is the interval between her acute attacks, for the evidences of a local lesion are not to be found here with any degree of certainty. The middle point of an imaginary line drawn from the superior spinous process of the ilium in this direction diagonally to the umbilicus would indicate the usual location for a tumor of the appendix; and if we were certain that such a lesion existed I should make the incision directly over that point. It might be perpendicular to the outer border of the rectus, or obliquely toward the middle of Poupart's ligament, but in either case it should not extend too far toward the pubis lest we wound the epigastric artery.

As it is possible, however, that we may find it necessary to remove one or both ovaries and tubes instead of the appendix, I have decided to make the incision along the

*Continued from page 53.

mesian line. In this case it will only need to be carried a little higher than is usual in tubo-ovariotomy so that the right iliac fossa can be readily explored.

Now I feel that there is nothing abnormal about the cæcum either in the form of an abscess, or an infiltration, or adhesions, and no tumor of any kind. Remembering that the appendix most frequently lies posterior to this caput-coli, I feel for it and draw it into view where you can see it lying outside the wound. It shows no sign of disease whatever, as you can attest, and we therefore return it to the peritoneal cavity.

(Both ovaries and tubes were found to be badly diseased and were accordingly removed. The right ovary was cirrhotic and the left one was the seat of three hæmatomatous cysts).

The final necessity for a double tubo-ovariotomy confirms the wisdom of my choice for the median incision. If I had made the usual section for appendicitis it would have been an awkward thing to have taken the right ovary through it, while to have crossed the abdomen and secured the left one would have been practically impossible; and to have made a second incision would have been still more hazardous and unfortunate.

February 5. The twenty-third day the patient left the hospital. At no time had her temperature reached 100°, nor had she had anything to complain of during her convalescence.

LAPAROTOMY FOR THE FOURTH TIME.—FISTULOUS ABSCESS OF THE BROAD LIGAMENT A SEQUEL OF PYOSALPINX.—THE PURULENT DIATHESIS.—Monday, January 23, 1893. A careful and extended lecture was given upon *Case 10,821*, the previous history of which had already been published.* The patient, unmarried, æt. 28, had been ill for six years and most of that time had had a purulent discharge from the right iliac region. The abdomen had twice been opened by a general surgeon who finally sent her home with a drainage tube lying diagonally across the abdomen and emerging through a counter opening in the right ilio-costal space. This tube she wore constantly for seven months when it was removed and the wound closed. Then for four months the flow ceased, and on its return she was brought to this hospital where Prof. Ludlam found and re-

*The CLINIQUE, Vol. XIII., page 229.

moved the right Fallopian tube, which was suppurating very badly, and discharging through a sinus at the right of the linea alba. There was no other existing lesion within the pelvis or the abdomen. She made a prompt recovery and returned home, where, for about six months she had no more discharge. Then it returned again and was accompanied by a great deal of pain in the right pelvis, and the flow became not only more profuse, but much more offensive than ever before.

Observe that, considering that it is the third incision which our patient has had along the mesian line of the abdomen, this cicatrix is not a bad one. But here, at a point mid-way between the pubis and the umbilicus, about an inch to the right of the cicatrix, and directly over the rectus muscle, is a prominent, purple swelling as large as the first joint of my thumb, which lies transversely across the abdomen. At its extremity is what seems to be the mouth of a sinus from which the pus emerges. I pass a probe into it and you see that it not only takes the direction of the pelvis, but easily enters almost its whole length, showing the track of a sinus and the probable location of another abscess. For recurrent abscesses are the rule and not the exception within the pelvic peritoneum and in this class of patients.

Taking her previous history into account, and feeling morally certain that other than surgical means must continue to fail in her case, I am decidedly of opinion that it is not only judicious and justifiable, but necessary that we open this abdomen again. For, beset as such an expedient is with contingencies when it is so often repeated, and in such a subject especially, it offers her only means of escape; and the sooner it is done the better.

I do not venture a thorough exploration of the pelvis under these circumstances, lest I might do mischief by rupturing the walls of an abscess that is discharging a foul-smelling pus, and so turn its vicious contents into the abdomen. For while stinking pus is sometimes sterile it is not always so. The fact that the probe passes so far into the sinus, which discharges so freely, shows that we have to do with a pus sac, or resevoir, that not only needs to be emptied, but if possible to be excised and removed.

Operation.—Tuesday, January 24. A fourth abdominal section was made on this patient before classes 3 and 13, the incision being at the right of the old cicatrix. It was found that the fistulous track extended from the integu-

ment directly into a large abscess lying mainly within the broad ligament. The sinus and the surrounding tissue with the sac were cut out and removed intact, the pelvis was carefully cleansed, the Mikulicz drain inserted, the wound aseptically dressed and the patient put to bed in a good condition.

Wednesday, January 25. She is doing well in every way.

Wednesday, February 1. The patient having died of pyæmic infection at the end of a week, the particulars of the case were detailed to the class and fully dwelt upon.

At my last clinic you saw three cases in which after laparotomies the wounds had healed by first intention and the patients had recovered without any morbid symptoms. In this poor woman's case the same and even greater care, if possible, was had to secure and to maintain the strictest asepsis. If the three cases, and a lot of others, including one of ectopic gestation at the fifth month, recovered promptly, why should this one suffer and die from a general systemic infection?

Here and there in your books and journals you will find it stated that if septic or pyæmic conditions occur after a laparotomy the fault is with the operator, or with the after-treatment. While in the great majority of cases this is true, there are some exceptions to the rule, cases in which no human foresight, or care, or skill, can avert disaster. I am persuaded that this was one of that kind, one in which the infection was progressive and of a necessarily fatal character. There was no introduction or escape of poisonous material into the wound either during or after the operation. The regional infection was established when the fetid pus began to be discharged from the sinus weeks before she came to us. And whether the pus-microbes were disseminated, or if their ptomaines were the source of pyæmic mischief, the clinical result was the same, and it was inevitable.

With all our advancement in abdominal surgery we should not forget that there is such a thing as the purulent diathesis, first described by Tessier; and that, whether it is inherited or acquired, it may lie in wait to destroy our patients through a cause that is entirely beyond our control. The six years' existence of a clinical form of suppuration in this case was responsible for such a transformation of the leucocytes, and such a lowering of the vital resistance, as finally made her an easy prey to the purulent infection.

Into such a soil there was no need to introduce the pyogenic microbes; for the tissues and the system were already charged with their poisonous products.

EPITHELIOMA OF THE UTERUS. VAGINAL HYSTERECTOMY. RECOVERY. Wednesday, January 11th. *Case 20,912.* Mrs. ——, æt. thirty-two, has one child thirteen years old. She had had no miscarriages. Puberty was established at twelve, with a normal menstruation, and a continuance of the same until July last. At that time she sustained a fall by having a chair slip from beneath her when about to be seated. Since then the menses have been constant, but not alarmingly so until six weeks ago, when the flow became hæmorrhagic, and was accompanied by severe abdominal and pelvic pains. In consequence of this metrorrhagia she has been confined to the bed, and has become very anæmic and emaciated. She is exceedingly weak, nervous, and sleeps very little. The bowels are inactive, but there are no vesical symptoms.

This case presents an example of uterine carcinoma which, although in a young subject, and the mother of but one child, is running a very rapid course. Until six months ago, when she sustained an injury, she believed herself to be well in every way. From that time until now she has had a constant hæmorrhagic flow, which for six weeks past has been at times frightfully severe. You will notice the blanched hue of the skin, the emaciated wrist and arm, and the bony, transparent hand.

This patient dates the beginning of her disease from an accidental fall, and you know how often I have called your attention in this clinic to pelvic and abdomical lesions that were referable to a traumatism of some sort. It scarcely seems probable that so slight a fall could cause such serious mischief, and yet it is possible. Ten years ago I amputated the cervix of a young woman of twenty-eight, a patient of the late Dr. R. F. Baker, of Davenport, Iowa, who in consequence of a fall while exercising with parlor skates, developed a cancer of the uterus which ran its course and destroyed her life in five months. Prior to the accident she was in perfect health, and there was no predisposition to the disease in her family. In those days our only surgical resources were curetting and amputation. Now, in such a case I would extirpate the womb and expect to relieve my patient of what seems to be an

acquired, or accidental form of this dreadful disease. And that is what we shall do in the present instance.

Operation.—January 17th, a vaginal hysterectomy was made before sub-class No. 12. The cervix and the body of the uterus were found to be filled with a friable, brain-like mass. Only the outer shell and a portion of healthy tissue lying between the inner orifices of the fallopian tubes remained. There was no apparent extension of the disease to the perimetric tissues.

Wednesday, February 8th.—The patient is sitting up, and has had an uneventful convalescence.

Concerning the vaginal extirpation of the uterus and its safety by the method of forcipressure, instead of ligation of the vessels involved, the best statistics thus far given are those of Péan, who during the years 1888 and 1889, made this operation in this way 157 times, with 157 cures.*

THE DIAGNOSIS OF HEPATIC FROM PELVIC TUMORS.—*Case 20,914.* Wednesday Jan. 25. This woman has a tumor which has been growing for eighteen months. She is twenty-four years old and has five children, the youngest being eight months old. This growth began before the last conception; the tumor was therefore present at the birth of the child, for which reason it was supposed that there was another fœtus in the utero. Since the lying-in the tumor has grown very much more rapidly and has presented more serious symptoms, and she has been brought here for an operation, if it is deemed wise to make one.

On inspection you will observe that the right side of the abdomen is most prominent. There is no especial protrusion, or profile along the mesian line. Palpation reveals a growth in the right abdomen, which extends from the lower margin of the thorax to three inches below the umbilicus, embracing the whole right hypochondrium. Its surface is smooth and resisting, and its border beveled with a sharp edge like the free margin of the liver. In the epigastric region the growth extends to the left of the mesian line and its contour is less sharp and regular. There is no sense of fluctuation in the right side until we reach the iliac region; but the left side gives evident fluctuation all along its lower portion and in the iliac region also.

**Lecons de Clinique Chirurgicale* Professées á l'Hopital Saint Louis, par M. le Dr. Péan, etc., etc. Paris 1892, tome 8, page 1426.

Observe now that, in so far as fluctuation is concerned, percussion confirms the signs that we already have of an effusion which is probably ascitic. The water-line of dullness corresponds with the patient's posture and, because there is resonance in the upper part of the left side of the abdomen, we infer that the intestines are floating upon a serous accumulation. Which proves that the ascitic collection cannot be very large, or at least that the abdomen is not full of it.

On the right side there is not only dullness over the whole extent of the growth but there is an absence of resonance at a particular point which is very significant as a diagnostic sign. Almost without exception in tumors of the liver, there is an absence of resonance at a point corresponding with the hepatic flexure of the colon, and with its tranverse portion also. In this case the sound elicited is obsolutely flat in all this region; and this, together with the evident growth of the tumor from above downward, its peculiar and well defined margin, and the coincident, ascites, make it morally certain that this is an hepatic and not a pelvic tumor. And this diagnosis is still further confirmed by the absence of all the physical signs of uterine and ovarian involvement.*

THE EXPLORATORY INCISION IN GASTRIC AND ABDOMINAL CANCER.—*Case 20,917.* Wednesday, Feb. 1. This patient was made the subject of a careful examination before the class, and it was deemed impossible without recourse to an exploratory incision to give a decided diagnosis. The case was obscured by a most unsatisfactory clinical history, and by the existence of a very thick and pendulous abdominal wall.

Operation. Feb. 3. The exploratory incision was made before sub-class 6. The section was through about three inches of adipose tissue. The tumor was found to be sarcomatous and attached chiefly to the stomach and the mesentery. It was covered with large veins and was very adherent. Since the growth could not be removed with safety the case was inoperable, and because of the depth of the wound the silver sutures were chosen.

Saturday, Feb. 11, the ninth day, the patient is doing well; the superficial stitches were removed on the seventh day; the wound looks well, but for greater security the deep sutures will be allowed to remain a few days longer.

*The case was referred to Prof. Arnulphy and was afterward made the subject of an especial clinic, Feb. 11, 1898.

Clinical Reviews.

AN AMERICAN TEXT-BOOK OF SURGERY FOR PRACTITIONERS AND STUDENTS. Edited by WILLIAM W. KEEN, M. D., LL.D., and J. WILLIAM WHITE, M. D., Ph. D. Profusely Illustrated. Philadelphia: W. B. Saunders. 1892.

One's first impression of this really excellent work is that it is large enough to be awkward; an impression which even a closer acquaintance does not entirely dispel. One cannot help feeling sorry that the authors and editors deemed it necessary to devote considerably more than one-twelfth of the book to such well defined specialties as the eye and ear, and nose and throat—can hardly help thinking that subjects of greater interest to the general surgeon must have of necessity been somewhat curtailed in order to confine the book to its present limits. The editors offer the explanation "That while the book represents in general the views of all the authors, each individual author is free from absolute responsibility for any particular statement." This, of course, explains any seeming contradictions to the teachings of those of the authors with whom we are most familiar.

The book is more suitable to the practitioner than to the student, touching upon the *why* and the *wherefore* with commendable clearness, but lacking in many places that close attention to detail in the explanations of *how* to do things, so essential to the student of surgery.

The chapters on bacteriology, wound repair, inflammation, etc., are all excellent, but where the book excels is in those chapters devoted to diseases and injuries of the head, the spine, and the abdomen. If there were nothing else of value in the book these few chapters are well worth the price. The authors, the editors and the publishers certainly deserve both the thanks and support of the progressive men of our profession.

H. R. C.

TEXT-BOOK OF NERVOUS DISEASES; Being a Compendium for the use of Students and Practitioners of Medicine. By CHARLES L. DANA, A. M., M. D., Professor of Nervous and Mental Diseases in the New York Post-Grad-

uate Medical School, etc., etc. With two hundred and ten illustrations. New York: William Wood & Co. 1892. Pp. 524.

There are two classes of readers to whom this book will "come home to their business and bosoms," viz.: the busy practitioner, who will use it as a reference work, and those students who are desirous of a practical and comprehensive knowledge of neurology. In the short, sharp efforts of the one and the long, laborious tramp of the other, it will prove an alpenstock of rare strength and assistance.

In the concise, conservative, and yet complete presentation of this difficult branch each will readily recognize the individual value, thus precluding the idea, as the author observes, "of comparing or competing with the larger treatises which are already in the field, or with the smaller introductory text-books."

An especially prominent feature is the introductory treatment, in a general way, of the anatomy, diagnosis and methods of examination of the nervous system, and the causes, pathology, treatment, hygiene, prophylaxis of nervous diseases, which will at once appeal to the readers as systematic, brief, yet thorough.

Comparatively there are but few characters in the alphabet when contrasted with the resulting combinations. Just so in neurology, there are certain features or symptoms common to all nervous diseases, but the many different phases which they exhibit and the groupings presented has caused many a student to hurl nothing smaller than a "tinker's malediction" at the head of Cadmus. Dana appreciates this for "again, although nervous diseases exhibit many phases and have many different morbid changes behind them, there are certain features common to all" and in his disposition of these same symptoms he treads virgin soil, pruning here, engrafting there and quite after planting a hardy young tree of modern thought.

Succeeding a lucid exposition of the knee-reflex, the manner of eliciting it, etc., the author writes as follows: "The knee-reflex is present practically in all healthy persons except the aged. Its absence is always of significance. The nerve roots involved are those of the fourth lumbar pair. The peripheral nerve is the anterior crural." Ranney however says that in about two per cent of healthy subjects the knee-jerk will be found to be totally absent, in spite of all possible care in employing the test. This di-

versity of opinion should serve to make us less dependent on a single symptom in diagnosticating our cases, and to remind us that several patients, each with diseases of the same name, present an individual feature wherein his treatment will differ from that of his fellow.

The author resolves the course of locomotor ataxia into three stages, viz., initial, ataxic and paralytic. "In the initial stage the patient first notices a slight uncertainty in walking, especially at night; he has numb feelings in his feet, and at times darting pains in the legs or rectum. His sexual function becomes weak, and his control over the bladder is slightly impaired. He has temporary attacks of vertigo and of double vision. A continuous sense of profound weariness oppresses him, even though he has made no exertion. The knee-jerk is lost. Such symptoms may last a few months or several years."

Chapter V will be found an extremely instructive one and supplying a long felt want, dealing as it does with such of baths, massage, climate and electricity as is germain to the subject matter in hand.

A decided innovation awaits the reader in the last chapter but one, it being devoted entirely to the disorders of sleep.

In this work the latest anatomical and physiological researches are presented, the latest theories incorporated and accredited with the reservation, "Prove all things and hold fast to that which is good." Wood cuts of exceptional merit to the number of two hundred or more are scattered throughout the book. In fine the book is essentially modern and satisfactory. O. L. S.

THE JOURNAL OF THE BRITISH HOMŒOPATHIC MEDICAL SOCIETY. Being a new series of the Annals of this Society and of the London Homœopathic Hospital. Edited by Richard Hughes, M. D., Vol. I, No. 1, January, 1893, London, John Bale & Sons.

This publication is a new and timely departure for a society that was founded in 1844, and which has been in successful operation ever since. It has already issued its very valuable annals in twelve portly volumes, and now proposes a serial that shall be up with the times and with the advanced position not only of the flourishing Society itself but also of the general interests of the profession "over there." That the enterprise is in the editorial charge of

our good friend Dr. Richard Hughes establishes its character and assures its success. Our readers should subscribe for this journal from the start and so help along the good work. It is clinical and practical to the last degree.

THE LONDON HOMŒOPATHIC HOSPITAL REPORTS. Edited by DRS. GEORGE BURFORD AND C. KNOX SHAW, Vol. II., London, December, 1892.

The enterprise which furnished an excellent volume of reports one year ago has resulted in a second issue, which in some respects excels the first. The papers contained in this volume are based upon the 755 hospital patients treated during the year, many of them being of a very interesting and important kind. The Therapeutic Sphere of Arnica in Surgery, by Dr. Alfred C. Pope; Studies in the Materia Medica. II. Ranunculus Bulbosus, by Dr. D. Dyce Brown; Lupus Carcinoma (with a very remarkable illustration), by C. Knox Shaw; Paroxysmal Hæmoglobinuria, by J. G. Blackley; Extra-uterine Gestation at the fifth month successfully operated upon, by Dr. George Burford; Paroxysmal Tachycardia or Heart Hurry, by Dr. Byes Moir; the Polymorphous Manifestations of Diphtheria, by Dr. J. Roberson Day; Nine Cases of Typhus Fever, by Drs. Blackly, Moir and Cox; and a Case of Pelvic peritonitis with rupture of the uterus at term of the ensuing pregnancy, by Dr. A E. Hawkes, are chief among the very readable and instructive papers in this volume.

From an essay entitled Original Investigations respecting the position of the Heart's Apex-beat in Children, by Dr. E. A. Neatby, we quote the following summary of conclusions:

1. That the heart's apex-beat is situated more externally in children than in adults.

2. That it is quite exceptional, if not abnormal, for it to be found external to the nipple line.

3. That the relative distance of that apex-beat from the nipple line varies rather with the age of the subject than with the size of the thorax.

4. That the more external position in children is explained by the large size of the heart and by the small transverse measurement of the chest in these subjects.

5. That the size and state of distension of the abdominal organs furnish a less constant cause for variation of the position of the heart.

6. That the heart is situated also at a higher level in the thorax than in adults, and that this is especially the case in infants.

7. That the apex-beat is felt at a higher level in the recumbent than in the erect posture.

8. That the heart's sounds are more widely audible in the chest of the child than of the adult.

Here is an extract from Dr. Day's paper on the Polymorphous Manifestations of Diphtheria.

The above (sixteen) cases are, I think, quite sufficient to show the polymorphous character of diphtheria, the difficulties of early diagnosis, the care to be exercised in prognosis, the importance of prompt and early treatment, and the constant watch that must be kept for any symptoms of paralysis—the latter being of the gravest import, and being present at some time or other in the majority of cases. The *prostration* of diphtheria is well known and is one of the points on which we depend in forming our diagnosis. This prostration has its origin in the nervous system, which is deeply involved, and when the innervation of the heart becomes affected we get the attacks of syncope which so often end fatally. Paralysis of other parts is not so dangerous, although where the diaphragm is involved, it is sufficiently grave. The palatal and pharyngeal palsies rarely cause death by food passing into the air passages, although this may occur. But *the* danger is cardic failure, and this must be borne in mind in every case. The first nine cases all suffered more or less from paralysis, and there is no doubt this is often the only symptom in diphtheria which gives any trouble or causes the patient to seek treatment. * * * * * * * *

The advantages of early treatment cannot be too strongly insisted on, and the nutrition must be maintained, as the system is profoundly affected. The principal treatment has been noted in the narration of the cases, the "sheet anchor" being mercurius in some form or other—generally the biniodide 3x trituration, when the throat is affected, and if there is membrane. When there are any signs of cardiac failure, belladonna, the mother tincture, in frequent two-drop doses is found to answer best. The local treatment of the throat is a valuable adjunct, but in order to be effectual it must be thorough, and this needs the personal superintendence of the physician, as it is one thing to give directions and another to have them carried out in these cases. The benefits of early treatment are well seen in case xvi, where the mother, an intelligent lady, gave aconite and bell. in alternation before sending for the doctor.

Where possible, those attending on the sick or exposed to any possible danger of contracting the disease should take bell. 1 and merc. sol. 1 in alternation, to act prophylactically, or should the disease be taken, to modify its severity. There is no doubt we have much to learn in this method of treating disease—to anticipate by our medicines. It is a well known fact that persons debilitated from any cause fall more ready

victims to disease; and why should not the converse be equally true, viz.: that those whose constitutions are under the influence of the remedies which cure the disease are rendered thereby better able to resist the disease ?

Many physicians are now in the habit of treating their patients beforehand, so as to prepare them to undergo the danger of parturition, or of a serious operation, and they claim that a greater measure of success has thereby attended their efforts, and I think with justice. The action of belladonna as a propylactic against scarlatina, or in modifying its effects, and the prophylaxis of quinine in malaria are well known. In diphtheria the nutrition of the patient must be carefully attended to, and where there is paralysis of the soft palate, solids or semi-solids are taken better than liquids. Rectal alimentation has been recommended; but in children, who constitute the majority of these patients, this method is rarely well tolerated, as the rectum often cannot retain the nutriment.

There is nothing of the air of a left-luggage office about this book for it is fully abreast of modern thought and progress.

HANDBOOK OF INSANITY FOR PRACTITIONERS AND STUDENTS, BY DR. THEODORE KIRCHOFF, PHYSICIAN TO THE SCHLESWIG INSANE ASYLUM AND PRIVATDOCENT AT THE UNIVERSITY OF KIEL. Illustrated with eleven plates, 362 pp., Wm. Wood & Co., New York, 1893.

If the Medical Practitioners' Library now being published by William Wood & Co., and of which this volume is a part, is to be judged by the merits of this book we advise our friends to subscribe for it forthwith. The text is completely de-Teutonized, the paragraphs are crisp and the chapters are short and very concise. For example concerning the medical history of psychiatry:

Even Weyer, the most celebrated opponent of the notion of witches, did not deny the reality of the pranks of Satan and did not dare to attribute them to mental disease. He merely attempted to restrict the assumption of magical influences to rare cases.

The influence of Luther, who was a firm believer in the devil and the doctrine of possession, long prevented a proper appreciation of the trouble in Protestant North Europe; and until a late period in modern times the insane were persecuted as sorcerers and witches.

The hopeless condition of the insane who were sequestered in prison is made clear by several descriptions which have been made known. Sometimes they were kept for years in cells which were destitute of doors and windows, with only an opening in the ceiling. Through this

opening food and drink were lowered to the patient. His feet and hands were often chained to the wall. Gloves with iron rings were used to prevent suicide. * * * * * * *

It was not until the beginning of this century that Langerman advocated the medical treatment of the insane in addition to mere detention. But the treatment long remained a cruel one. In addition to emesis repeated cartharsis, and cold douches with hundreds of pails of water, rotary machines played an important part. By means of a revolving chair the patient was rotated around his vertical axis a hundred times a minute, and vomiting often followed. The resulting exhaustion was regarded as sedation, and such tortures were supposed to possess indirect psychical and curative powers. It was also thought that patients could be cured by placing them in a closed sack. The ingenuity of physicians in inventing new measures of restraint as curative remedies is hardly credible.

CORRESPONDENCE.

THE LOCATION OF THE APPENDIX VERMIFORMIS.

Editor of the Clinic: Having been present with sub-class 9 at a laparotomy, Jan. 13 made by yourself in which the vermiform appendix was found and brought into our full view (See page 91), I was reminded that in my dissections in an Eastern college I observed the position of that curious little organ to vary greatly. In two subjects it was found to extend upward and outward, to lie over the kidney and to be firmly bound by peritoneal attachments to the outer wall of the ascending colon. In one of these cases it was about six inches long, and reached as high as the liver, the end being free and curled upon itself. Diseases of the organ in this unnatural position might easily have been mistaken for trouble in the colon, the kidney or the liver. In still another subject the appendix was between five and six inches long, extended downward into the pelvis, had a sort of mesentery of its own, and was not curled upon itself. In Gray's anatomy it is described as extending upward and inward behind the cæcum.

J. A. O., '93

Concerning the points at issue we are tempted to reply to the very interesting note of our correspondent by publishing a brief translation from the best and most recent book upon Appendicitis and Perityphlitis.*

**Appendicite et Pèrityphlite* par Ch. Talamon, Médecin de l'hopital Tenon, Paris, Rueff et Cie, Editeurs, 1892.

It is important to know the location of the appendix within the abdomen, especially since its excision is so often advised and practiced. Two points should be determined, viz., the insertion of the appendix into the cæcum, and the general position of the organ in its relation to the intestine. Its insertion is found at the posterior and inferior portion of the head of the colon. This point corresponds to the middle of a line drawn from the anterior superior spinous process to the umbilicus, which is the seat of the fixed pain that indicates appendicitis; and this is where one should seek for the organ when he wishes to tie it or resect it.

As to the position of the free portion and its relation with the neighboring organs, these are far from being constant. Of 200 cases studied by Ferguson, the direction and the situation of the appendix were as follows: In nineteen cases it was located upon the external face and the right side of the cæcum; eleven times it looked directly downward; eighteen times it was turned inward; seventy-five times it was in relation with the posterior part of the cæcum; and seventy-seven times it was so applied against the iliac fossa that (although the author does not say so very definitely) its perforation would necessarily discharge it into the subperitoneal tissue and thence occasion an abscess in the iliac region.

The frequency of its relation with the posterior face of the cæcum has also been noted. In this position Sappey says that it has been known to reach upward to the free border of the liver and by its extremity to come into contact with the gall bladder.

The frequency of this form of deviation of the organ is shown by the statistics of F. Hartley, who, in fifteen cases in which he removed it, observed its position very carefully. In this list of cases the appendix was located behind the head of the colon, 8 times; behind and beneath it, 1 do.; below and partly behind it in 1; below and in relation with the abdominal wall in 1; below and partly upon the anterior face of the cæcum, 1; upon the pelvic border and within the cæcum, 1; upon the internal side of the cæcum, 1; and upon its anterior face, 1.

According to Biggs, in three-fourths of the cases the appendix points downward and outward, while in a litte more than one-fourth of the cases it is situated behind the cæcum and the ascending colon.

To our mind these variations in the direction and the

relation of the appendix explain several important things. They show how palpation, when it is applied to locate the pain and the tumefaction, may lead one to believe that there is an inflammation of the cæcum when there is in fact a lesion of the appendix which is attached to it. They explain how purulent collections that have originated in the appendix do not always have the same location, since the perforation of the vermiform process sometimes occurs within, sometimes without, sometimes below and sometimes behind the cæcum. They also show how certain surgeons of the present day by relying upon the seat of the purulent collection in order to establish a distinction between appendicitis and perityphlitis, and who, by holding that the latter is never in relation with a lesion of the appendix, only expose their ignorance of the variable relations of this little organ.

THE CÆSAREAN SECTION BY HOMŒOPATHIC SURGEONS.

BOSTON, January 26, 1893.

Dear Dr. Ludlam:—Many thanks for the copy of the December *Clinique* and the article on your case of Cæsarean section. My congratulations on the successful issue. I think it is a great thing that we are able to grasp the circumstances in such a case and then when the time for delivery is at hand to step in and be instrumental in preserving both mother and child! * * * * * *

Have you observed that the journals of our school are very indifferent to the work that has been done by the surgeons of the homœopathic school? You will perhaps recall my case of Cæsarean section a few years ago. It was reported in the *N. England Medical Gazette*, but, as far as I know, no other journal made note of it.

Very cordially,

HORACE PACKARD.

It *is* a reproach to our literature that the best work of some of our best men has not been recorded and appreciated as it should have been. As a school of practitioners we have been forced to develop certain specialties, and the measure of our success is becoming established with our pupils and with our *clientele*, but we submit that the proper fraternal civilities on the part of our editors and younger authors especially is too often "dispensed with."

Miscellaneous Items.

We have the good news for our readers that, beside being granted an equal representation on the Board of Education of the Columbian Exposition, a location has been assigned for a Homœopathic Hospital and Dispensary on the World's Fair grounds, and the necessary building will be erected immediately. Parties interested and who are willing to help the enterprise in any way should write to Dr. G. A. Hall, 2400 Prairie Avenue, Chicago.———Prof. Shears has been ill but happily is around again. ——Dr. C. H. Evans, the well-known authority in Materia Medica, is lecturing before the first course class on the Organon.——Dr. C. C. Shinnick, of Salt Lake City, is Secretary of the Board of Medical Examiners for Utah Territory.——Dr. Belle Sheppard, formerly of Citronville, Ala., was recently married to Mr. C. F. Ayres, and will reside in Rockland, Maine.——Remittances for the current volume of the CLINIQUE are earnestly solicited by Prof. Bailey, 3034 Michigan Avenue.——Since leaving Vienna, Dr. C. J. Swan has been Clinical Assistant to Mr. Morton, Surgeon of the Royal London Ophthalmic Hospital.——Our current issue is undersize because of a twenty-page overflow in the January number.——The Medical Almanac for the season reads: about this time prepare for your final examination. ——Dr. O. L. Smith is winning his way bravely as assistant in the Clinic for Nervous Diseases, and Prof. Cobb's Clinic for the Diseases of Children is one of the most popular and satisfactory in the whole course.——The Commencement is set for March 23d, and we expect a good, big crowd of our friends to be present.——The annexed Circular from the Alumni Association will show what the attraction is to our friends and graduates from that quarter.

ALUMNI ANNOUNCEMENT.

CHICAGO, Feby. 12, 1893.

Dear Doctor: On the evening of Wednesday, March 22d, at half past eight o'clock, in the lecture room of the Lexington hotel, the tenth annual meeting of this society will occur. Each and every alumnus, whether or not a member of the society, is most cordially invited to attend this friendly reunion. On the following afternoon the thirty-third annual commencement exercises of the "Old Hahnemann" will take place in the Grand Opera House at two o'clock, to be followed by the annual banquet of the alumni, faculty and graduating class at "The Lexington" in the evening. Tickets for the banquet can be obtained from the Secretary upon early application for $2.50.

The plans which were decided upon at the last meeting of the society for raising an alumni subscription have been carefully and zealously carried into effect. Class Secretaries were appointed, and from them every alumnus has received a personal letter asking for assistance. *Two thousand dollars* already paid into the Treasury proves how faithfully they have labored for their Alma Mater, and it is earnestly hoped that this sum will be greatly augmented by the time of our approaching reunion.

Various suggestions have been offered as to how this money shall be used to the greatest possible advantage. Some prefer it to equip and endow an alumni ward in the new hospital; others to establish and continue a medical library for the use and reference of students and physicians in the new and now completed college building; still others propose to equip and carry on a laboratory for bacteriological research; and yet others suggest the purchase of a museum. This will be one of the important matters for the members present at this session to discuss and to arrange for.

The President will deliver a short address of welcome, to be followed by speeches from other members present.

Dr. H. P. HOLMES, Pres.
Dr. R. LUDLAM, Jr., Secy.

THE CLINIQUE.

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Original Lectures.

HERPES.

A LECTURE DELIVERED IN THE HAHNEMANN HOSPITAL OF CHICAGO, BY H. V. HALBERT, M. D., CLINICAL PROFESSOR OF SKIN AND VENEREAL DISEASES.

This term, so far as the above diseases is concerned, is in many respects a misnomer. The name was first used by Hippocrates as applied to "shingles," an eruptive disease which had a tendency to "creep" around the body, until it became a fixture in our medical nomenclature as referring to all eruptive forms of disease which seemed to extend around any part of the body in line with certain cutaneous nerve filaments.

To a certain extent the term is a correct one but it was easily confused with every form of "eating sore" which afflicted the integument, thus including lupus, certain forms of syphilis, eczema and even the graver parasitic skin troubles; on the other hand while the word herpetism is accepted in this eruptive disease which constantly invades new and adjoining tissue, it must not be understood as excluding other allied forms of dermatitis. The generic name has been given to many forms of vesicular disease which in reality belong to the different varieties of erythema. Herpes iris, herpes gestationis, pernicious urticaria and

pemphigus have now been eliminated from its class and there are left but three varieties which are known as herpes facialis, herpes genitalis and the most important of all herpes zoster.

Herpes facialis is known as the simple form and occurs most frequently on the lips, at the angles of the mouth or upon the alæ of the nose. As it generally appears as a sequela of coryza, or as the result of inflammatory or febrile conditions it is characterized by fever blisters. The eruption is grouped in the form of pearly vesicles which generally dry up and leave thin brownish scales which very soon heal. Should the vesicles rupture a painful erosion remains and, if seated at the angle of the lips, is liable to continue for some time as a painful, discomforting sore. The movement of the lips irritates the eruption and retards the healing. In connection with this form herpatic vesicles may appear on the mucous membrane of the lips or nares and, if excited by the acrid mucous secretions, may scab and crack until the erosion becomes fetid and pernicious. It is the most perplexing form of simple herpes and requires persistent local and internal treatment.

There is also a form of dermatitis which so clearly resembles herpes in its eruption that it is termed dermatitis herpetiformis. It is a rare disease and is not always typical inasmuch as it may appear in the erythematous, papular, vesicular, bullous or pustular form. The prodromal symptoms are pronounced. They begin with malaise and febrile disturbance, and are followed by excessive itching, which does not abate until the disease has run its course. The eruption is diffused and is generally of a form resembling erythematous patches, slightly studded with fine vesicles. The tendency is however to multiformity, and one variety so quickly changes to another that a correct diagnosis is insecure. These peculiar changes do not always come during the same attack, but are often manifest in an entirely different type in a relapse. For instance, in the first part of the illness the eruption is characterized by vesicles or pustules, but as recovery seems apparent the pri-

mary febrile symptoms are renewed and the eruption partakes entirely of the bullous or other forms. On account of these exacerbations, which may occur at intervals of weeks, or even months, the disease may be truly called a chronic one. All regions are liable to invasion, the extremities however being its favorite resort. Pigmentation, of a mottled or brownish hue, is liable to be the result of an extremely chronic case, and for this reason the marks of the disease are frequently confounded with specific taints.

Herpes of the genitals is found in both male and female subjects, and it is of frequent occurrence. It is seen in small clusters of clear vesicles located on the mucous or cutaneous portion of the labia or upon the glands. These vesicles are soon macerated, leaving small superficial excoriations. It is a recurrent trouble, and many times it is due to uncleanness and sexual excess. In its early stages it is easily confused with chancre, and it is, for that reason, often improperly treated with caustics. A few days' delay will settle the diagnosis and by no means impair the chances for internal treatment.

In herpes zoster we find the typical form of the disease under discussion. The first noticeable symptom is either a severe neuralgic pain or a marked burning or numbness in a circumscribed area corresponding to the superficial disturbance of a sensitive nerve. This may continue for days, when there will appear in the line of this pain groups of small red papules, each of which is surrounded by an "erythematous halo." These very rapidly change into vesicles, each of which seems to be seated on an elevated inflammatory base. The groups may come in succession but the vesicles of each group are co-eval. The groups which appear first are nearest to the central nervous system. The contents of the vesicles are at first clear, later milky, and last of all purulent, or in some extreme cases hæmorrhagic. The eruption may abort at the papular stage. The vesicles generally dry up and exfoliate in two or three weeks' time. Sometimes they break, leaving an ulceration, which causes a return of the neuralgic symptoms. This is due to the

cicatricial irritation at the finest terminal nerve filaments, and may continue for years.

Pathologically speaking herpes zoster is a neuritis having its origin in the ganglion of the posterior or sensory nerve, and the disease is manifest in the hyperæmia or inflammation of the corresponding cutaneous distribution. Robinson claims that it is due to a perineuritis, while other authors trace the lesion still deeper to the central spinal cells. When the disease is severe, and of long standing, the motor nerves partake of the neuritis and paralysis follows. This is clearly illustrated by the facial palsy in herpes involving the fifth nerve. Another fact is that the neuritis is always descending, and for that reason the eruption, in following the superficial terminal branches gives the appearance of a zone or belt.

As to causes there are no absolutely positive reasons. It may be from traumatism—the contiguity of inflammatory action, toxic or miasmatic conditions.

Relative to its location we have more definite knowledge. It is therefore best described as it appears. For instance we speak of the facial form which follows the distribution of the fifth or seventh nerves; the cervico-brachial follows the distribution of the four lower cervical and the two upper dorsal nerves, thus including a great proportion of the neck and shoulder; the dorso-pectoral follows the distribution of the third, fourth, fifth, sixth and seventh dorsal nerves. The last is the most common form and is so easily confused with intercostal neuralgia. From the fact that it is so near the "girdle" it has helped to define the term zoster. There are still other forms known as the dorso-abdominal; lumbo-inguinal; lumbo-femoral, etc., all of which have the same reference to particular nerve distribution.

The prognosis of herpes may be considered as almost always favorable. Especially is this true of the simple form which often terminates in a few days. In zoster the acute features do not last more than two or three weeks, and unless ulcers form, the eruption disappears without

cicatrization. The most unfavorable symptoms are the neuralgic pains. These may bother the patient for a long time, especially if there is any history of scrofula or rheumatic diathesis. In such cases the complications of a relapse may be most unyielding to all remedial agents. The frequent irritation of an affected part or any negligence of the proper diet or hygienic principles may cause an intermittent recurrence of the disease for years.

The treatment should be local, general and by internal remedies. The first is not properly curative, but limiting. To prevent the spreading of the local irritation, or to remove the poisonous secretions of the eruption proportionally lessens the demand for medication. In other words, we must recognize the local treatment as an adjuvant by no means inimical to the internal remedy. By the proper local protection we may anticipate or abort the severe cutaneous development—or when the eruption has appeared we may, by some bland application—prevent inflammatory extension and encourage an earlier resolution. For illustration, by painting the parts at the first sign of irritation, with flexible collodion or possibly with camphor chloral we may arrest the ulceration which is by all means to be avoided.

Again, to anoint the vesicles and surrounding parts with plain cosmoline and then cover them with soft absorbent cotton, or even an old silk handkerchief will not only afford relief, but will hasten the cure.

In the simple form of herpes the local requirements are few, as the tendency is toward a spontaneous recovery. Yet the application of dilute hamamelis, soda water, or even cologne water give great relief. Calendula jelly, or better still, the mild eucalyptus cerate keeps the parts soft and free from irritation. Should there be much excoriation or chafing from the clothing it may be well to dust on a little starch or prepared chalk, or equal parts of boric acid and hydrastis.

In zoster more astringent applications are required. Camphor cerate, belladonna cerate (especially in the

neuralgic form), or an ointment of lanoline and cocaine—five grains of cocaine to an ounce of lanoline—may be used to relieve the initial pain of the eruption. Equal parts of camphor and chloral hydrate, applied with a camel-hair brush, will often relieve when other applications fail. This, however, should not be used too frequently. Carbolic acid solutions, as a general thing, should be discouraged as being too liable to excite the parts. The excessive itching can be overcome by urtica urens cerate applied two or three times daily. The burning can be checked by zinc oxide. In addition to all this protect the parts as much as possible and give them rest. Light cotton batting slightly covered with cosmoline will greatly aid this effort. The individuality of each case should be studied, and no application should be used which in any sense is an irritant.

It may be added that the above measures are not considered as a means for removing the cause of the disease. They rather prevent its local development and keep the parts soft and pliable.

By the general treatment I refer to all the requirements of cleanliness—dietetic habits—and proper food. Considering the nervous pathology of the disease we must insist upon sufficient rest and freedom from nervous strain. All debilitating cachexia must first be removed, and if necessary, the tonic of another climate must be sought. The perfect care of the skin is important. Excessive bathing debilitates its functional activity, while too little attention in that respect leaves it in a dry and hard condition. The invigorating stimulant of a morning tepid sponge bath is sufficient. Equally important is the complete action of the alimentary canal. The liver and the bowels must perform their own duty, for the integument, which is overtaxed to remove too much of the systemic excreta, cannot withstand or overcome the additional poison of herpes.

And now most important of all is the internal remedy. This is to be chosen from its indications and potentized according to the demands of the case. I believe in the totality of symptoms, yet a totality which represents honest

symptoms and not the belief of enthusiastic provers. For that reason we must be guided by absolute physiological symptoms.

The first impulse gained from the general practice of the profession is to resort to graphites. There is no doubt of its value in vesicular eruptions, but it should not be used indiscriminately and if used at all, it should be in the higher potency. The inert plumbum is a positive irritant to the skin and is cumulative in its power. The primary action of the drug is upon the skin, lymphatics, digestive tract and the sexual organs. For that reason in the positive indications all of these parts will show some sign of disturbance. If the eruption is upon the face the neighboring lymphatics are always enlarged. For herpes genitalis, with enlarged inguinal glands, it is almost always a specific. It acts best upon the obese patient, that is an unhealthy obesity where there is a tendency to suppuration. In this respect it is the opposite of arsenicum but is allied with hepar sulphur, calcarea carb. or silicea, all of which are valuable should this remedy fail. The eruption of graphites "oozes a corrosive, watery, sticky fluid" and is attended with pronounced itching. It generally begins behind the ear and then spreads to the face. If the oozing is of short duration the skin becomes dry and cracks. If the discharge is lasting it becomes gummy. Graphites is really a remedy for children and does not always give such decided results in older patients.

Conium, though not often mentioned for skin diseases, has in my hands been of great usefulness. It is mostly indicated in middle aged or old people. Its value comes from its stimulative power on the cerebro-spinal system. It acts also upon the lymphaties and in older subjects will often avail where graphites fails. It resembles in many ways the action of gelsemium.

In the acute stage, when there is much neuralgic pain, there is no remedy which equals belladonna. If the skin becomes red or œdematous rhus tox., apis or arnica can be used, for a short time, with success. When the eruption

tends toward ulceration arsenicum, mercurius, kali bichromicum, or sulphur, are called for. Iodium is many times indicated in the latter part of the disease when the eruption becomes indolent and of a dirty yellow color. Should the herpes be surrounded by small boils or pustules, kali iodatum is useful.

Often there is an aggravating itching which is not confined alone to the eruption, but affects the whole body. The sores may become indolent and dark brown in color. Then it is well to administer lachesis for a few days. This should always be used in a high potency. Tartar emetic is decidedly indicated where there is a vesicular or pustular eruption which covers the greater part of the body and is associated with any catarrhal inflammation. After the eruption shows signs of disappearing it is well to hold to the tissue remedies.

From the symptoms and the remedies named above it ought to be no difficult task to treat any ordinary case of herpes.

THE SURGICAL DISEASES OE 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.

PAGET'S NIPPLE.—*Case, 20,921*, Mrs. —, æt. 49, mother of five children, is passing through the menopause, the menses having for the last year varied from six weeks to three or four months. She complains of her right breast which began to trouble her nineteen years ago, four months after the birth of her child. At first there came a lump about the size of an egg which she scattered by the local use of camphor and lard. It gave her no further trouble when with her finger nail she tried to remove what looked like a crust from a dried secretion on the nipple. This was five years ago. It bled, became very sore and was

*Continued from page 97.

followed by an eruption resembling eczema which has continued from that time and defied a variety of applications. She has had no internal treatment for it, but has been earnestly advised to have the breast removed. Her general health is good and there is no family history of malignant disease. She has never had any eruption of any kind elsewhere.

While this patient lies here comfortably I want you to examine this lesion very carefully. Observe its resemblance to a localized eczema, and the entire absence of glandular involvement both in the mammary and the axillary regions. Here we have a superficial eruption, and we ought not to advise the extirpation of the breast for its cure if we can get her well without it.

This is a case of what is known as Paget's disease of the nipple. It is apt to be mistaken for eczema, and is sometimes thought to be necessarily malignant. It differs from eczema in not being accompanied by itching symptoms from the first, in its sharply defined outline, slightly elevated border, and in its more brilliant color. There are no vesicles and no pustules, nor are there any such exacerbations as occur in eczema. There is a slight superficial induration which we do not find in eczema; but there are no such lumps and knots as occur in the gland when the lesion is cancerous. It came on insidiously and was chronic from the start. There was no suspicion of its malignancy until it had existed for some years and had failed to be cured by the routine methods that are applied to the ordinary forms of eczema. * * * * *

The clinical point for you, then, is that this affection is parasitic. It is a form of cutaneous psorospermiasis. The psorosperms are constantly present in it and are responsible for its inveterate character, and for its ultimate degeneration should it finally become cancerous. We shall withhold the knife and try the effect of the tar plaster locally, with graphites 6 internally.

THE CURETTE IN SARCOMATOUS DEGENERATION OF THE UTERINE MUCOUS MEMBRANE.—*Case 20,543* is that of a wo-

man aged forty who comes for relief from a recurrent menorrhagia of a very bad type. She was once curretted for it in this clinic and for fifteen months was exempt from an excessive flow, but now it is as bad as ever. When here before she was advised to undergo a vaginal hysterectomy, but she preferred that other means should be tried first; and now, in spite not only of the return of the hæmorrhage, but also of the fact that the chips brought away by the curette were decided by an expert to be sarcomatous, she insists that the same operation shall be repeated. [The uterus was, therefore, carefully and thoroughly curetted.]

CŒLIO-HYSTERECTOMY FOR MULTIPLE FIBROMATA. RECOVERY. *Case.*—Miss ———, æt. forty-one, began to menstruate at thirteen, the periods being normal until twenty, when they became painful during the first few days of the flow, and accompanied by great bearing down. At twenty-six she sustained severe injuries by jumping from a carriage, and ever since the back has been lame. For a long time she could not extend the right leg without a severe pain in the region of the right ovary. She had barely gotten over the effects of the fall when she was called to nurse a relative through a severe illness. Soon after, in 1889, she discovered a lump in the abdomen occupying the left center, and about the size and shape of a hen's egg. The tumor itself was not painful, but she ached all over and was extremely nervous. She had always suffered from bilious headaches, which now increased in severity. Urinating and lying on the right side would cause the tumor to change its position. July 13, 1890, this tumor was removed by Prof. Ludlam. She made a prompt and good recovery, but not long after detected a second growth which has been steadily increasing for two years past. Physically she is much stronger than she was before. Three months ago she had much pain and soreness in the lower part of the abdomen. When that left an eczema appeared upon the lower extremities accompanied by swelling of the same. Micturition is frequent and the urine copious.

February 13. While our patient is being anæsthetized I will call your attention to a few important clinical facts in her case. This will be my second operation upon this woman, for two and a half years ago I removed an oval

fibroid that was attached to the anterior and inferior portion of the uterus. It was as big as a cocoanut, and its short, beefy pedicle was as thick as my wrist, so thick, indeed, that I did not dare to trust to any form of ligation other than the rubber ligature, as you have seen me apply it in supra-vaginal hysterectomy. She made a good recovery and in due time resumed her duties as a teacher. The body of the uterus was somewhat enlarged, but there was no evidence of an interstitial growth, and no fibroid buds could be found anywhere.

Now, however, we recognize another tumor that has grown more rapidly than fibroids usually do, and which seems to include the body and fundus of the womb; while, by the conjoined manipulation, we can also feel several smaller ones just above the vaginal roof. So that, especially since the physical signs are confirmed by our previous knowledge of the case, we can make a "bold diagnosis," and give an equally decided opinion as to what should be done for our patient.

It is probable that some of you have already decided this to be a case of "recurrent" fibroid. Such a title would be inappropriate because genuine recurrent fibroids are sarcomatous and therefore malignant, or semi-malignant. After removal they recur at the old site, or somewhere else, with the same characteristics of a low grade of vitality and a manifest tendency to degeneration. But the nature of the white, firm fibroid, such as I have already taken from this patient, is benign, and although when they are very large they do sometimes break down through age, or accident, or from having been tampered with, only a small share of them ever become malignant. Besides, they are almost always multiple, and having found one, you should always look carefully for more of them. Especially is this true of such as are extra-uterine, for having removed a large one you may usually detect some smaller ones that are half hidden beneath the peritoneal coat of the uterus.

It is these duplicate buds which may develop and finally

reproduce the same local symptoms that were first relieved by the excision of a single fibroid. But the lesion does not recur in the sense that a malignant disease repeats itself; it only persists in illustrating a strong family propensity to multiply and increase. I have recently shown you a specimen in which by vaginal hysterectomy I removed a uterus that had twenty-one fibroids attached to it; and another with nineteen, and yet none of these tumors showed any signs of malignancy, all being firmly encapsulsed, white and fibrous. Both women made good recoveries.

The choice of surgical intervention in such a case as this is very important. Evidently a hysterectomy of some sort is called for. If our patient had borne a child, or children, and the vulvo-vaginal passage had been developed, the infra-pubic operation for the removal of the uterus and the tumors that are attached to it would be preferable. But those conditions are not present. Or, if the uterus had ever been enlarged and elongated as it is at term, it could be much more easily brought to the lower angle of the wound and its stump secured than it can in this case. And yet I believe that an abdominal hysterectomy is best in this particular instance.

Operation. A cœlio-hysterectomy was accordingly made before sub-class No. 1. The pelvis was found to be so completely filled with the womb and the fibroid growths that they were dislodged with great difficulty. The uterus was like an impacted fœtal head, and could not be made to rise except by the conjoined manipulation. The pedicle was secured by the rubber ligature, and, the scar-tissue and the old stump having been cut away, the wound was dressed aseptically with the greatest possible care.

On examining the tumor afterward seven fibroids were found attached to the abdominal cervix and to the lower segment of the uterus, and one as large as the fœtal head that grew from the body and fundus of that organ. All were of the hard, door-knob variety.

Wednesday, March 8 through the most assiduous care on the part of our house physician, Dr. Alexander, and of

her excellent nurse, Miss Martin, this patient has done extremely well. In view of the fact that the pedicle did not drop until the twenty-first day, and that during that time she was exposed to the risks of its necrosis and to infection from it, this is saying a great deal. Here is what remains of that pedicle, with the pins and the ligature intact. You will observe how nearly the rubber had cut through the stump, and with what fidelity it kept its place. The abdominal wound has healed throughout and very firmly except at the site of the stump the umbilicated depression of which will soon fill with healthy granulations. Our patient's recovery is assured.

FLOATING KIDNEY WITH CONSEQUENT NEURASTHENIA AND OBSCURE PELVIC DISORDERS.—Mrs. —, aet. 22, menstruates irregularly and with much pain; has been married two and a half years but has never conceived; complains of general weariness, and cannot walk or stand long without distress. She has pain through the entire abdomen and the right side, which pain has been worse during the last year. There is alternate constipation and diarrhœa, and she suffers greatly from "nervous dyspepsia."

Wednesday, Feb. 22. Examination revealed a floating kidney in the right side, which was carefully demonstrated to the class.

You are aware of the fact that a mobile kidney like this one is sometimes associated with dyspepsia and neurasthenia, with abdominal tumors and with chronic invalidism. But you may not have realized that it often plays a more or less important part in the clinical history of utero-ovarian disorders. Indeed a knowledge of this fact is one of the many lessons that have been taught by gynæcological surgery; for, until the wandering kidney could be identified in the living subject, and its associate and accidental symptoms noted and studied, we really knew very little about it.

That this lesion of place is much more common in women than in men is significant, and so also is the fact that whenever it is characterized by a decided array of

nervous symptoms, as it usually is, those symptoms take the form of hypochondriasis in men and of hysteria in women.

Among the alleged causes of the ectopic kidney to which women are especially exposed are frequent and rapid child-bearing, the traumatism of blows and falls, tight-lacing, the wearing of high-heeled shoes, relapsing peritonitis, uterine displacement, and disease of the uterus and its appendages. The effect of emaciation and inanition from low fevers and lingering disease is to predispose to this displacement through the absorption of the mass of fat in which the renal capsule is imbedded and by which the kidney is suspended. * * * * * * * *

Such a displaced kidney as we have in this case is sometimes associated with chronic peritonitis and ascites.

Case.—Fifteen years ago a woman was sent to my clinic with what was supposed to be an ovarian tumor. The abdomen was so large that a satisfactory diagnosis could not be made, or at least we thought so in those days, without tapping. When the fluid had been removed, a tumor resembling the kidney was found high and dry to the left of the mesian line. I pronounced it a misplaced kidney and she was put upon remedies to prevent the return of the dropsical effusion. But she soon filled up again and then I made an exploratory incision, took the floating kidney in my left hand and satisfied myself of the nature of the case. The peritoneum was studded with tubercles; there was only a rudimentary uterus and no ovaries, a congenital condition which explained the fact that she had never menstruated. My friend, Dr. Steinhaus, afterward tapped that patient a dozen times or more, and when she finally died our diagnosis was confirmed by a careful autopsy made in the presence of a number of the students.

That a luxated kidney may be an important factor in the diseases of women was forcibly advocated by Thiriar, of Brussels, at the last meeting of the Obstetric and Gynæcological Congress. He went so far as to insist that twenty per cent of these special diseases were due to this cause, and very properly insisted that in every case of obscure pelvic disorder one should look for a misplaced kidney. But that this lesion is often and usually overlooked is no

argument against its frequency; and that all sorts of operations have been ineffectually made upon the uterus and ovaries when one or both the kidneys were away from home does not prove that nephrorrhaphy is a cure for all kinds of intra-pelvic mischief.

THE CHOICE BETWEEN TUBO-OVARIOTOMY AND VAGINAL SALPINGECTOMY.—Wednesday, March 8. This is the fourteenth day since we made a double tubo-ovariotomy in *Case 20,930*, and our patient is going on well. The case was a bad one, the ill health dating from an attack of typhoid fever twenty-five years ago. Sub-class 3 will remember that we found the left ovary prolapsed and firmly adherent in the Douglas pouch, while the right one and its tube were lost until found and separated from a bed of unusually firm adhesions.

Before the operation one of my assistants asked, "When it is so accessible, why not take away that prolapsed ovary and its tube through the vaginal roof?" Let me answer the question for the general class. With the improved technique of the present time access to the peritoneal cavity *per vaginam* is much easier, safer, and more expedient than ever before. But, like other operations, the removal of the uterine appendages through that passage instead of through an abdominal incision is not suited to all cases indiscriminately. Indeed, it is only exceptionally called for. If the appendages on both sides are so diseased that they need to come away; if the prolapsed ovary is fixed and immobile in the Douglas pouch; or if the case is one in which for many years the patient has had relapsing peritonitis, dysmenorrhœa and dyspareunia that have failed to be benefited by careful and judicious medical and local treatment, a laparotomy and the Battey-Tait operation should have the preference. These were the conditions that determined our choice in the case under review.

If the clinical history of our patient had shown an absence of severe inflammatory attacks and an exemption from their immediate consequences; if the neurotic and

hysterical symptoms had predominated; if the lesion had been unilateral, and the ovary free, or less firmly anchored between the uterus and the rectum; and even if the trouble could have been traced to a comparatively recent labor or abortion, a vaginal salpingectomy might have been our choice. For, whenever it is expedient, there are certain advantages that attach to this operation. It can be more quickly made, and there is less shock attending it; if one ovary and its tube are healthy it can be detected and the organs spared, while if they also, and the womb as well, are seriously diseased, the operation can be so extended as to remove them all by a vaginal hysterectomy. And this method secures more thorough asepsis and better drainage than is possible in a certain share of laparotomies. I have no doubt that, when its limited range is more definitely made out, it will be more frequently practiced than formerly.

The after-treatment of this case, which is now convalescent, illustrates a point of which I have spoken to my classes quite frequently, *id est* the propensity in women who are fat, flabby and anæmic to the formation of abdominal abscess along the line of incision. You will remember that in this case the probability of such an experience induced me, as it always does under similar circumstances, to close the peritoneum separately with the lost suture so that if pus should form above it, the door for its admission into the abdomen would be closed.

Bearing this fact in mind and not forgetting that the morphine habit sometimes favors such a complication, you will not be alarmed when on taking some of the sutures at the end of the first week there is an escape of nasty, stinking pus; or when a few days later a lot of sloughing tissue is discharged from the wound. This is what happened in the case before us; and it was wholly due to the conditions named. But under the persistent and careful use of the peroxide of hydrogen locally and silicea internally the parietal absc ss is being disposed of and she will soon be well again.

Clinical Society Transactions.

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

FEBRUARY MEETING, 1893.

The regular monthly meeting of this Society was held in the Great Northern Hotel, Saturday evening, February 25th. Dr. A. A. Hinkle, First Vice President, in the chair.

REPORT OF THE BUREAU OF CLINICAL SURGERY.

BY GEORGE F. SHEARS, M. D. CHAIRMAN.

IX. MALIGNANT TUMORS OF THE PAROTID, BY DR. G. F. SHEARS.—In selecting the following case for the subject of a report, and in devoting some time to its anatomical relations, its tendency to take on a malignant growth, and the manner of its removal, I have been influenced by the fact that so little is said on this subject that is helpful, and so few cases are recorded in our journals. Thus in looking over a most excellent journal devoted entirely to surgery, I could not find in its issue for the past five years but one recorded case of removal of the parotid gland.

On the other hand the journals are full of cases of removal of the breast, with minute directions as to the operative technique, with carefully tabulated statistics showing the value of the operation at different periods in the history of the growth and the results obtained in the different varieties of malignant growths that affect this organ.

Much of this is due to the comparative infrequency with which the parotid gland is involved compared with certain other glands or organs, as the breast, uterus, stomach, liver or axillary glands.

Thus, while a celebrated writer on malignant disease is enabled to collect statistics from one source of six hun-

dred removals of the mammary gland, from another two hundred and sixty-six, he is enabled to quote only twenty-nine patients from whom the parotid was removed for sarcoma and seventeen for carcinoma.

While this does not of course represent the actual number of operations performed, it does give some relative idea of the frequency of the disease and of the operations made for its treatment.

The gland is not an easy one to remove. My colleague, Prof. Ludlam, to whom I described the operation, said he remembered distinctly that during his college days a discussion took place among several celebrated surgeons as to the advisability of the removal of this gland, and his professor of surgery (Gibson) declared that the gland could not be removed.

Let me call your attention to its anatomical relations. Briefly, it may be described as an irregular shaped gland lying in front of the lower half of the ear and below it. It extends from the zygoma above to a little below the angle of the jaw, and from about the middle of the masseter muscle to the external meatus. Posteriorly it is quite irregular in shape, being bounded by the external meatus, the mastoid process, and the sterno-mastoid and digastric muscles. It not only lies over the masseter muscle superficially but also dips down behind the ascending ramus of the jaw and ascends forward beneath the ramus between the pterygoid muscles. It sends two processes deeply into the neck, one of which extends behind the styloid process and the sterno-mastoid muscle, and the other in front of the styloid process and behind the articulation of the lower jaw.

It is anatomically important, not only because of its irregular shape and prolongations, but because of the important vessels and nerves which penetrate its substance or lie close to its borders. The external carotid artery passes through it, the posterior auricular, the transverse facial and the internal maxillary are given off in its substance; the latter passing deeply behind the neck of the jaw.

Upon its outer surface lies the vein trunk formed by the union of the temporal and internal maxillary veins, and through its body passes a venous branch connecting this trunk with the internal jugular. Close to its deep surface are the internal carotid artery and the internal jugular vein. It is pierced from before backward by the facial nerve and its branches. Thus it is not only in close contact with important structures, but its removal necessitates the absolute severance of important arteries, veins and nerves. Malignant tumors of the parotid may be either sarcomatous or carcinomatous, the gland being subject to either form of growth. But statistics are so imperfect that it is almost impossible to determine very accurately the relative proportion of these growths. Personally I have met more frequently with the sarcoma than the carcinoma, although C. O. Weber's table of the frequency of growths in this locality would indicate a very different condition of things. He says: enchondromata 28; sarcomata 20; carcinoma 26; adeno-sarcoma 4.

But whether you accept my own personal observations or the table furnished by Weber, the relative proportion differs very much from that found in malignant tumors affecting the mammary gland where the percentage of carcinoma is much greater than that of sarcoma. The sarcoma may be either round or spindle celled. Quite frequently it contains a large amount of other tissue—cartilage, mucous, adenoid or fibrous tissue. The proportion of this tissue is often so large that it is mistaken for a chondroma or myxoma, unless examinations are made from several portions of the tumor. Indeed, the history of these growths leads me to believe that many of them are primarily chondromas, myxomas, or fibromas, and that malignant growth does not take place for some time after the appearance of the tumor.

In this way is to be explained, I believe, the many cases in which the tumor has remained in a quiescent state for ten, twenty or thirty years, and then commenced

to grow rapidly and show all the signs of malignancy. Take the case of Mrs. E. R., age sixty-three, who consulted me in regard to the advisability of removal of a growth involving the ear. Twenty years ago she first noticed a small, hard nodule in front of the lobe of the ear, and underneath the skin. It grew slowly and without pain; when it had reached the size of a small egg it apparently ceased to grow. She consulted several physicians who said that its removal would be dangerous, and advised that it be left alone. A year ago it began to grow until it involved the ear and extended below it. It became irregularly nodulated, and a few months ago several of these larger bunches began to soften. One of them has ulcerated, and discharges a bloody pus. Another looks very red and angry, and presents evidences of fluctuation.

Examination of certain portions scraped from the ulcerated surface shows evidence of sarcomatous degeneration. I have no doubt this case was in its incipiency one of chondroma. In this connection Chavasse suggests that the presence of these tumors may be explained on the theory that certain cells destined for the ear were stranded in the parotid, and there remained quiescent until puberty, when starting into growth the cartilaginous nodules by irritation excited a new formation. This might remain innocent for years, and then a degenerative step result in the formation of a sarcoma.

Whatever the cause or form, sarcoma of the parotid is more benign in its earlier stages than one would expect from its location and vascular supply, much more so than sarcoma of the antrum, testicle, the bones or the lymphatic glands. The tumor usually grows slowly and does not invade the neighboring lymphatics nor produce ulceration of the skin until it has reached a large size. Much of this sluggishness is probably due to its composite character and its tendency to be encapsuled. The carcinoma on the other hand is a much more rapidly progressive and dangerous growth. It may attain a large size in a few months,

involve the whole gland, invade the lymphatics and infect the healthy tissues, bone, muscle and skin.

It is this tendency which makes it difficult to remove the whole disease. Like carcinoma in other parts of the body secondary deposits may form in distant organs simultaneously, or nearly so, with the appearance of the primary tumor. The differentiation of these growths chiefly depends upon the rapidity of growth. Bilroth considers the occurence of facial paralysis from the pressure of a parotid tumor to be regarded as a sign that it is probably carcinoma.

Other tumors rarely produce paralysis by pressure, although paralysis frequently follows their removal. Much discussion has been indulged in by physicians of the advisability of interfering with malignant growths of the parotid, and earnest advocates have been found for and against it. As usual I believe the safest and wisest ground is found somewhere between the radical advice of the enthusiastic surgeon, and the conservative advice of the cautious physician.

Each case must be decided on its own merits. Thus a rapidly growing tumor, soft in feel and accompanied by dyspnœa, dysphasia, facial paralysis, or in which accompanying masses may be felt in the fauces, offers very little hope of benefit by operative procedure. And the conscientious physician may believe that the best interests of the patient are conserved by advising non-interference. While a slowly growing tumor, not accompanied by these evil signs, even if it has attained large size, is adherent to the skin, and that discolored, may be quite successfully treated by excision, and the surgeon may with clear conscience advise his patient to submit to removal by means of the knife. The line of incision depends upon the extent of the growth. If the skin is not involved, a longitudinal incision over the tumor in such a way as to expose the temporal artery above, and the carotid below, joined by a transverse one over the facial part of the tumor, will best expose the growth. If, however, the integument is involved, no regu-

lar line of incision can be adopted, but all infected tissue must be removed.

Whatever plan is followed the exposure of the growth must be ample in order that every tissue to be cut may be inspected before division. Two methods of extirpation may be now considered, each one of which has its advantages. You may commence after freeing the anterior portion below, and work up or above, and work down.

As stated by M. Berrard, by the first method the blood flows away from the wound and does not obstruct the operator; the same vessels do not have to be cut more than once, and if any large vessel has to be cut, it is secured early diminishing the amount of hæmorrhage.

By the second method you have the opportunity of freeing all the less important parts first, and having a clear field when you are ready to deal with the more important structures. This is the plan I have usually adopted, and so far satisfactory. Prompt control of the hæmorrhage, the prevention of facial paralysis, and the complete extirpation of diseased tissue are the three points to be kept in mind.

The vessels to be looked for are the superficial, temporal, the transverse facial, the occipital, the posterior auricular, the internal maxillary and external carotid arteries, and the external jugular vein. At the same time it must be remembered that many of the smaller vessels are much enlarged as the result of the presence of the morbid growth and that therefore mistakes as to the vessel presenting are liable to be made. The old advice to tie the common carotid artery before commencing the operation is not, I believe, commonly practiced and may be dispensed with if one is careful to pick up every large artery between two pair of forceps before dividing it. This same procedure may be practiced in the case of large veins, thus not only preventing hæmorrhage but also the danger of the entrance of air. In the case of large malignant growths paralysis cannot usually be prevented. If the nerve is

stretched out over the tumor it may in the case of encapsuled sarcoma be dissected off.

Unfortunately the nerve is usually found on the under surface of the growth or passes through it, in which case the preservation of the nerve is still more difficult. In cases in which the tumor is small, and the deep incision is not carried above the level of the line drawn horizontally three-fourths of inch below the lobule of the ear, the nerve trunk may be avoided. The complete extirpation is more easily accomplished in a sarcoma on account of its frequently being encapsuled than in carcinoma. In the latter and in the round celled sarcoma the breaking down of the soft tissues often baffles all attempts at thorough removal. The results of operation so far as I am able to determine from my own experience, and from information gleaned from others is that fully fifty per cent of cures result from the removal of moderate sized sarcomas, while life is prolonged and suffering relieved by the removal of those of large size not excluding the tumors in which ulceration has occurred. Carcinoma on the other hand offers little prospect of cure.

The patient who has been the text for these remarks and whose photograph I now show you, was operated upon by me in Hahnemann Hospital November 11, '92, before the entire class. His history is as follows:

Case.—Mr. B., age 60. Twelve years ago a tumor was noticed a little anterior and below the right ear. It grew gradually and without pain. As it grew it seemed to lift the ear up and to close the auditory canal. The skin was not adherent to the growth. Two years ago an incision was made over the tumor by his surgeon, Prof. Peck, the integument dissected off and the tumor removed.

No sooner had the wound healed than a nodule appeared in the cicatrix. When the patient presented at the hospital the recurrent growth was thirteen inches in circumference and involved the entire ear. It extended from the external canthus to about an inch below the ramus of the jaw and from the malar bone in front to a point one and one-half inches behind the ear.

It stood out from the head fully four inches. The base

was hard and lobulated. The surface presented three soft fluctuating lobules covered with angry, purple integument and an ulcerated surface from which hæmorrhage occurred daily.

The patient was failing rapidly, but the appetite was good and the heart beat regular, although he claimed he was subject to attacks of angina pectoris. Believing that unless the tumor was removed the frequent hæmorrhages would soon destroy his life, operation was advised.

Observing the usual antiseptic precautions the tumor was removed, the incision being elliptical in shape and extending clear around the base of the tumor, sacrificing the integument and removing the external ear. The wound was packed with iodoform gauze and a moist dressing applied. The patient reacted nicely and the wound granulated readily. No attempt was made to cover the granulating surface, the patient being advised that skin-grafting would not be attempted until it seemed probable that there would be no immediate recurrence of the growth. The part removed was submitted to Prof. Lyon, who made the following report: The specimen removed is a fibro-sarcoma, the fibrous tissue forms the body of the tumor while sarcomatous elements are sparingly distributed through the growth. All the lobules are of the same character.

The patient made a good recovery and left the hospital three weeks later.

March 16, 1893. Patient returned with wound healed and no signs of recurrence. General health much improved.

Hospital Notes.

THE EYE AND EAR CLINIC.

SERVICE OF PROFESSOR WATRY.

HYPOPION, KERATITIS COMPLICATED WITH IRITIS. *Case 14,880.*—November 8. A laborer fifty-two years of age, while shoveling small bits of stone out of a quarry on a very windy day three weeks ago, had a sudden feeling in the left eye, as though something had gotten into it. The eye felt bad all day. The next morning it was very much easier, and he paid no more attention to it until a few days later, when the eye began to feel weak to the light, and would leave a darting pain through it occasionally during the day. It gradually grew worse day after day. He ascribed all the suffering to a cold in the eye, and thought that by staying at home it would soon get well. Contrary to his expectation, the eye, and the whole side of the head, became so painful every evening for the last week, that he had to walk the floor and spend many sleepless hours.

Present state.—Very much photophobia and lachrymation. A very bright red zone of blood vessels around the corneal margin, with considerable congestion of the ocular conjunctiva. A large gray infiltration on the lower half of the cornea, reaching almost from the corneal margin to the upper portion of the pupil. The remaining cornea slightly hazy, like a clear piece of glass which has been breathed upon. Along the lower portion of the eyeball between the cornea and the iris, a small quantity of yellow pus is noticeable. Although only the outer margin of the iris can be seen, it distinctly shows a change in its color as compared with that of the other eye. There is almost total loss of sight.

This is one of the most dangerous eye troubles that we have to deal with, because the sight is almost always lost, or greatly impaired, either through the extensive sloughing of the cornea causing leucoma, or through perforation of the ulcer causing prolapse of the iris, and obliteration of the pupil due to the anterior synechia and the opacity of the cornea which results when the ulceration heals. Corneal ulceration with pus in the anterior chamber is

not so very frequent, but it cannot be mistaken when present.

By an inexperienced eye hypopion might be mistaken for onyx, but the difference is quite apparent as in the latter condition the pus forms between the layers of the cornea, and the opaque substance is not as deep in; further, if the onyx is not too large you can always see the iris behind the pus between the lamella of the cornea, while in hypopion the iris behind the pus cannot be seen at all.

Hypopion may take place in three different ways; first, the ulcer may be deep-seated, and the fibrinous infiltration may ooze through the remaining layer and drop down into the anterior chamber; second, the cornea may perforate and the pus enter the eye; or third, a severe form of iritis may cause a great deal of exudation to be thrown, out which usually collects at the bottom of the chamber. Our chief endeavor in this case must be first to reduce the inflammatory condition of the eye ball; second, to check the sloughing of the cornea and reduce healthy granulations.

To bring this about we must combine local with the internal treatment. We will have to depend mainly upon atropine and hot water to relieve the pain, and to bring about healthy granulation. As we have a rather extensive sloughing of the cornea and considerable iritis we prescribe a one per cent solution of the sulphate of atropia to be used every three hours, and to apply hot fomentations whenever there is severe pain. In order to hasten suppuration we give the patient hepar sulphur 30, to be taken four times a day, and apply the pressure bandage.

November 10th: The patient has had considerable pain but has been able to keep it under control with the hot applications. Had to get up several times during the night to make the application. There is a great deal more pus in the anterior chambers, it now reaches almost to the center of the pupil. The cornea of the base of the ulcer bulges slightly. Although Saemisch's operation, which consists in cutting through the base of the ulcer, is usually advocated in similar cases; it is best not to be too hasty as it is connected with a great deal of danger to the eyeball. There is no doubt that there is considerable more pus in the anterior chamber than there was two days ago, yet it seems that the infiltration of the cornea has not been spreading, nor is it possible to have such a large quantity of pus in the eye without rupture of the cornea, unless there is some other form of inflammation going on at

the same time. Although the iris is hidden from view we must conclude that there is as a complication a severe inflammation of the iris, and that a great deal of the exudation has its origin from this part of the eye. We advise to continue the same treatment.

November 15th. The cornea is hazy, the ulcer not so deep; the hypopion somewhat smaller. The pus in the anterior chamber has now a reddish-yellow tint. The local treatment the same. Internal treatment merc. sol. 3, three times a day.

November 22d. Patient has not been obliged to make the hot applications as often; the hypopion is about the same; the cornea is healing. Local treatment the same. Hepar sulph. 30, three times a day.

November 29th. Has had considerable pain through the head; the eyeball has not been so painful; the hypopion is gradually lessening. Same treatment.

December 15th. The hypopion has almost entirely disappeared. Has had hardly any pain. Did not have to get up for several nights to make hot applications. The ulcer of the cornea is very nearly healed. Local treatment same. Internally, merc. sol. 3, three times a day.

December 29th. No more pus in the anterior chamber. The cornea is a great deal clearer, so much so that almost the entire iris can be seen for the first time. The pupil is small and irregular. Posterior synechia, capsule of lens along the lower portion of the pupil opaque. The upper portion of the pupil about the size of a large pin head; is clear; vision $\frac{10}{100}$. Same treatment.

January 10th. Has had no pain whatever. The light does not seem to annoy the eye very much. Treatment atropine twice a day; merc. sol. 30, once a day. Colored glasses.

February 23d. Same treatment has been kept up. He has been at work for several weeks. Has had no difficulty with the eye to speak of; vision $\frac{10}{50}$. Complains that the eyes feel sandy and that the lids are somewhat stuck together in the morning. Sulphate of zinc ½ per cent solution twice a day in the right eye; once a day in the left.

INCARCERATED IRIS DUE TO INJURY. *Case 13,460.*—March 12, 1889. Boy three years old. Last Saturday the child happened to get hold of an open pen-knife. Suddenly he began to scream, and when the mother went to take him her attention was at once called to the right eye by the

bleeding and watering. A physician was called who prescribed some medicine to be dropped into the eye, and gave instructions to tie it up. The child has been very restless nights and has a good deal of fever.

Present Condition. Slight photophobia. Very little redness of the eyeball; a large incision through the center of the inner half of the cornea. The incision runs somewhat oblique beginning one and a half line from the upper corneal margin, running downward and inward ending in the lower portion of the ciliary region. The corneal wound is closed. A small portion of the iris projects somewhat and adheres to the cornea. There is some blood in the anterior chamber. The eyeball is slightly tender on pressure. A similar condition must always be looked upon with a great deal of suspicion, for we can never tell when and where the trouble will end. An injury that involves the ciliary region is always very dangerous to the other eye. This danger is increased when there is incarceration of the iris into the corneal wound. If we had seen the patient very shortly after the injury, that is, before adhesions had taken place, we might have been able to release the iris and hold it back by using a strong solution of atropine. Such an operation at the present time is not advisable, because the iris does not prolapse far enough and too strong adhesions have already taken place between the iris and the cornea. There seems to be very little inflammatory reaction of the ciliary body or else the eyeball would be very sensitive to pressure.

Taking the general condition of the eye into consideration, it seems that we are not justified in removing the eyeball at once. But it is best to wait for more serious developments. It is not as though the patient was many miles away from an oculist. If such were the case removal of the eyeball would by all means be advisable. Being within the reach of an oculist every day treatment is advisable. Although the eye will never be of use as far as sight is concerned, yet it is far superior to an artificial eye at this stage of life. It remaining in the socket will cause the orbit to develop in the same proportion as the other, while if removed, even if the artificial eye is fitted, there will be more or less arrest of the development of that side causing at times considerable asymmetry about the face.

The treatment will be a one per cent solution of atropine to produce traction upon the pupilary portion of the iris in order to draw it in as much as possible. This will

give nature a better chance to cover the incarcerated portion of the iris with corneal tissue and thus to lessen the irritation to the iris. The atropine will also help in keeping down the inflammation.

For the fever and restlessness we prescribe belladonna 3 x every two hours. A pressure bandage is very necessary to support the cornea.

March 14. The mother states that the child has less fever and rested more quietly. There is some bulging of the cornea; otherwise the eye is about the same as when seen last.

March 19. The child has been feeling very much better generally. The cornea bulges somewhat more than before, but there is less blood in the anterior chamber. Same local treatment. Prescribed merc. sol. 3, three times a day.

March 28. The iris has receded somewhat; the cornea does not bulge near as much, and the blood is almost entirely absorbed. Atropine twice, and merc. sol. once a day.

April 4. The lower half of the anterior chamber is obliterated through the adhesions between the iris and the cornea. The cornea now bulges but very little. Some slight circumcorneal congestion. Discontinued atropine protective bandage and merc. sol.

April 16. The inflammation has entirely subsided. Prescribed colored glasses. No treatment.

May 2. Eye has been somewhat inflamed for a few days. Locally, atropine, twice a day.

May 7. The inflammation has again subsided. No treatment.

December 8, 1892. The mother returns with the patient. She stated that the boy has not had the least trouble with his eye until two weeks ago, when the eye began to look a little red and the boy complained of the light hurting it. He has been going to school all winter. The eyeball looks about the same in shape as it did three years ago. There is a slight congestion of the palpebral and ocular conjunctiva. No tenderness whatever of the eyeball on pressure. Advised the mother to keep the boy out of school and to let him wear colored glasses. Prescribed atropine, to be applied twice a day.

February 23, 1893. The eye feels all right again for the last two weeks. Discontinued treatment.

HYALITIS.—*Case 14,829*, Sept. 28, 1892. A woman 47 years of age has had weak eyes as long as she can remember. For many years she has been obliged to make a living by sewing. During the past six months the eyes have given her a great deal of trouble. Sometimes they would blur and pain her so much that she had to rest them for a day or more. For over a week past she has not been able to use them. Everything looks very blurred and she sees many black specks in front of the right eye. She has been subject to frontal headaches for years, with a great deal of dizziness. The eyes appeared weak and congested, with large pupils. The ophthalmoscope showed a slight turbidity of the vitreous humor. The fundus, although it could only be seen indistinctly on account of the existing hyalitis, showed a change in the choroid along the macular region. This change consisted in a number of small patches considerably paler than the rest of the fundus. The edges of the atrophied spots were irregular and bordered with pigment. The direct ophthalmoscopic examination showed the right eye to be myopic and the left to be hypermetropic. The actual sight with the right eye was $\frac{1}{10}$ and with the left $\frac{1}{40}$. The fact that the patient has one near-sighted and one far-sighted eye, with inflammation of a portion of the refracting media, explains why she is having so much trouble. What the patient needs most is rest for a short time and then be properly fitted with glasses before she begins to use the eyes.

In order to give the eyes complete rest, we will use a one-half per cent solution of atropia twice a day and have the patient wear dark colored spectacles whenever she is exposed to the light; and also advise her to stay in a dark room as much as possible. Belladonna 3 four times a day.

October 6.—Headaches some better, the dizziness has disappeared and the eyes look clearer. Same treatment.

October 13.—Has been steadily improving. Is feeling much better generally. Belladonna 3 once a day.

October 20.—Has had no headache for a week. The sight is better. Discontinued the atropine.

October 27.—Tested the eyes for glasses. With — 2 D cyl. axis 180 for the right eye she could see $\frac{1}{10}$; left eye + 1 D cyl. axis 90 she could see $\frac{1}{30}$. She could now see to read the finest print with the right eye, but with the left eye everything looked very blurred, which was to be expected as the presbyopia was not yet corrected. After adding a + 1 D spherical to the above lens she could

see almost alike with both. Prescribed the glasses for near work.

November 10.—Has been using her eyes all day long for the past week. Has had no difficulty in seeing, but the eyes feel tired evenings. No treatment.

CONVERGENT STRABISMUS.—*Case 15,051*, January 24, 1893. This patient has had trouble with her eyes as long as she can remember. She is now 17 years old. When looking steadily at an object for a short time the eyes begin to ache. On holding the finger at about eighteen inches from the patient's eyes and asking her to look at it, it is observed that the left eye fixes the finger, but the right eye moves independently of the left and turns in toward the nose so that we can see only a portion of the pupil. On measuring with the strabismometer we find that the eye turns in to a degree of 11 m. m. The vision is greatly impaired, for she can count fingers only at ten feet. The sight of the left eye is almost normal. Glasses do not improve the right eye. The left is a little far-sighted. The patient is very anxious to have the eye straightened. Frequently patients are under the impression that when the strabismic eye is operated on the sight will return. This is an erroneous idea. Exceptionally the eyesight does improve some, but usually it remains about the same. It is well therefore to inform the patient that the operation will be merely for cosmetic effect, and if she is satisfied to return next month.

Feb. 16th. Patient returns for the operation. The operation does not depend so much upon manual dexterity as upon a thorough knowledge of the anatomy of the parts. When we sever the internal rectus muscle from its insertion it recedes from 4 to 7 m. m.; the degree depends somewhat upon the severing of the connective tissue fibres between the muscles, Tenon's capsule and the sclera.

Having by actual measurement a degree of 11 m. m. in this case it is at once apparent that the defect cannot be corrected by simply performing tenotomy of the right internal rectus muscle. We may follow one of two methods, either perform tenotomy of the internal with advancement of the external rectus muscle, or divide the internal rectus muscle of each eye. As the patient cannot stay in the hospital we will perform tenotomy of the internal rectus of the right eye to-day.

Feb. 23d. She reports having had no pain. The eye-

ball looks very much congested along the inner half. The effect of the operation is quite noticeable. The right eye now looks straight while the left appears to turn in. Performed tenotomy of the left internal rectus. Feb. 28th. The patient is very much delighted over the result of the operation. Corrected the existing degree of manifest hypermetropia, and instructed the patient to wear the glasses constantly.

THE CLINIC ON PHYSICAL DIAGNOSIS.

SERVICE OF PROF. B. S. ARNULPHY.

CHRONIC AORTITIS. *Case 19,586.*—Mrs. K., æt. forty-four, complains of shortness of breath. She also coughs a great deal, and suffers pain around the heart. She awakens from sleep toward 2 or 3 A. M., and cannot go to sleep again. Has suffered much from insomnia of late. She cannot lie on the left side. Has had eleven children. Her father has been troubled with rheumatism. She never had any rheumatic trouble herself.

Examination failed to reveal any marked respiratory sign. Palpation of the heart indicates a weak impulse; apex beat at home. Auscultation of the heart reveals a weak first sound; over the aortic arch there is a faint systolic murmur; the aortic second sound is slightly reënforced. The test of bimanual pressure over the upper thorax is applied; it produces a marked sensation of faintness, with sickness at the stomach. The pulse is weak and small. No especial induration of the peripheral arteries. Plumbum 30.

If insomnia persists antim. arsen. 3, will be given, as it is almost specific for the insomnia of chronic aortitis.

Note the symptom: Shortness of breath; it is very frequently observed in chronic aortitis. Considering that cough is frequent also, though no special pulmonary trouble be present, we may infer that there is some irritation of the pneumogastric. I call attention to the great value of the bimanual pressure in the detection of aortitis; I hardly ever saw it fail yet.

The morning insomnia is also a feature of this particular affection, and is sometimes very troublesome both for

the patient and the doctor. When that insomnia is caused by præcordial pain, spigelia is the remedy; when connected with dyspnœa, or cough, or both, then antim. arsen. acts very well.

FATTY DEGENERATION OF THE HEART. — *Case 19,588.* Mrs. B., æt. forty-one, is referred to our clinic from the clinic on the "Diseases of Women." For years she has been troubled with spells of fainting, and of late the spells have become more frequent. During those attacks some consciousness is retained. Of late years she has experienced pain in the præcordial region. At times she is troubled with palpitation. She describes *a peculiar sensation of coldness* over the præcordia during the intervals of pain.

Two years ago she had a slight stroke of paralysis involving the right leg. Since that time she has noticed, upon arising in the morning, a general stiffness of the left side of the body. The left leg is inclined to swell and become painful. The patient is weak, irritable, and nervous. She has been compelled to work hard all her life. She now has a dry, hacking cough. She also complains of buzzing and dizziness in the head. She is subject to *spells of cold perspiration.*

On examination, we find a small goitre on the right side of the neck. Pulmonary signs negative. No apex beat can be seen or felt. At auscultation, the first heart sound is found to be weak, distant, slightly prolonged. The second sound is weak both over the aortic and the pulmonary area.

The heart intermits every twenty or twenty-five beats. The pulse is small, feeble, compressible; the left pulse seems still smaller than the right. Crotalus was given, to be followed by phosphorus and arsen. strychn. The patient reports better.

We arrive at a diagnosis of fatty degeneration through the characteristic signs of weakness of the cardiac muscle, coupled with the symptoms given by the patient, especially the cold sensations over the præcordia, the cold sweats, the spells of fainting, the buzzing and the dizziness which are all classical in their significance.

TOBACCO POISONING. — *Case 19,593.* August 17, 1892. M. K., æt 29, slim built, face pale, neuropathic eye. This

patient is employed as a cigar maker. Since the age of 14 he has been chewing and smoking tobacco freely. Three months ago, while on the street, he was suddenly taken with a violent spell of dizziness. All grew dark before him, then as the spell diminished the objects seemed to be fleeting before his eyes; he had to lean against a telegraph pole not to fall to the ground. At the same time he noticed that his heart was beating violently. Since that time he had no spell of the kind until three weeks ago. But his health and strength have been failing steadily. When at work in the shop he is constantly troubled with dyspnœa. The least excitement brings about a spell of dizziness. He says that when all his symptoms are aggravated he feels a pain in the region of the seventh cervical vertebra. There is usually some stiffness of the neck and some pain in the cordial region. His appetite is now very poor, and occasionally nausea and vomiting occur. He feels very weak and discouraged. He looks very much depressed and acts with a sort of feminine timidity.

On examination we find the apex beat at home, but very weak. The first sound is deficient in muscular tone, short and rather abrupt; the second sound is reduplicated. The rhythm of the heart is irregular, but no intermissioni s observable.

The pulse is small, irregular, slow, about 50 per minute.

The knee reflex is intact, but there is a marked tremor of the fingers.

Nux vom. was first given, then ignatia was substituted for it. At the same time a course of Turkish baths was advised, and the patient cautioned to take one powder of sulphur 30 before the bath. The use of the weed was strictly forbidden.

Sept. 24. Reports much better. Appetite increased. The dizziness and the præcordial pain are much less. Pulse more regular and stronger, 76 per minute. He has entirely abstained from tobacco since and promises to continue to do so.

INCIPIENT EXOPHTHALMIC GOITRE. *Case 19,595.* Fannie O., a little girl 11 years old, is brought to the clinic by her mother. She complains of a pain in the præcordial region with which she has been troubled for the last few months. This pain is sometimes very severe, and appears to alternate with spells of palpitation. The least excitement or exertion brings about painful beating of the heart, attended with dyspnœa and præcordial anxiety.

On examination we find evidence of a slight enlargement of the thyroid gland. The mother says she had noticed some swelling of the neck for some time past. The eyes are bright and large but not especially prominent.

On palpation we find a strong cardiac impulse over the whole præcordial region. The apex beat is clearly located in the fifth interspace, slightly within the nipple line; it is plainly visible.

Auscultation reveals no murmur over the præcordia. The heart sounds are loud, especially the aortic and pulmonary, indicating an increased tension in both circulatory systems. There is some throbbing of the carotids.

The pulse is strong, full, 80 per minute. We prescribe spigelia 3.

A marked improvement is reported two weeks afterward.

Though there is but a slight degree of goitre and hardly any exophthalmos at all, still when we take into consideration the marked increased arterial tension, the spells of cardialgia alternating with palpitation, the evident nervousness of the subject, we certainly feel justified in arriving at a definite diagnosis of Basedow's disease. It is just at such a stage of the disease, before it has taken too firm a hold on the system, that we may hope for some therapeutical results.

FUNCTIONAL DISTURBANCE OF THE VAGUS.—CASE *19,607*. Mrs. McM., æt fifty, has had the "grippe" last winter, and winter before last. The more recent attack however, was quite severe and affected the pulmonary form. She has coughed constantly since that attack, and at times she is greatly troubled with palpitation. Her cough is worse at night and toward morning. She raises an abundant yellowish sputum. The appetite is poor and variable; the thirst is very marked. Urine scanty, high-colored, contains a sediment. She accuses spells of profuse perspiration on the slightest provocation, also when getting warm in bed. She says she has lost considerable flesh, and that she was strong and hearty prior the attacks of "grippe." Now she feels weak, nervous, and is conscious of a constant tremulousness.

The patient looks pale and wan. The hands and tongue are trembling. We find on palpation some epi-

gastric pulsation. The apex-beat is located in the sixth interspace outside the nipple line. We note therefore a displacement of the apex downward and outward. The impulse is spread over a large area but lacks the powerful heaving of hypertrophy. It is a plain cap of dilatation.

The area of superficial dullness of the heart is considerably increased. On auscultation no adventitious sounds are perceived. The valvular clapping of the mitral is loud and clear; The tricuspid sound is duller; The aortic and pulmonic sounds are both weak. The muscular element of the first sound is manifestly deficient; its booming and rumbling tone have faded away. We note a rapid action of the heart.

The percussion resonance is fair over both lungs. The general quality of the breath-sounds is weak, subdued. The respiration is hurried, shallow. Over the left anterior apex we note some broncho-vesicular breathing, and a pronounced bronchial element in the breathing between the shoulder-blades. The pulse runs at the rate of 124. The respiration is 40. *The temperature is normal.* The patient does not seem to be conscious of any dyspnœa.

We consider this case is one in which the "grippe" toxine has expended its main effort on the pneumogastric. It appears to have produced a condition of the semi-paresis in that nerve. We know the trophic and the restraining influence of the vagus of the heart. Hence the relatively acute dilatation of the cavities of that organ; hence also its rapid action, the stimulus of the sympathetic having now full sway.

The catarrhal condition of the lungs, and the irritative cough are also due to the weak action of the vagus; as to the unconscious dyspnœa, it very likely arises from the fact that the lungs do their best to keep pace with the heart, and pant and puff after it.

The prognosis is rather dark, as we know from experience with what tenacity the "grippe" poison clings to its victims. Still we gather some encouragment from the fact that the heart, though dilated and overworked shows no sign of immediate failure, since its rhythm runs unbroken by any intermission or false step.

Sulphur 30 is prescribed. We have derived more satis-

faction from the use of this remedy in the after effects of the "grippe"—tuberculosis excepted—than from any other.

This woman returned a few weeks afterward, showing a marked improvement.

Strychnine Arsen. 3 will be given later on to steady and strengthen the action of the cardiac walls.

INTERCOSTAL NEURALGIA WITH PROBABLE LURKING TUBERCULOSIS.—*Case 19,618.* Miss C. S., æt. 30, has been in ill-health more or less all her life. When three years old she had paralysis of her left side. She now complains mostly of her lungs. She says she has pneumonia (?) almost every winter. The pains she describes as being of a sharp, shooting character, going through the chest, and recurring frequently, She sleeps fairly well, but wakes at about 3 or 4 A. M. with a cough; the cough does not trouble her during the day. The appetite is poor, the bowels costive. No night sweats. Menstruation regular but painful. Her father is in poor health and suffers with asthma. There is a history of consumption on her mother's side of the family.

She had the "grippe" two years ago; was in bed with it five weeks, and had pneumonia. Since that time the pains in the chest have grown much worse. On examination I find that by digital pressure I elicit a pain in the left axillary region in the sixth interspace; the pain seems to be aggravated when drawing a long breath. It extends backward, under the shoulder-blade. I make out two distinct points of exacerbation, one posteriorly on a level with the seventh dorsal vertebra, one anteriorly in the sixth interspace.

Percussion creates a little soreness over both lungs; the resonance is normal however.

On auscultation, the only suspicious sign I make out is a peculiar obscurity of the vesicular murmur over the left posterior apex; the breath sound only clears up on a forced inspiration, or after coughing.

The pulse is weak, 80, showing poor arterial pressure. The temperature is 99°. Two-fifths arsenicum will cover the ground for the present. Calc. phos. 30 may be given later on.

This is one of the numerous examples of thoracic pain that we have observed in this clinic as a result of the "grippe." In some cases the pain was distinctly muscular,

in other cases neuralgic. The former variety we have found to be especially rebellious to treatment, until sulphur was given.

In the present instance the neuralgic character of the pain is evident, but we carefully refrain from prescribing sulphur on account of the strong suspicion of impending tuberculous invasion.

Although no positive physical sign of specific deposit can be made out yet, with the exception of a slight apical change in the vesicular murmur, still family history and the "grippe" toxication warrant the caution here exhibited. This kind of negative indication appears to us fully as valuable as the most positive.

MITRAL INSUFFICIENCY.—*Case 19,610.* Emma M., aged 14 years, has been attending this clinic for a number of months. She has had, and occasionally still complains of a sharp pain in the præcordial region. *She had diphtheria in a severe form when six years old, and has suffered more or less from pain in the region of the heart since that time.*

On examination it is easy to see that the left chest is more salient than the right, within the confines of the præcordia. The cardiac impulse covers an extensive area, and is rather forcible. It is clearly felt at the epigastrium. The apex-beat is easily found in the sixth interspace, about one inch to the left of the nipple line. A well defined systolic thrill is communicated to the hand. The area of superficial cardiac dullness is manifestly increased. On auscultation a loud systolic murmur is perceived, the maximum of which is midway between the base and the apex. The murmur is distinctly propagated to the left in the axillary region, and is plainly heard at the angle of the scapula. It is not propagated into the arteries of the neck.

The second sound is reduplicated, the pulmonic part of it being reinforced to a degree. The pulse is small, but not otherwise weak.

The steady use of naja trip. has evidently been of benefit in this case. The præcordial pains are of much rarer occurrence. When they return, a few doses of kalmia latifolia always give relief. I consider naja as the greatest mitral remedy in our possession.

CARCINOMA OF THE LIVER.—*Case 19,624.* Mrs. E. H. is 24 years old, and has had five children, the youngest of

which is eight months old. She says she began to notice an enlargement over the right side of her abdomen one year and a half ago. She then became pregnant and the unusual size of the abdomen (owing partly to the presence of the growing tumor) led her and others to the belief that she was going to give birth to twins.

The patient complains of great weakness, of palpitation of the heart, of dyspnœa, and of inability to walk or even stand on account of rapidly increasing dropsy of the lower limbs. This swelling began to show itself two weeks ago. She also accuses some nausea; her appetite is very poor, the bowels are constipated, and the stools are dark in color.

This woman has not menstruated for the last three months, and since she has been in our ward she has had nasal hæmorrhage two or three times a day. Signs of icterus have appeared the last few days.

The family history shows that her mother was suddenly carried off by some acute pulmonary trouble—she says pneumonia—at the age of 40, while she was in a dropsical condition.

This case was examined before the general class by Prof. Ludlam some days ago, and a diagnosis of hepatic tumor was arrived at. It is now referred to our clinic for further examination.

Palpation reveals a large tumor filling the whole right hypochondrium; it is resistant to the touch and smooth all over its accessible surface; its inferior border which extends below the umbilicus is limited by a sharp edge, which extends obliquely upward and to the left across the mesian line, presenting two indentations in the epigastric region, and disappearing under the left chondro sternal articulations.

The surface of the tumor is uniformly renitent, somewhat elastic and smooth. It has never given rise to any particular pain except in the right lumbar region. No pain on pressure is elicited. The percussion sound over the growth is decidedly flat. I notice some enlargement of the spleen. There is some dullness over the lower abdomen, and a clear, tympanitic resonance above the line of dullness.

By gently tapping the right side of the abdomen, a distinct wave of fluctuation is generated. We certainly have here a moderate amount of ascitic effusion. These signs absolutely confirm the diagnosis of hepatic tumor formulated by Prof Ludlam.* Now the question is: Can we venture a step further and determine what is the nature of the tumor? Let us try.

The choice lies between an abscess of the liver, an hydatid tumor, amyloid degeneration and carcinoma. Surely we may dismiss the hypothesis of an abscess, as the history does not bear it out, and in abscess we have a smooth liver enough, but soft and fluctuating, which is certainly not the case. The hydatid hypothesis has more to it. The tumor of echinococcus is smooth and elastic, sometimes occupying a large portion of the abdomen, but it has a peculiar tremor, a purring sort of vibration which cannot easily be mistaken for anything else, and which we fail to perceive here.

The amyloid liver also has a large, smooth, uniform surface to it, and induration as in the present instance. But we do not discover in the personal history or in the present condition of the patient any evidence of any such degenerative process in the organs as we would find in connection with amyloid liver; no history of prolonged suppuration, of caries of the bones, of empyema, of chronic pulmonary tuberculosis or of constitutional syphilis.

There remains for us to consider the hypothesis of carcinoma. Note that the primary cancer of the liver is more frequently hereditary than any other form of malignant growth, and let us remember that the mother of the patient died of intercurrent pneumonia while presenting signs of a dropsical condition. Pneumonia is a favorite way of exit for carcinomatous subjects that have reached the cachectic stage.

We have against the supposition of cancer the smooth surface of the tumor, and the absence of pain, spontaneous

* See the February number of the CLINIQUE, page 96.

and on pressure. The cancerous liver is usually nodulated, irregular. But there are exceptions to that. Likewise all cancerous tumors are not painful. A few days ago there died in the ward a man who presented symptoms of impaction or stricture of the sigmoid flexure of the colon, and autopsy revealed a diffused cancer of the stomach involving the duodenum and extending to the spleen. He had never complained of his stomach further than from symptoms of advanced dyspepsia. Therefore pain, though a valuable sign, is not a necessary one.

The age of the patient is not in favor of the cancerous hypothesis. But here also we find numerous exceptions to the rule. We strongly lean to a diagnosis of cancer on account: 1st, of the mode of death of the patient's mother, which savors of malignant disease; 2d, of the extreme improbability of any other hypothesis compatible with an hepatic tumor; 3d, of the rapid development of the growth quite consistent with the mode of diffuse infiltration of the primary hepatic cancer; 4th, of the simultaneous presence of the three leading clinical signs of hepatic cancer, *ascites*, *jaundice* and *cachexia;* also of the rapid loss of appetite and of the constipated condition of the bowels.

The word cachexia may appear strong as applied to a case of such recent date. But do not the rapidly increasing symptoms of bodily weakness, of œdema of the lower limbs, of ascites, of depression of the spirits, of frequent epistaxis of depressed circulation offer a striking picture of acute cachexia ?

Such is our diagnosis, cancer of the liver, and considering the general condition of the patient, we suspect an imminent thrombosis of the portal vein which may prove immediately fatal.

The woman died out of the hospital a few days afterward. The post-mortem examination fully confirmed the diagnosis given.

CHRONIC ŒDEMA OF THE LEFT LUNG FROM TUBERCULAR ADENOPATHY.—Appendix to *Case 19,606.* Albion W. short-

ly after the examination held in our clinic October 29, 1892, was taken to Pueblo, Col., in charge of an aunt of his. The treatment advised has been and is yet faithfully adhered to. A marked improvement has set in; the cough and the dyspnœa are much less; the appetite and general strength are improving. The boy is out of doors every day and is now able to walk quite a distance without discomfort.

Here is the last bulletin I have received showing a comparative table of the pulse, the temperature and the respiration. It is quite instructive, as evidencing the peculiar organic, mechanical and auto-toxic difficulties under which the boy labors:

	Temperature.	Pulse.	Respiration
Feb. 16, 9 A. M.	99⅘	112	20
" " 1:45 P. M.	101⅘	109	27
" " 9:15 P. M.	100⅘	108	32
" 18, 9 A. M.	100 1/10	112	28
" 17, 1:45 P. M.	101⅘	112	24
" 18, 8:30 A. M.	99⅘	105	30
" " 1:30 P. M.	100⅘	116	21
" 20, 9:15 A. M.	99⅘	101	26
" " 1:45 P. M.	100⅘	106	30
" 21, 9:30 A. M.	100	109	24
" " 2 P. M.	100⅘	99*	28
" 22, 9 A. M.	100	100	20
" " 1:45 P. M.	99 9/10	100	24
" " 8:45 P. M.	101	101	26
" 23, 8:45 A. M.	100	104	20
" " 1:30 A. M.	100⅘	109	30
" 24, 9:30 A. M.	100	106	20
" " 1:45 P. M.	100 9/10	103	30
" 25, 9:15 A. M.	100⅘	115	27
" " 1:30 P. M.	100⅘	103	29
" " 9 P. M.	101⅘	120	25
" 26, 8:30 A. M.	100⅘	106	23
" 27,	98⅘	104	20
" 28, 9:30 A. M.	99⅘	103	30

* See the January number of the CLINIQUE, pages 1 to 16.

Clinical Reviews.

DISEASES OF THE NOSE AND THROAT. A text-book for students and practitioners, by HORACE F. IVINS, M. D., Lecturer on Laryngology and Otology in the Hahnemann Medical College of Philadelphia. With 129 illustrations, including eighteen colored figures. 508 pages. The F. A. Davis Co., Publishers. Philadelphia and London. 1893.

We have before us a book promised some months since and for which we have been anxiously looking. Its existence means more than appears on the surface, and marks another step in advance for the homœopathic school.

The development of special study in reference to the nose and throat has been given a great impetus, and within a comparatively short time several books have been welcomed. Lennox Browne, Bosworth, and McBride have very recently attracted our attention, and now Ivins adds a volume to this interesting subject.

Were this all—that it was a new book—it would assure a careful reading; but to be the first book which has appeared from the hands of any representative of the homœopathic school, upon this subject, makes it of very especial importance and worthy of careful perusal. There are a good many points worthy of mention, in reference to the handling of subjects, as well as the thorough treatment.

The book reads easily, and is as easily comprehended by the student and practitioner as by the specialist, from the fact that synonyms of terms which might not be generally understood, are bracketed and accompany the text, rather than being made part of a glossary, as is so common. The style is plain and straightforward, and yet sufficiently elaborate to give a thorough understanding.

The table of contents shows three grand divisions: I. The nose and naso-pharynx. II. The pharynx and its diseases. III. The larynx and its diseases. Each general division opens with a concise, short, practical chapter on anatomy.

The illustrations are especially worthy of notice. "With few exceptions they are from original photographs, drawings, or oil sketches," and therefore differ quite materially from the ordinary text-books. The frontispiece is only one of a number of full page illustrations, photographs of very carefully prepared anatomical specimens, prepared by Dr. R. B. Weaver, who has already attained renown from his painstaking dissections.

So many times in looking over a new book are we confronted with old illustrations, that it is a pleasure to find here new illustrations, as well as new subject matter. The colored plates, showing cases from practice, are well done, and evince careful observation as well as laborious preparation.

When reference is made to other authorities, the name of the authority is given in brackets, and generally the book or magazine from which it was taken, thus allowing of ready reference when desired, and showing also the subject to be written after thorough comparison with other writers.

The book is thoroughly up to date as shown by quotations from recent books and current journals. The handling of subjects is not especially different from other text-books, except so far as the treatment is concerned. Here lies the especial point of interest. The book gives the modern methods of local treatment as used by the other schools, and then adds what can be added by those who practice according to the law of similars. In reference to this I quote from the preface:

"In preparing the therapeutic indications it has been my endeavor to present a few of the remedies which are chracteristic and reliable; it is, however, not always easy to separate the true from the spurious. Where possible, I have tested the various symptoms recorded, and finding most of them reliable, allowed them to stand upon their own merits. * * * Another class of symptoms deserves especial reference, namely, those that have repeatedly proved curative from a clinical standpoint. * * * Even with this intended care in the selection of the therapeutic feature, it will be found far from accurate. * * * It is unfortunate that the instruments of precision, the ophthalmoscope, the rhinoscope, the laryngoscope, were not in existence when Hahnemann and his early followers made most of our best provings."

The book is not full of special appliances invented "by the author," as many are, but if anything the author is too modest in that he has introduced much that is new and will be thoroughly appreciated, and yet takes it quite as a matter of course. There is so much that is

worthy of mention that it would require special treatment of each chapter, hence I must refer all who wish to know more of the treatment of nose and throat diseases to this valuable book. I most heartily recommend it to all who treat those organs, whether they be general practitioners or specialists. C. GURNEE FELLOWS.

VERDI'S SPECIAL DIAGNOSIS AND HOMŒOPATHIC TREATMENT OF DISEASE FOR POPULAR USE; INCLUDING SUCH FUNCTIONAL DISTURBANCES AS ARE PECULIAR TO GIRLS AND TO MATERNITY. BY TULLIO S. VERDI, A. M., M. D., K. C. L. Philadelphia; Boericke & Tafel, 1893, pp. 579.

Whoever is familiar with the author's style, directness and general reputation, would expect that a Domestic Practice from his pen would be of the most satisfactory kind. This book is untechnical, and is in no sense designed to substitute the intelligent and experienced physician when his services are needed, in confirmed and chronic diseases especially. It abounds in the hints and helps that an intelligent parent can apply to ward off an acute attack, or to mitigate suffering while waiting for the doctor. It furnishes the sort of information of which all educated and sensible persons should be possessed, and would therefore constitute a valuable safeguard in any well-ordered family. The chapters on Accidents, Poisons and their Antidotes, Maternity, Nursing, the Diseases of Children, and Disinfectants are especially valuable. We commend the book as one of the very best of its kind.

Miscellaneous Items.

The Commencement in the Old Hahnemann, and the Re-union of the Alumni Association are set for March 22 and 23, and all our friends are heartily invited to be present.—Twenty publishers have promised their journals regularly to the reading room of our new College building. —Dr. A. H. Baldwin has removed from Webb City, Mo., to Anthony, Kan., and Dr. Alfa R. Lieb, from Kalamazoo, Mich., to 171 22d St., Chicago.—The London Homœopathic Hospital Reports, 5s per volume, can be had by writing direct to the hospital, and the journal of the British Homœopathic Society, by addressing the editor, Dr. Richard Hughes, Brighton, Eng.—The Kansas City Homœopathic College held its Commencement March 15.—The Re-union of the Alumni of the Hahnemann Medical College Jr., of Philadelphia, is called for April 19.—Our old friend, Dr. W. D. Gentry, has taken his office to Rogers Park, Ill.— The class of '93, just now in the state of great expectations, has generously given a first-class Berlin operating table to the new college amphitheatre, and it is already *in situ*.— Dr. A. J. Abell, of Joliet, Ill., will deliver the address before the Alumni Association of the Old Hahnemann on the evening of March 22.—Professors Gilman and Vilas are out for a brief vacation in Florida.—The Homœopathic Hospital within the World's Fair grounds is coming up in good shape, and so also are matters concerning the Homœopathic Congress, set for the week beginning May 29.—Dr. J. A. Vincent, of Springfield, has been appointed a member of the Illinois State Board of Health.—Prof. Shears is on duty again.—The state of the *Pulse* shows a good circulation.— The Bureau of Skin Diseases, Dr. H. V. Halbert, Chairman, will report at the next meeting of the Clinical Society, March 25.—A lot of papers, reviews, etc. are crowded out of this issue.

DR. E. J. ABELL.

THE CLINIQUE.

VOL. XIV.] CHICAGO, APRIL 15, 1898. [No. 4.

Original Lectures.

LARYNGEAL TUBERCULOSIS.

A CLINICAL LECTURE DELIVERED DURING THE WINTER SESSION TO THE STUDENTS OF THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, BY C. GURNEE FELLOWS, M. D., ASSOCIATE CLINICAL PROFESSOR OF THE DISEASES OF THE THROAT AND NOSE.

The patient before you presents himself for the relief of what he is pleased to call, simply hoarseness. As you see, his voice is a very rough whisper, with only an occasional loud tone. Without inspection we shall be able to arrive at some idea concerning the disease to be studied. He tells us that he has lost his voice only within a few weeks, and that at first it was only an occasional loss, but that it has been growing worse until now his present condition has existed for some little time. When questioned in regard to his symptoms, we find that he has more or less cough, that he is losing flesh, that he has had a few night sweats, that there is consumption in his family, and lastly he presents a diagnosis of pulmonary tuberculosis from the hands of Prof. Arnulphy.

We shall now examine the throat to decide whether the symptoms point to the laryngeal trouble being an invasion by the constitutional disease, or whether they are due to

some passing trouble. In the one case we shall find a state of things serious so far as the prognosis is concerned, and in the other, a ray of hope for the patient. Upon inspection we find that the arytenoids are somewhat infiltrated, but lack the characteristic pyriform shape of tuberculosis, and the interarytenoid space is considerably encroached upon, with some subglottic swelling: that the vocal bands are congested and thickened, especially near the processus vocalis, but that their failure to act in their normal manner is due to the arytenoidean swelling. If you will pardon inaccuracies I will show you, by a drawing upon the board, how this is possible. (See Figure 7.)

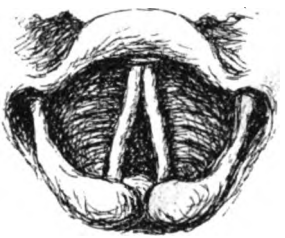

FIG. 7.

Upon attempting phonation the cords swing in, but are mechanically prevented from meeting because of the sudden stoppage between the arytenoids. Were it possible to reduce this swelling, there is no inherent reason in the bands themselves, why the tone should not be good. I can discover no ulceration above or below the glottis, and since these symptoms are comparatively recent, the laryngeal invasion of tuberculosis is correspondingly recent, for such I consider it to be. Since he has no pain or cough, I will make an application of lactic acid which should be frequently repeated in the hope of reducing the infiltration and preventing further development. (Exit the patient.)

As you see, the patient is not alarmed to find that the laryngeal trouble is but a further manifestation of the constitutional disease he already has. But it rests with us to do what we can to stay the dread malady.

He asks if a change of climate would be beneficial. If he could at once go to New Mexico, and in addition to the climatic change, could have careful constitutional treatment as well as the local laryngeal attention, he might prolong his life indefinitely. The laryngeal manifestation of tuberculosis is one degree more serious then the pulmonary alone, and it becomes still more serious as the manifestation approaches the outer surface.

From this examination the laryngeal invasion is, I believe, but recent and therefore more hopeful, and I should expect by proper treatment to prevent many of the more serious results, but perhaps not to entirely remove the present local conditions.

FIG. 8.

The question comes up, how often is the larynx invaded in pulmonary tuberculosis? Bosworth says in about one-third of all cases. Since then this is so, and has not been taken advantage of as much as it should be for the relief of the many local symptoms, I wish to impress it upon you as worth your while to examine the larynx and interpret the signs which you there obtain.

This case is apparently one in the initial stage of laryngeal invasion but case 5, which you saw some weeks since, is much farther advanced. You will remember that she complained, in addition to the loss of voice, of a most distressing cough, which so weakened her, that after each paroxysm she fell into a collapsed state. She had had hæmorrhages from the lungs for two or three years,—her larynx had been involved for some eighteen months, and the local appearances were such as I represent here, (Figure 8.)

Non-symmetrical infiltration of the arytenoids; thickened vocal bands, somewhat ragged in appearance, the left one anchored, as the result of past ulceration; thickened and stiffened epiglottis, and a long ragged ulcer, commencing on the interarytenoidean space and extending down below the glottis, onto the posterior tracheal wall.

Local applications of cocaine, zinc chloride, and inhalations of eucalyptol were very soothing, and relieved the cough. But because of her already failing strength, she was unable to come regularly for treatment, and finally ceased coming altogether.

I told you at the time, you remember, I feared she had not long to live. This I judged, in addition to the pulmonary signs, from the extensive invasion of the larynx and because ulceration had already appeared.

Authorities tell us that, after laryngeal manifestations of this constitutional disease, the length of time to the fatal end is rarely as long as three years, with the average at eighteen months; that after ulceration occurs, six months is apt to terminate the case.

You may ask how much the laryngeal symptoms have to do with the seriousness of the disease. Ordinarily it is the pulmonary manifestation which is the real cause of death, but much of the horror in the later months is absent when the larynx is not involved. With the development of laryngeal disease appears the cough, pain, loss of voice, difficult deglutition and sometimes difficult respiration. The explanation of the cough and pain lies in the involving of the superficial laryngeal nerves.

Difficult deglutition only appears when the epiglottis is involved either by great swelling or ulceration, and sometimes when the epiglottis is partially or totally destroyed the taking of food is more dreaded than the going without.

Difficult respiration is the least common sympton mentioned, but does sometimes occur when the infiltration is so great that the lumen of the glottis is encroached upon, and tracheotomy sometimes becomes necessary.

I have recently had a case in private practice which

illustrates another phase of the disease, and which I believe worth relating. In consultation I was called to see what I could do toward relieving the distress of a man in the last stages of consumption, who presented the following local symptoms: distressing cough, pain, dysphagia and dyspnœa.

Upon examination I found the usual infiltration, but with ragged, dirty ulceration of the arytenoids, the vocal bands, the subglottic space and the whole of the epiglottis. Persistent efforts removed only a part of the accumulated discharges, but the application of the chloride of zinc controlled these symptoms somewhat; the inhalation of a spray of the oil of pine needles soothed the cough and assisted respiration.

Bryson Delavans' alimentation bottle was advised, but did not work satisfactorily, and what little liquid food could be taken, was allowed to run down into the œsophagus while holding the head in some peculiar position. It did not seem possible that over two months could elapse before death, but in six weeks the suffering was mercifully ended. (Figure 9.)

FIG. 9.

Dr. John D. Hillis, of Dublin, calls attention to the fact that catarrhal laryngitis in a tuberculous patient may easily be confounded with laryngeal tuberculosis and adds the points which may distinguish the latter, viz.: A peculiar pale anæmic color of the larynx and pharynx, submucous infiltration, the more irritable cough depriving the

patient of sleep, more erratic voice—stronger in the morning and weaker in the evening.

None of these three cases corresponds to a typical case of laryngeal tuberculosis. (See figure 10.) But in prac-

FIG. 10.

tice you will find far more cases which do not correspond than those which do. The points to be drawn out from these three cases are these:

Case 1 presenting in the initial stage should demand all our energies toward arresting its development and this is much more satisfactorily and easily accomplished in the beginning; hence I urge you to watch the larynx, to carefully examine it in all your cases of tuberculosis.

Case 2 furnishes a type which demands constant and persistent treatment to prevent the breaking down of tissue and consequent advancement of the disease.

In case 3 we are confronted with the simple necessity of temporary relief by any means within our reach, and do not hope in any measure to stay the progress of the disease.

I must leave the treatment of the constitutional malady to others, but the local treatment must be by sprays of the chloride of zinc (2 to 5 per cent), lactic acid (2 to 50 per cent), menthol (20 per cent), according to Lennox Browne, and the inhalation of the balsams and fine atomized essential oils and often the indicated internal remedy. The insufflation of powders, iodoform, morphine &c., is generally condemned as harsh, but may be necessary. The internal treatment must receive your most careful and studious attention.

Clinical Society Transactions.

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

MARCH MEETING, 1893.

There was an unusual attendance at the monthly meeting of the Society on Saturday evening, March 25 to listen to the

REPORT OF THE BUREAU OF DISEASES OF THE SKIN.

BY H. V. HALBERT, M. D., CHAIRMAN

X. THE SKIN CLINIC IN THE HAHNEMANN HOSPITAL OF CHICAGO, BY DR. H. V. HALBERT.

Since the last report on skin diseases there have been presented at the general and sub-clinics in this department 204 cases involving the greater majority of diseases ascribed to this specialty. This of course includes many of the patients left over from the last year and possibly for several years previous. It also includes some patients treated between clinics which, however, belong to the statistics of the department.

Among these are included such diseases as seborrhœa, comedo, acne, sycosis, eczema, psoriasis, herpes, erythema, urticaria, prurigo, lichen, lupus, dermatitis herpetiformis, exfoliative dermatitis, pemphigus and many cases of cutaneous inflammation due to certain poisons.

The object has been to keep the clinic exclusively in its own sphere, thereby refusing many patients with skin affections which were, from the nature of other complications, allied to other chairs.

In the venereal part there have been many cases of syphilis in all its revolting forms and stages, gonorrhœa, simple urethritis, orchitis and lymphatic enlargements of different degrees, have been numerous, and they have been treated

internally and locally according to the demands of the case.

It will be readily seen from the beginning that the majority of the patients who come to this clinic are those whose history and daily life are anything but favorable to the treatment by internal medication. Taken from the ranks of filth and poverty it is not to be expected that any of them follow out to any degree of perfectness, the admonitions for care and cleanliness which are the proper adjuncts of our treatment. More than this they frequently come to us after exhausting every panacea of the advertising quack and the heroic treatment of the old school.

Notwithstanding all this we can safely say that, of those who have held faithfully to our prescriptions the majority have been cured or greatly improved.

Believing that a clinic is the place for study and experiment, we have tried to find the utility of all measures of treatment from local applications to the highest potentized form of the indicated remedy.

It is not possible to give in detail the features or history of each case presented during the year, but a few are singled out which we may study as specimens.

Case 1. ECZEMA.—Minnie L., aged 13, entered the clinic more than a year ago. Her case was then correctly diagnosed as eczema capitis. For the past six years she had been under the care of old school clinics and the alternate treatment of home remedies. The latter were prescribed mostly by kind friends, all of whom, as usual, had seen similar cases cured by some wonderful patent remedy. She was given graphites 6x for a week, then graphites 30x for a month or two. There being but little sign of improvement, hepar sulphur 30x and 200x were used for some time with no better results. In October last, when the clinic came under my charge, she was indeed a sight to behold. The entire scalp and a greater portion of the face and neck were simply covered with a mass of greasy scabs and excreta. This was the accumulation from the exudating disease for several months. She was thin, pale and weak, giving the appearance of a child not more than four or five years of age. She had no appetite,

could not sleep, would not take exercise and had never possessed any of the youthful vigor of that age. In fact her mother had given her up to inevitable consumption, as her wasted condition and increasing cough seemed to be drawing her to that end. She had the history of enlarged cervical glands and the frequent occurrence of boils which would neither heal nor suppurate. Her face was pale and waxen; the head and neck were inclined to emit an offensive perspiration; her bones were small and in every way she had that chronic cachexia so clearly indicative of the proving of silicea. For these symptoms and because it is so efficacious with children the 6x potency was given to her four times daily for a week; the mother was directed to wash the scalp and face thoroughly every morning, with a warm soda solution, taking extra care to keep the parts clean after that; following this she was to apply with the hands the least bit of pure olive oil simply to lubricate and keep the parts pliable. Regular outdoor exercise—a plain nourishing diet—morning sponge baths and absolute relief from school duties were to be insisted upon. The mother was advised by all means to make her child's life one of comfort and freedom from irritation as a means necessary to build up her debilitated condition.

In one week's time she reported as a little better. The silicea was then raised to the 30x potency. In two weeks she returned decidedly improved. The remedy was then given in the 200x potency for three weeks, after which she came to the clinic claiming she had not felt so well for years. By means of the remedy and the sanitary measures she had improved from week to week. Her countenance bore the expression of life, she had gained flesh and color and the dirty eruption had almost entirely disappeared. The remedy was now stopped though the ablutions were continued for weeks. She was directed to report regularly but she is virtually cured.

There are three things to be remembered in this case: First, and most important of all are the physiological indications of the remedy, the gradual use of the potency and the ceasing of the same at the first positive sign of improvement. Second: the perfect system of local cleanliness which was in no manner inimical to the remedy. Third: the regular reporting of the patient even after the euruption had disappeared. It is of the most positive

importance to watch a case of this kind to complete recovery for fear of the lapse of local care or the appearance of new and aggravated symptoms.

Case 2. ECZEMA.—Miss S. aged 18. Entered the clinic about four months ago. Her case was diagnosed as facial eczema. It was of the usual characteristic form, having started as minute watery vesicles behind the right ear until it had involved a greater portion of the right side of the face and scalp. The patient was one of those mild, tearful and yet irritable temperaments, who was as fickle in the statement of her symptoms as she evidently was in her daily life. She had been irregular in menstruation before the eruption appeared, having first interrupted the flow by getting her feet wet. On this account pulsatilla 3x was prescribed. In one week she reported an improvement. The remedy was then raised in potency. In two months the menstruation had appeared, the eruption had mostly disappeared and she is now reporting regularly as a convalescing patient.

The interest in this case is centered around the fact that the disturbed menstrual function was evidently the cause of the eczema. The indication was clearly for pulsatilla, and when it was administered menstruation returned and the eruption was cured.

Case 3. PSORIASIS.—Carrie H., age 10. For four years she has been covered literally from head to foot with an eruption which appeared in little, small, isolated red spots, seated on an inflamed and elevated base, which very rapidly terminated in an exfoliation of pearly white scales. She had been pronounced incurable, and after a prolonged medical treatment had gradually grown worse until mother and child were utterly discouraged. As a last resort she came to a homœopathic clinic. The parts seemed to burn like fire; the skin was exceedingly dry; the stomach and digestion were disturbed and a diarrhœa—worse at night and aggravated by fruits and water—was sapping her strength daily. For this reason arsenicum 3x was prescribed. In one week she returned with many of the symptoms relieved. The remedy was repeated in the 6x potency and at the same time we experimented upon one limb with a cerate of ichthyol. The potency was increased at

each clinic until the 1m was used. By this time the eruption had disappeared and the patient was really a new child. She had gained flesh and strength and felt as if she was entirely well. The scalp was however not perfectly relieved, little spots of accumulated scales still remained. She was then directed to wash the scalp twice a week with buttermilk soap, taking care to rinse well with warm water and then apply a little pure olive oil. At the present time she is apparently cured, though she is still directed to report regularly.

The point to be observed in this case is that the local application seemed to be of no value, though I have used the ichthyol cerate in other cases with decided success. I do not claim a cure by this, but that it limits the local inflammation.

Case 4. PSORIASIS. George E—, aged 8 years. Had been nearly cured in the clinic, before I took charge, by asafœtida 30x and 200x. The eruption, however, returned and after experimenting in vain with many remedies, he was given hydrastis 3x simply on account of the perplexing catarrh which had bothered him for a long time. Unexpectedly the disease manifested a decided improvement. The remedy, in progressive higher potencies, was repeated for several weeks until now the child is almost entirely relieved of the eruption.

We may learn from this case that it is well, many times, to give a remedy on one pronounced and positive symptom.

Case 5. ERYTHEMATOUS LUPUS. Mrs. B—, aged 44. This patient presented the following history: Two years ago little hard lumps appeared deeply seated in the tissue of the face near the nose. These developed slowly until they formed variably sized reddish patches covered with whitish or fatty scales. These spots spread rapidly and had a tendency to coalesce. They never reappeared at the same place and the scales seemed to cling by means of little adherent prongs. The case was pronounced one of erythematous lupus and the difficulty of cure was fully realized. It was determined, if we could possibly hold our patient, to do our best with the single remedy. She prom-

ised to remain with us for a year, if necessary, and we proceeded to evolve the following symptoms: Before the eruption appears the parts feel as if they were bruised, then swelling comes on and is accompanied by an irritating stinging pain; there is also swelling under the eyes, at the wrists and ankles, when the symptoms are worst; prostration is excessive; urine is scanty and the bowels are irregular. The whole visible integument is pale and œdematous. The case seemed most accurately to call for apis and it was therefore given. As in the other cases the potency was regularly raised when the symptoms improved. She has now been with us for six months. The eruption has almost entirely disappeared and every indication points to recovery.

The case is quoted as an example of what may be expected from a proper physiological homœopathic prescription if wisely selected and carefully used, even in this class of cases supposedly incurable.

Case 6. VARICOSE ULCER.—Mr. S., a Swede, age 40, entered the clinic in August last having a bad varicose ulcer on the lower and outer part of the left leg. He had received treatment at various hospitals, for years, with little or no benefit. The ulceration and inflammation had so invaded the leg that for some time he had not been able to use it in the least. There evidently being a syphilitic history, and inasmuch as no definite symptoms could be ascertained an aristol cerate was prescribed locally and mercurious corr. 3x was given internally. The local application was continued for a month or more, while the remedy was regularly raised in potency. In two months the ulcer had healed, the inflammation had disappeared and the patient was able to use the limb.

This case is reported to show the value of local applications in circumscribed ulceration and inflammation and the good results from murcurious corr. when a history of this kind is presented with no other positive symptoms.

Case 7. BARBERS' ITCH.—Mr. B., aged 42, came to the clinic a few months ago afflicted with what he supposed was barber's itch, inasmuch, as it was presumably contracted while being shaved by a barber whose patronage was not of the se-

lect variety. He had then been suffering for more than two weeks' time and his face was covered with a scraggy beard. Interspersed in this, particularly in the region of the lips and chin, were innumerable reddish papules, most of which were perforated by a single hair. The older papules had become pustular and were surrounded by an areole of inflammatory infiltration. The face was considerably swollen and he complained of excessive burning and some itching. From the pustular portion of the eruption a sticky discharge had dried into crusts and scabs which were excoriating the surface more and more each day. The disease had evidently started within the follicles, but it was now rapidly invading the peri-follicular tissue. To a slight extent single hairs had fallen out, leaving in their place flat reddish scars.

Complicating this condition the patient was suffering with an acrid nasal catarrh, which had evidently made the eruptive condition much worse in the region of the upper lip. The patient had consulted a local doctor who had advised him not to shave the beard and to use no soap upon the face. His only treatment had been an internal prescription of quinine and a local application of carbolized cosmoline.

The first direction given him was to shave the beard regularly, using the Vinolia shaving soap. After that he was to wash the face carefully with warm water and apply a little zinc oxide cerate. He was also advised to wash the face every night with junipar tar soap and to rinse well with warm water. After this he was again to apply a little more zinc oxide cerate.

Internally he was given tartar emetic 3x on account of the excessive catarrhal discharge and the tendency of the papules to rapidly become pustular. It was also indicated by the great pain, heat and burning. In a week he was better. The remedy was continued in a higher potency from week to week. In a month the eruption had almost disappeared. He reported a month later and there was no sign of facial eruption.

The prime object in the treatment of this case was to keep the face free from the irritating beard by regular shaving. The inflammation having started within the follicules was to be kept there by the astringent cerate. When the peri-follicular tissue is involved it is not so easy

to stop the eruption. The internal remedy was clearly indicated as the result proved.

Case 8.—CHRONIC URETHRITIS WITH PROSTATITIS. Mr. S., age 23, came to the clinic last fall suffering with what seemed to be an acute attack of gonorrhœa. While admitting that he had previously been afflicted with this disease, resulting from the usual cause, he still firmly denied any recent exposure. There was the typical discharge from the urethra and the attendant burning and pain during the act of micturition. This condition was accompanied by considerable inflammation of the inguinal glands. He was troubled also with obstinate constipation, itching and burning of the rectum and a bothersome dragging sensation in the sacral region. It was with difficulty that he could stand on his feet long at a time, and the act of locomotion gave sharp pains in the loins. Headache in the occipital region was constant. His appetite was impaired, his strength was waning and he had become so nervous that to perform his daily routine of work was almost an impossibility. He had previously been of an athletic habit and had spent most of his leisure time riding a bicycle. Besides this he was somewhat addicted to the use of stimulants.

Taking his history, habits and present condition into consideration his case was pronounced one of chronic urethritis with prostatic complication. He complained of spasmodic pain in the urethra, especially before and after micturition. He had also suffered with involuntary seminal emissions and there had been slight urethral discharges of blood.

Our first object was to correct the seminal loss, and for that reason he was given nux vomica 3x for a week. Reporting a little improvement in that line he was given the 30x potency for two weeks longer. At the end of this time this weakness was checked, but the urethral discharge was no better and the spasms of micturition were much worse. Hydrargia 3x was given every two hours for a week, which seemed to arrest the local suffering entirely. He was then given hydrastis 6x four times daily for several weeks, and was directed to drink freely of lithia water. By these means the catarrhal discharge was corrected, still the other symptoms did not abate, and as there was considerable swelling of the left testicle the patient was examined in private when a sound was passed for the location of a

possible stricture. This gave so much after relief that the local treatment was continued every other day for two weeks. Phytolacca cerate was used locally for the orchitis until the testicle was quite normal in size and free from pain and inflammation. At intervals of a week or more the discharge would return, but it was of a gleety character. This, with the increasing rectal irritation, became so persistent that an examination of the prostate was made. The gland was found to be so sensitive and enlarged that it was almost impossible for him to endure the touch of the finger through the rectal wall. It was then concluded that most of the discharge and the incident pain were due to prostatic enlargement. This could easily be accounted for from the history of constipation, the proctititis, the bicycle riding and the previous attacks of gonorrhœa. Accordingly the sphincter ani was gently dilated, and by means of a small speculum eucalyptus cerate was applied through the rectum directly over the posterior portion of the prostate. At the same time a recurrent syringe was passed through the prostatic urethra and through this a douche of warm water containing a small percentage of mercurius bichloride was passed. This was continued three times a week for some time. In a month all the unfavorable symptoms had disappeared, the discharge had ceased and the patient was to all appearance cured.

The following features of this case are worthy of remembrance: First: The use of hydrargia in spasmodic pain of long standing in the urethra. Second: The use of nux vomica to stop the nightly emissions. Third: The value of hydrastis internally for chronic urethral discharges. Fourth: The importance of passing the sound to relieve the strictured condition of the urethra; the use of the rectal application for the prostatic inflammation and the recurrent urethral douche for a persistent gleet. The final discharge was no doubt due to these latter points of irritation, and when these were corrected the case was cured. This could not have been done alone by internal medication.

DISCUSSION. DR. SKILES: This is an interesting subject, because it seems that eczema is more frequently met with than almost any other skin disease, and I think that

graphites has helped my cases more than any other remedies. There was one thing of peculiar interest that I noticed in Dr. Halbert's paper, and that was the local use of olive oil. I presume that is the best thing in such affections with one exception, and that is unsalted butter. It is an excellent application for skin troubles. I used olive oil until I fell upon this, from a nurse who used to be in the hospital, and I have always been glad that I learned its use. If you will apply unsalted butter instead of olive oil you will have better results. The skin is softer after applying it and it will help your patient very much, and you can also use massage with this which will be a great help to the skin. Of course I always dip into orificial work and have a case which comes to my mind now. A lady had been under the care of a skin specialist for two and a half years. She had an eczema of the face that was simply horrible. The whole face clear back to the ear was one flame. I took her symptoms and elicited from her history that she had had an operation for laceration of the cervix. She had a very tight os-uteri and therefore she only menstruated about half a day. I operated upon the cervix and the rectum. She returned in four or five days and to my surprise the face was clean. I had given her no medicine at all.

I remember a baby which I treated some four or five years ago for eczema of the face. It was covered with sticky scabs. The mother had to have it wear a muff to keep it from scratching. I circumcised the boy and the next morning one side of the face was very markedly improved. I gave him no medicine and in ten days I met the father upon the street and he told me the boy's face was clean. He is now all right.

DR. C. H. EVANS: There is really no room for discussion so far as the paper is concerned. The cases reported were treated by the indicated remedies and got well. There is nothing more for us to do but to congratulate Dr. Halbert upon his cases and perhaps to add some similar ones.

Nothing that we can do is more thoroughly appreciated

than the cure of a case of psoriasis where an individual has had the scales for years with a somewhat limited motion of the part, where the tissues around them have become hard and the patient has almost become disgusted with himself. When a case of this kind is cured in a few weeks it is very gratifying to all concerned.

Of a number of cases I recall one of a man who stands high in position in the grand army in this State. When he was sixteen years old he was run over by a wagon, the wheels striking a short distance above the external malleolus. The leg was bruised, but there was nothing broken, although the skin was discolored for a long while afterward and very much swollen, but it passed off with some little stiffness and he forgot all about it. Some few months after that he noticed that the skin was getting thick over this region, and finally scales commenced to form and psoriasis developed, spreading over a surface nearly the size of my hand. When he came under my charge he had endured this for seventeen years; had tried all kinds of patent medicines; had tried advertising and nonadvertising doctors, and had used all manner of spring waters and all sorts of lotions, but the psoriasis held the fort. He came under homœopathic treatment from the fact that a very serious case in one of his family connections had gotten better, after he had said that he knew she would die, and when she did not he thought there might be something in homœopathy to cure psoriasis.

He was in apparent good health and only had a single symptom, and in that it resembled the case in which Dr. Halbert gave hydrastis. He said that locality burned night and day; it was a constant burning heat.

I gave him arsenicum 6, four doses a day. He came back in a week and said, "You are doing no better than the rest." I advised him to give it a little more time, and so he took the remedy for another week, but still no response except there was a diminution of surrounding redness. On the third week he said the heat was not more than half as bad as it had been, but he did not see any

difference in the thick scales. The following week the heat was nearly all gone. A week later the scales commenced to fall off and a perfect cure soon followed. That was seven years ago and the skin of that leg is now as smooth as the palm of his hand; arsenicum 6 cured him. I meet him from time to time and it has never appeared in any other locality.

DR. LUDLAM: Did you make any local application?

DR. EVANS: None at all, and let me add that he has never had a sick day since.

DR. E. S. BAILEY: Eczema is often a peculiarly distressing disease and quite a formidable antagonist to the physician's best efforts. The local relief is often demanded and the ether soap is a soothing application. I have also used creoline, 1 to 3 per cent, in solution as a wash when one is needed to stop the fiery itching and burning.

DR. EVANS: One reason, probably, why patients who go to Baden Baden receive the evident benefit that they do, is not altogether due to the spring water. When any one goes there he is examined by one of the physicians who are connected with the company, or the spring, and he lays down a most minute rigid diet for the patient. He is told what to do at certain hours and what he shall not do, and he has a code of how to eat, what to eat, what to drink, when to take it; how many hours he shall exercise, etc., all of which conditions no doubt, have a very great deal to do with the production of the cure.

DR. LUDLAM: One of these cases was very interesting to me, and they are all of a class which we ought to be on the lookout for. It was the case in which the eczema followed the suppression of the menses, or an irregularity due to taking cold. I think such cases are easily managed if taken in time, and they constitute a class which should be kept distinct from others. They belong to a group which was spoken of by Dr. Skiles where he refers to his "orificial" work. Whatever suppresses a function, say the menstrual function, may induce an eruption indirectly, as

everybody knows. If that discharge is resumed, it stands to reason that the indirect disease often disappears. If the cervix is narrow from any cause almost any one would go to work and dilate it and bring on the menstrual discharge.

With reference to psoriasis I can say only this. Before any of you were born (medically) Dr. Coe, of St. Charles, brought to a meeting of our State Association a very singular case. It was about the worst case that I ever saw of psoriasis all over the body. The disease had no history of any sort in the family; it was simply caused by eating large quantities of salt. The boy ate common table salt, and ate it for years, and this was the consequence. The recollection of that case has led me often to the use of natrum muriaticum in the treatment of psoriasis.

DR. HALBERT: The idea which Dr. Ludlam has eliminated here has been the one with which I have started to conduct my clinic. My idea of materia medica, limited as it is, is one which I hope is pathological, and these symptoms are not those which I have learned from the books, but those which I can see in a patient himself. What I have really turned to is to classify the anatomy of the symptoms, objective symptoms, and the next idea has been most of all, to hold to one homœopathic remedy. If that remedy has acted well, to potentize it and after using a while to stop. The next idea has been more than all the question of cleanliness.

The first case I mentioned, one of eczema, was literally covered with dirty crusts and filth, and the first thing I ordered was that the scalp should be washed, and washed with Sanitas soap. I have used juniper tar soap, buttermilk soap and Sanitas soap with the idea that they should cleanse the parts once a day, and then I apply the oil and make the skin healthy. I believe that has been the reason of the success we have had, almost as much as the use of the indicated remedy. At the same time I have been searching for the indicated remedy to treat the symptoms.

I am very much obliged for the criticisms that have been made here to-night.

XI. VULVAR ECZEMA AS A SEQUEL OF THE CLIMACTERIC PERIOD. BY CORNELIA S. STETTLER, M. D.—At the request of our honored Secretary, I have been induced to submit the following report as a slight contribution to the Bureau of Diseases of the Skin. My notes are from a case in which I was greatly interested and which occurred in the private practice of Dr. R. Ludlam.

The patient is a married woman, æt. 47, and, although pregnant many times, she has never given birth to a child at term. Puberty was established between 15 and 16 years of age. Until that time she was delicate, slender and anæmic. The menses were regular and about normal until 27 years old, when they became of too frequent occurrence and lasted too long, continuing so for three years. Before and after each period there was a troublesome vaginal discharge of a muco-purulent nature, which was profuse and corrosive. Local applications afforded only temporary relief, but persistent internal treatment for three years finally overcame this trouble, as well as the menstrual irregularity. The climacteric change, concluded in 1892, occupied about one year and was unaccompanied by any unusual symptoms.

Until she removed to Florida, which was about a year ago, she had never had a pimple, a boil, or a blotch of any kind upon the surface of the body. Then, however, in consequence of breaking her vaginal syringe and not being able to get another for a month or more, the acrid and irritating leucorrhœa returned with increased severity. This caused an intolerable pruritus of the vulva and the vaginal mucous membrane. The eruption extended over the vulvar and anal regions, down the inside of the thighs and was accompanied by a scalding sensation that was aggravated by the watery oozing from the ruptured vesicles. The drying of this serum covered the surface with delicate scales, which gave rise to an insufferable itching, so that between the scalding sensation and the pruritus she suffered constantly and was often driven to the verge of distraction. It was impossible for her to sleep, and her sister, who was her constant companion, actually feared that she might be driven to suicide. Having once been bitten

by a rat, she described a peculiar biting sensation, which she had whenever the eruption appeared as being of a similar nature. At other times there was a feeling as of insects crawling beneath the surface.

When we first examined the case the vulvo-vaginal mucous membrane was highly congested and inflamed, the vulva, the perineum back to the anus, the integument covering the large share of the gluteal region and the whole inner surface of the thighs was the seat of a violent and most aggravated eczematous eruption.

The condition of the patient and her evident suffering excited the warmest sympathy. She had been prescribed for by a number of physicians, and had tried the effect of local treatment by the use of powdered starch, salicylic powder, carbolic lotion, zinc ointment, and a solution of the sulphate of zinc, and various other preparations, all to no effect. She had also taken various homœopathic remedies internally with the same result. Nothing that she had done had been of any service whatever, and she had finally returned to Chicago in the hope of being cured. The first that was done was to test the urine for sugar with a double object of learning if there was a malarial influence as a source of disease, and of determining whether the local suffering might be ascribed to the effect of saccharine urine on the inflamed parts. This examination, however, failed to discover any evidence of sugar in the urine, and on the principle of exclusion was of very great interest. A local examination showed that there was no lesion of the cervix nor of the ovaries or tubes, and that, therefore, there was no cancerous origin for the troublesome leucorrhœa.

After having tried the effect of cologne water, graphites cerate, urtica urens cerate, and the peroxide of hydrogen, none of which had any effect, the tar plaster was used and this brought immediate relief. This was continued for a fortnight and until the parts became almost healed, when its use was continued at night only, a simple cerate being applied during the day. From the time the eruption disappeared, the parts have been kept thoroughly clean and are always dusted with pulverized starch.

When the eruption began to decline isolated pimples appeared on different parts of the body, but they did not develop into vesicles nor were they troublesome in any way. Excepting this slight affair there were no other sequelæ, and now for three months or more she has been entirely well. The only internal remedy given was hepar sulphur 3.

DISCUSSION: DR. SKILES: Was that eruption due to the discharge?

DR. LUDLAM: It seemed to be connected with it in some way, but it disappeared very soon after the eruption did. She now has no discharge and the eruption is entirely healed.

This was one of the most interesting cases that I have ever seen, and I think the worst case of vulvar eczema that I ever saw. In my experience I have had a good deal to do with this sort of eruption and when I get such a case I begin in a rational sort of way to decide to what class it belongs. I ask myself whether it is of malignant origin, or diabetic, or syphilitic, parasitic, or scrofulous.

DR. E. S. BAILEY: I think a good many severe cases of intense burnings or itchings can be relieved by the tar plaster. I can simply testify to the fact that in one case several years ago, that I know it was cured from that form of eczema where the parts had become thoroughly raw by scratching. We used it a great deal in all cases of ulcerations on the skin and where there was a great deal of burning and itching. I think it is an excellent preparation and it combines a disinfectant and protects it from the air. I used to think that it was one of the best things in tar plaster, that after mixing it with oil, the heat of the body helps to make an almost air-tight dressing over the parts.

Hospital Notes.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

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

DIVULSION OF THE CERVIX FOR DYSMENORRHŒA AND DYSPAREUNIA.—*Case 20,936*, aged 33, married ten years, began to menstruate at 15, has never conceived. Menses regular, but scanty and painful in the extreme, sometimes inducing convulsions. Five years ago she had severe vesical symptoms for which she underwent some kind of an operation in the urethra by electricity, since which time she has suffered from vaginismus and a complete intolerance of sexual intercourse.

Operation.—March 11. The canal of the cervix having been found almost completely closed by atresia, its divulsion was practiced and the class instructed in the technique of the operation. The dressing consisted in the introduction of a narrow strip of iodoform gauze, which was allowed to remain within the womb and the cervical canal. There was nothing wrong with the urethra, neither with the meatus, as so often happens in vaginismus.

In this rapid dilatation we use an anæsthetic not so much because of its possible relaxing effect as to overcome the extreme sensibility of the parts involved, and the patient's resistance. In one form or another this is an old operation, and it is not always efficacious. It may need to be repeated once or twice, perhaps, but in a milder way and without chloroform. You will recall a striking case of this kind (20,844) in my clinic only a short time ago in which our patient had been a barren martyr for eight years from a similar cause. We made this same operation of divulsion before the class and now she is happily pregnant.

*Continued from page 124.

SPINAL TRAUMATISM. A FLOATING OVARY. DYSPAREUNIA WITH CONVULSIONS. OVARIOTOMY. DEATH FROM CEREBRO-SPINAL EFFUSION.—Wednesday, March 11, Prof. L. summed up *Case 20,931* as follows: There are several points of clinical interest in this case. The traumatism at 12, with a possible prolapse of the ovary in consequence of the injury; the struggle for five years to establish the menses, which finally came on at 17; the occurrence of slight spasms during that long interval, and their assuming a more aggravated and distinctly menstrual type at puberty; the resulting convulsion from the first and from every sexual act during the seven years of her married life; and the exemption from the fits throughout her three pregnancies and labors, each and all give ground for the belief that the sexual factor has very much to do with this remarkable case. Fearing, however, that the original shock might have induced a serious lesion of the cerebro-spinal apparatus, I requested my colleague, Prof. H. B. Fellows, to examine her carefully, and to give me the benefit of his special skill and experience. He has decided that the spinal trouble is functional and not organic; that the spasms are largely hysterical and reflex, and probably due to some intra-pelvic irritation, and that, if she is strong enough to undergo the operation, the removal of the floating ovary might do great good, and possibly cure her.

Operation, March 27. Before operating, the following remarks were made to the class: I had about concluded to remove the floating ovary, and possibly its fellow also, by way of the vagina, but there is a hard tumor that lies along the lower lumbar spine, which some of you have felt through the abdominal wall, and which should be examined more directly and thoroughly than it is possible to do without access to the abdominal cavity. I shall, therefore, make the usual incision, and the first part of our operation will really be an explorative laparotomy. This will enable us to decide what that ante-spinal tumor is, and afterward to remove one or both the ovaries, as the circumstances may require. The chloroform acted admirably, and was well borne.

The spinal tumor proved to be an egg-shaped exostosis that was attached to the bodies of the lower lumbar vertebræ. It was hard, smooth and immobile. Except for an intimate adhesion to a kunckle of intestine the left ovary was floating and free, while the right one was buried in a mass of adhesions. Both were sclerous and cystic, and both tubes were very much swollen and congested. All these appendages were removed and the wound dressed aseptically.

When the patient had been carried to her room Prof. L. said: Although the conditions for recovery in this case, so far as the operation is concerned, are all that we could desire, I cannot help feeling that there is an obscure element of spinal mischief which may be connected with that bony tumor, and which should modify our prognosis. For it sometimes happens that an abdominal operation will precipitate a fatal crisis which might otherwise have been delayed, and but for which the patient might have made a good recovery. This is especially true, I think, in chronic lesions of the brain and spinal cord when they are of traumatic origin.

Wednesday, March 29. For the first ten hours our patient did well, but then the spasms returned quite frequently. They were not very severe but were accompanied by a marked dilatation of the pupils and a demoralization of the pulse. When these short paroxysms had passed she seemed to be doing well again. The pulse became nearly normal and the temperature did not exceed 101°. It was never sub-normal, and there were no signs of collapse. Her first night was as good as they usually are after a laparotomy, and the second one was about the same until six o'clock this morning, when she had a severe fit with entire unconsciousness and extreme dilatation of the pupils, after which she suddenly expired. The mode of death and all the circumstances leave no doubt that the old traumatic lesion of the spine was responsible for this unfortunate result.

DERMOID CYST OF THE OVARY. OVARIOTOMY. RECOVERY. *Case 20,935*, æt. 40, sent to the hospital by Dr. E. A. Brown, of Madison, Wis., was the mother of two children, the youngest being seven years old. She had had two miscarriages, with severe post-partum hæmorrhages, but no untoward effects. Her general health was good, with the exception of frequent headache, slight hæmorrhoids, and a dull aching in the left renal region. Local examination detected a tumor, apparently as large as a navel orange, in the right iliac region.

Operation. March 11 an ovariotomy was made in presence of sub-class 8, and a dermoid cyst of the ovary removed. The pedicle was ligated with catgut. The cyst was unilocular, and filled with solidified sebaceous matter containing a quantity of hair, but no teeth or bone. Its lining membrane was shown to be true dermoid of the epithelial type. The probability that this growth was congenital, and the possibility of danger from too long a retention of it in the abdomen were explained to the class. So also was the absence in this case of any marked local symptoms, and the occasional effect of pregnancy to hasten the growth of tumors of this kind that may have been latent and harmless for years.

Wednesday, March 29. After an uninterrupted convalescence, the patient left the hospital for her home.

REPORT OF THE CLINIC ON GYNÆCOLOGICAL SURGERY, SESSION, 1892–93.—Wednesday, March 22. At the close of his clinic for the Winter Session, Prof. L. remarked: This department, devoted to the Surgical Diseases of Women, has furnished the class 64 clinics and 6 special lectures on Minor Gynæcological Surgery. Of these clinics in which an abundance of material has been brought before the class, 29 have been given in this large amphitheatre, and 35 to the middle and senior students in the sub-clinic rooms. In each of the latter there were from one to three important operations and many rare and interesting cases for diagnosis.

In my sub-clinics I have made *twenty-three* laparotomies

before the pupils, of which four were explorative; two for abdominal hysterectomy; one for a ventro-vaginal, do; four ovaritomies; eight tubo-ovariotomies, and four vaginal hysterectomies. Of these twenty-three cases all but two recovered and left the hospital in good condition. Of these two, one had a very large malignant sarcoma of the uterus that was a forlorn hope, and the other was a case of fistulous abscess of the broad ligament which had already undergone three laparotomies and in which a clinical form of pelvic suppuration had existed for six years. The vaginal hysterectomies all recovered.

Beside these more serious cases we have also made the various plastic operations that pertain to this specialty, including colporrhaphy, trachelorrhaphy, amputation and discission of the cervix uteri, perineorrhaphy, closure of vesico-vaginal fistulæ, curetting the uterus, etc.; and thanks to a strict asepsis with good nursing and after-treatment, our results have been all that could be desired; for surely no teacher and operator ever had better assistants than Drs. Stettler, M. V. Clark and Alexander, and our nurses have been kind and faithful to the last degree.

With the completion of the new hospital, now almost ready for us, there will not only be more space for our patients and more of them, but with a separate sub-clinic room for this department, these clinics with operations will be even more interesting and useful than ever before.

Commencement Exercises

OF THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL—SESSION 1892–93.

The Thirty-third Annual Commencement Exercises of the "Old Hahnemann" were held, as usual, in the Grand Opera House, Chicago, at 2 P. M. of Thursday, March 23, 1893. The programme was in charge of Professor Crawford, who carried out its details to the delight of a large and thoroughly appreciative audience. The music and the decorations befitted the occasion, and the blooming graduates bore the honors with becoming dignity and decorum.

THE ANNUAL REPORT OF THE REGISTRAR.

BY PROF. E. STILLMAN BAILEY, M. D.

In another hour the thirty-third annual course of lectures and the commencement will be ended. This school year has been one of unexampled prosperity. The class about to receive their diplomas, numbering seventy-three names, have each and every one completed the legal requirements of having had four years of study and three full courses of lectures of six months each. In recommending these students as fit candidates for graduation to the Honorable Board of Trustees, whose province it is to award the degree, it was not too much to say that in point of scholarship, attendance and recognition of the true spirit of professional attainments, this class knows no superior in the history of the institution; and while the class-room exercises are over, the new responsibilities assumed are well understood and will be bravely met. This city, as a medical center, has great attractions for the ambitious students of the day. Two hundred and fifteen students have been in attendance during this term, their homes being scattered all over this fair land.

The old college building, with memories dear to those of this class, as well as to the former classes for many

years past, has been torn down. The handsome new college building that has been erected on the same site, is practically completed. As the doors swing open to all the class of 1893 to move on into the world of practice, the present indications are that another large class will come in to fill the empty benches. With the new and strictly modern, commodious and elegant college building, equipped for the demands of modern study, there can be no hesitation in predicting the future of this institution to be one of continued prosperity.

The hospital interests have not been neglected. Twenty-one clinics and sub-clinics have been maintained weekly, besides the bedside instruction. With the completion of the new hospital building now reaching several stories above its foundations, and still going upward, a much needed improvement will have been made. With the finishing of this building, excellent in all its appointments, a long life dream will have been realized, and the new Hahnemann Hospital will have taken a place in the front rank of the public institutions of this city.

It is not time for talking but for doing. I have the pleasure of requesting the following named students, to take the places assigned to them on this platform at the proper time that they may at the hands of the President of the Board of Trustees, receive their coveted and merited degrees of doctor of medicine and surgery.

LIST OF GRADUATES.

SESSION OF 1892–1893.

ALEXANDER, J. LLOYD,	Illinois.
ANTHONY, FRANK H.,	Illinois.
BELL, MARCUS RICE,	Ohio.
BENNETT, RUTH PARKER,	Illinois.
BENTLEY, WILLIAM SPENCER,	Michigan.
BIGGER, HARRIET F.,	Illinois.
BLOCK, ROBERT C.,	Illinois.
BOUSLOUGH, E. E.,	Illinois.
BROWN, LINCOLN STOTLER,	Pennsylvania.
BROWN, MORTIMER HOUGHTON,	North Carolina.
BROWN, WILLIAM HARVEY,	Pennsylvania.
BROWN, WILLIAM T.,	Wisconsin.

BURDICK, A. LOVELLE,	Wisconsin.
BURKHARDT, ANNA L.,	Pennsylvania.
CASWELL, EMMA A.,	Illinois.
CHEATHAM, LIZZIE C.,	Ohio.
CLARK, MARGARET VAUPEL	Iowa.
CODINGTON, MAUDE A.,	Florida.
CULVER, G. SHERIDAN,	New York.
CUMMINS, MARY GAMBLE,	Iowa.
DAVIDSON, MRS. FLORENCE A.,	Iowa.
DUKET, PETER P.,	Michigan.
DUNCAN, SARAH B.,	Iowa.
EWING, MARY L.,	Wisconsin.
FOWLE, ELLA M.,	Texas.
FRANZ, ERNST	Indiana.
GAMBLE, ROBERT T.,	Illinois.
GILBERT, WILLIAM S.,	New York.
GOODWIN, SARAH L., M. D., *ad eundem*,	Missouri.
GREENE, EVA B.,	Wisconsin.
GRIFFITH, H. EUGENE,	Kentucky.
HAIGH, F.,	Illinois.
HALPHIDE, ALVAN CAVALA,	Illinois.
HANLON, EDWARD OWEN,	Michigan.
HENDY, CLARA A.,	Wisconsin.
HICKS, JAMES MAURICE,	Indiana.
HOLLINGSWORTH, RACHEL E.,	Illinois.
HOLTON, ELIZABETH SANDERS,	Illinois.
HUBBARD, ALLEN P.,	Michigan.
HUNT, ELLA GRACE,	Ohio.
HUNT, FLORENCE IRENE,	Ohio.
JULY, LOUIS E.,	New York.
KETCHUM, FRED GRANT,	New York
KIMBALL, FANNIE GRAY, M. D., *ad eundem*,	Illinois.
KNIGHT, THOMAS W.,	Ohio.
LANE, MARY M.,	Wisconsin.
LEE, ANNA F. S.,	New York.
LEFFINGWELL, JOSEPH L.,	Massachusetts,
LYON, ROY MUIR,	Colorado.
MACMULLEN, DELLA MARIE,	Illinois.

MACOMBER, HENRY JEWELL,	California.
MASON, STELLA M.,	Iowa.
MCNIFF, MARGARET S.,	Iowa.
MIGHELL, INA M.,	Illinois.
MISICK, OEL SAGE,	Illinois.
MURPHY, JENNIE C.,	South Dakota.
O'BRIEN, MARY E.,	Michigan.
ORDWAY, GEORGE ALBERT,	Massachusetts.
PATTERSON, CLIFTON E.,	Iowa.
PHILIBERT, MRS. ELIZABETH,	Texas.
PRINDLE, EARLE STANLEY,	Vermont.
PROSSER, CLEORA E.,	Pennsylvania.
RANDALL, NETTIE H.,	Wisconsin.
RANDALL, SILAS WARREN,	Wisconsin.
ROSE, PAUL,	Indiana.
SCHUHMANN, H. H., D. D. S.,	Illinois.
SMITH, CAROLINE F.,	Illinois.
SMITH, FRANK CLINTON,	New York.
SPAULDING, EDWARD M.,	Minnesota.
STEPHENS, THOMAS WILLIAMS,	Pennsylvania.
TAYLOR, RICHARD W.,	Wisconsin.
WALL, O. L. M.,	Iowa.
WOLLAM, J. F.,	Ohio.

THE CONFERRING OF THE DEGREE.

BY PROF. R. LUDLAM, M. D., PRESIDENT.

The members of the Graduating Class having been called upon the platform in three separate groups, amid cheers of their friends and the plaudits of the assembly, the President formally 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.

BY REV. L. P. MERCER, OF CHICAGO.

I have had before me the question: "What can a minister usefully say to Medical Graduates about to enter into practical touch with the problems of life and death?"

I honor too much your high function to detain you with commonplace reference to its responsibilities; and know too little of medical science to adventure any advice as to medical practice. It has seemed to me clear so far that my only safe ground is that whereon our professions meet both in theory and practice, the intercourse between the soul and the body in the relation of physiology to psychology, the realm of cause and effect in disease and cure.

Priest and physician minister to the same subject, viz: the mind embodied. The priest ministers to a mind diseased, the physician to the diseases of the body; and whether the one or the other be called it is a sick man that has to be considered. Man as he lies stretched upon his bed is still both a soul and a body—more strictly a soul embodied. For the mind is the man including all things of the will and understanding, and these things are in principles in the brain and in principiates in the body. The body, therefore, is the mind produced into, the ultimates of itself in which it lives, in a theatre so correspondent with itself as to constitute together with it one identical man. The miracle in life is the conatus in perfect health of all the forces, spiritual and physical, in the harmony of equilibrium. Disease as the word indicates is a departure from this same equilibrium. Whether disturbances are in the mental or physical form, primarily, the whole man is sick in a way. The mind conscious of its own disturbed balance seeks the priest: conscious of a broken limb of its body, it sends for the surgeon; conscious of a disturbance about the liver, it calls for the physician; but the subject of ministry in any case is the man, and in a degree the whole man, and the individual man. This is really involved in all of our talk about the influence of the mind upon the body; for it is not the influence of the mind upon the body so much as of the mind in the body. The mind makes not the muscles only but the organs of the body tired or vigorous according to its states; not voluntarily but involuntarily, as it seems it acts upon the brain, then upon the heart and lungs, and upon the liver and kidneys, and lower down still.

It can make the whole man feel well or ill, contented or depressed. If diseased in some bodily organ but of good courage and even soul, the mind "limits the mischief down to the organ, and keeps it from ascending in vapors of fear and apprehension," so though the organ be ill the mind is sound. Again as we know the mind can dissipate

the inclinations of self-indulgence and sloth, and throw its forces into hands and feet in pursuit of duty; or if it please, and love its indulgence it can "shroud itself in a coffin of habits" and plead the sickness of every part of the body for the sympathy and ministration of others. It can localize its self-indulgence and make organs sick, expecting them into disease. It can make mortal diseases mortal before their time, summoning them from the grave of heredity.

Observe that the principle urged is a very old perception and at all the baseless speculation which would merge physics into metaphysics and get rid of bodily disturbances by denying the body.

My contention is simply that we have to consider a mind embodied; you, a body with a mind in it. "In the embodied man every communication is a real transference of his spirits." The states of the mind strike correspondent organs with force and can easily arrest or pervert their functions. On the other hand the diseased organ reacts upon the mind and its morbid states ascend in vapors and distempers.

My friend, Dr. Wilkinson, of London, is felicitous in this field, and he says:

It has been recognized since the earliest ages that the head has the conscious mind within it; that the breast feels affections and emotions; that the heart is love, and joy and sorrow, and that the breath is of hope and straitness, aspiration and despair. Also it is written upon experience that the liver is of much metal, and sympathizes in function with anger and its gall; that it uses cupid's arrows; as the old saw is, *Cogit Amare*. The moderns find it a great sugar maker and starch modifier, as it ought to be, corresponding to cogent courtesies and inclines, depressing passions, glooms; unseasoned pessimism may come of it when it does not purge its better mind. The spleen, besides much else, is a holiday and playground for the abdominal blood, in which little is asked of it beyond exercitation; it is let out in batches as it were school boys to shake its sides. "The spleen sets laughter afoot, the liver compels to love"

* * * The bodily functions in their words have also become mental words, used directly for conditions of mind. Jealously is yellow, is jaundice, is liver; there is also black jaundice and green jaundice; always yellow still. Spleen or explosion of petty wrath is no exception, for here the clotted spleen is meant; the playground blocked away, where the reverse laughter is shaking ague; in the organ

ague-cake. The reins, the kidneys, reprove and admonish in the night season, and care is near to the beseeching loins.

They are eliminating organs, often especially active during sleep, purifying their blood for the morning. The hearts and the veins are used together in the Scriptures as spiritual organs. The bowels yearn with mercy in the merciful; and he who is without mercy is said to have no bowels. The stomach, which seems to include both the stomach for food and the whole abdomen, is courage mentally. It requires no small habit of courage to put into it what it has to stomach. It is mostly treated as a brave stomach. We read of one who "greatly daring, dined," his reliance on his stomach is meant. Good digestion fills the edile man and builds him. It prepares him for anything; for love and for war—Waterloo—but after breakfast. The stomach has much mental language; especially with regard to hard words, or unwelcome tidings and indigestible proposals; these we cannot stomach. The mettle of horses when beyond easy control makes grooms call them "stomachful." And again Shakespere says:

"If you can fight to-day come to the field; if not, when you have stomachs."

So the brain, the heart, the liver, the spleen, the stomach, the bowels and the kidneys are all used in a tradition immemorial for mental organs and substances and states. Seeing which, it is not much farther to see that all these real loves, affections, passions, imaginations, fancies, senses, married to the organs; and fruitful with them in the world's language, and continually agent and effective there as mental added to physiological forces, are themselves the correspondences and superior actors of whatever goes on in the secret councils and gymnasia of the constitution. They are different in every man because he is his own life from inmost to outmost.

Manifestly then, since it is man, and individual man, in his own embodiment and theatre, to whom priest and physician have to minister our main consideration is to equilibriate disturbances and give him a chance to live his own life. In large measure whether we consider the one or the other we consider an art—the deft habit of healthful tact.

If you are at the bedside of a man to heal him he takes good out of your frame, sympathy and skill, even though you pour bad out of your bottles; he feels the warmth of a brother present, as the envoy of one of the arts of heaven. And not the least of the medicine he takes out

of your person is the courage and mental poise he draws from trust in your skill born of the knowledge of the natural history of diseases. His panic is that he does not know what he is drifting to; his reassurance is that you know and can warn off undiscovered calamities. That to begin with is mental equilibrium, it lifts the weight of fear off the organs.

Medicine has been one of the comforts of the human race, and a wholesome souled and observing administrator of it cannot well fail to be useful. The "consolation of the mind" is indeed a preëminent function when regarded in its elements; for since the mind, as we have seen, is to a good extent lord of the body, "to be its chancellor and privy-councillor in pains and difficulties is to sit in a very high seat of power and responsibility." We might grant, as has been contended that if there were no doctors many would be alive who are now in their graves, and that on the whole the human family would be in better health, but it is not to the purpose, for the need of the people for "consolation of the mind" calls for and creates the physician's function. As Dr. Wilkinson says, "they will and must have him for their heart's sake." If he is in more power and greater place than belongs to him it is the fault of their need; nothing can abolish him but a change in human nature; the lifting up of mankind into a higher plan of self help and mutual help through godliness; and, indeed, as has been said, the only thing that would then happen is that the medical man would be also a priest. He should be always of priestly function, but where he is now one-tenth a priest and one-tenth a medicus he would then reverse his proportions.

What I want to urge upon you first of all, is the inevitableness and priestly function of this personal element in medical practice. It is the touch of a healthy person with a disordered person; instructed faith and watchful courage with ignorant fear and foreboding anticipations; of good will with mutual need and helpless dread.

Where our psychology is so much a matter of guess work as it is, and has been, there is little to say about this personal element in medicine, except to demand wholesome good will, faith in the divine order of the universe, and strength which is tender, and sympathy which is strong in courage and devoid of the sentimentality, as elements of character in the physician. These traits are of higher potency for good than any medicine you can taste, or pills you can see.

But there is this one other thing to say of this personal element, and that is, in proportion to its potency to heal when right human and wholesome, is its power to spread disease when wrong, inhuman and full of experiment. If a man finds you at his bedside to watch him for experiment, that his life and death or throes may figure in your statistics "do not suppose that you are innoxious for you are a potent poisonous drug, calling forth sorrow, despair, fear and other destroyers and aggravating the sensibilities of his organs." Experimental physic, backed by a mind and will with no faith in any law of cure, only determination to experiment with sharp drugs and sharp knives on an organism, regardless of the states of the man in it, always has been one of the most fruitful sources of disease and epidemics. Bad medical practice is an enormous factor in the development and spreading of diseases, and this less by the bad drugs used, than by the bad personal spirit that consents to experiment with them for self-aggrandizement and the justification of self-conceit. While it is true, counting the personal element in medical practice at its full worth, almost any practice which has a few precedents to correct it is better than no medical practice, it is equally true that many would recover better by simple watching and the application of a few obvious means, mostly suggested by the patient's feelings than where a large apparatus of drugs is employed; and while we may say that any practice which has the touch of a priestly man with it is better than no practice, it does not by any means follow that any science is as good as another science, or that any practice which is followed by the improvement of the subject of it, or which cures by luck, is in itself, or tends to the discovery of, a law of cure.

This brings me to speak briefly of what is at once your charter of rights and your protection against the evils that beset experimental physic even in the best intentioned hands, namely, the law of *Similia*, as the only possible law of cure. I do not need to expound that theory, which is fundamental to the studies in which for the past four years you have been engaged; but it may not be amiss to make a distinction between the formula of homœopathy as a rule and a maxim of practice, and its statement as a recognition of a fundamental law of nature. It is undoubtedly a good maxim for the guidance of the physician, but that only because it is the discovery of a universal and unchanging law. Dr. Chas. Mack, of Ann Arbor, a better authority

than I, having shown that the law of cure must define the antipathic or else the homœopathic relationship, that by which we may recognize a drug as curative, proceeds to dispose of the only principle which can contend against the claim that *Similia* is the only law of cure.

"What claim," he asks, "may *contraria contrarias curantur* make to being a law of cure? What is the contrariety which *contraria* would exact? What is an antipathic drug?" "There are two distinct meanings," he says, "with which we use the word opposite. We may say that one symptom is the opposite to the other, meaning that the two vary in diametrically opposite directions from the standard found in health; as when we say that a too rapid heart action is the opposite of a too slow, or that a temperature above normal is the opposite of a temperature below normal. There is no occasion for our denying that we may at times palliate by directly opposing a system, on the principle of *contraria*, but such opposition must always be aimed at individual effects of disease. Disease effects of which such opposites can obtain seem comparatively few, and probably there is no disease of which, taken as a whole, such an opposite can be predicated. What, in this case, are the opposites of itching, nausea, headache, inflammation, fatty or other degeneration, rheumatism, pneumonia, typhoid fever? The fact seems to be that there are none. We conclude that *contraria* cannot be the law of cure, if the oppositeness which it would exact be such as we have here defined and illustrated.

"We said that the word opposite is used with two distinct meanings. We find it impossible to regard *contraria* as the law of cure, if by opposites we mean effects varying in diametrically opposite directions from the standard found in health. Using opposite with its other meaning we may say that health is the opposite of any disease, and that in health is found the opposite of any symptom. If this latter is the meaning with which we are to use the word opposite, *contraria* demands that a curative drug must be one which, taken in health, would produce health. The *reductio ad absurdum* is complete.

"Having first demonstrated that the law of cure must define the relation between unmodified disease effects and unmodified dynamic drug effects, we have now by exclusion demonstrated," he says, "that no possible law of cure can exist, excepting that which defines similarity between unmodified disease effects and unmodified dynamic drug effects as the criterion by which we can know that a drug is curative. We are thus obliged either to fix our belief in *similia* as the law, and the only possible law of cure, or as regards curative medicine, to take up with that most dismal unbelief which has come to be known as medical nihilism. Medical nihilism is to the healing art what political nihilism is to the State—viz., it is subversive of all progress, all order, all that is good and true. As regards curative medicine homœopathy is, and forever will be, the only champion of law and order."

Homœopathy is the champion of law and order, because it expresses a law and order written in the constitution of things, and operative in the causes of disease and of drugs; and to recognize this in its fundamental nature is wholesome to the physician; though it may not be absolutely indispensable to the art of practice. For we should distinguish between the science of homœopathy and the practice

of homœopathy. The practice is invariably and inevitably an art; it has to be learned and proficiency has to be acquired by orderly doing. The practice of homœopathy, therefore, may be ever improving, but the law on which it rests remains absolutely and eternally the same, and the science of homœopathy is the knowledge of that law in ever fuller or deeper understanding. The building of bridges is an art, while the science of civil engineering comprises the principles upon which the scientific bridge builder proceeds; the principles and facts are absolute and permanent when discovered. Man's knowledge of them grows and improves; and this, the science of them, constitutes the basis for all improving and perfecting practice under them. Of course none know better than you how important it is for the homœopathist to know as acurately as he can the facts of those two distinct sciences upon which the art of practicing of homœopathy is based, viz.: The science of unmodified disease effects, and the science of modified dynamic drug effects observed in human beings. But one thing more occurs to me as of importance to the homœopathist, both to his theory and practice. I may indicate what I mean by asking what do you mean by dynamic drug effect? This is a question which strikes back of the observation of the law, and deals with the cause operative in its unfailing action. And it has often seemed to me that an understanding of the philosophy of cause and effect in disease and cure, would confer upon the homœopathist such a rational holding of the law of *similia* as would give the judgment poise, and the faith firmness, against all experiments and in the midst of all sophistries of appearances. How is it, and why is it, that that drug which will produce certain symptons when introduced into the human economy in health will operate curatively when such symptoms are, from other causes, present in disease?

I had allowed myself to contemplate a somewhat lengthy excursus into this unlimited and always interesting field of inquiry, but I have not left myself time to do it even scant justice.

I must ask you to enlarge our first postulate, that we have to do with a mind embodied, and consider embodied man in this world. Reflect also that we have a spiritual world embodied in the great world of nature which environs man. As he is a soul, with a body on, so as he is ultimated in nature we have to consider him in his two-fold relation of soul and body, and we have to consider his universe in its

two-fold nature as spiritual and material. As the man or mind terminates in the body and operates there and is the cause of all function, and its states the cause of all arrest and disturbance of function; so in the spiritual world are the causes of all those substances and potencies with which we deal in nature. The greater part of our human ills exists in us, from us, and by us. There is no general proposition about man more certain than this one. If you could cancel the vices and evils, or wickedness of mankind, a new era in the history of the body would be at once inaugurated. The flood of almost universal mismanagement would cease, and men would have clearer perception, where now they are besotted and astray. Think of all the people you know, and of all they do and all their ways of going on, crochets which they must indulge; all the things they take upon them, of their distempers, indulgences or hatreds and lusts. Add to that one day's reading of the newspapers, and then generalize, and you will see what a mighty factor of unhappiness, misfortune and disease you have to do with in the human beings, and what the play of it downward in the human body, and its disturbances health is likely to amount to. If once you get into this contemplation and look upon sin and wickedness as the "macrobe" in mankind, says Dr. Wilkinson, you will wonder that anybody is alive, and perchance remember the divine mercy that the evil genius is limited to the third and fourth generation by the mercy of God, while His mercy extends to thousands of those generations who love Him and keep His commandments. When you begin this study you can see not only in imagination that the affections and cares and lusts and passions of human beings disturb and prevent their bodily functions, but if you go deep enough, study patiently enough, you will be able to correlate the symptoms and disturbances with those mental states. This that we cannot do, through ignorance, only awaits the progress of science to be done intelligently, viz.: To trace the correspondence between cause and effect, in mental states and bodily diseases; not always the personal states of the sick man, because he is a part of the whole humanity and is subject to the pressure of its mental sickness and to the transference of the effects of other people's sins in physical contagions, but the cause belongs to mankind as spirits, in mental diseases and disorder, and the effect is written in man and mankind in bodily distemper and chronic misplacement and pain.

Now turn your eye over to that great spiritual world which is the cause of this theatre of our activities, and of these physical forms and forces by which we are environed. Conceive of the multitudes who continually go over into that world with their great body of mental distempers and cares and passions; of the great multitudes of evil men and women who have gone over from the beginning into that world, and imagine them in organic societary life seeking their own ends and pleasures, and then conceive the gall, in all its virulence and variety, which they perpetually secrete as a tendency and potency into nature, and you will not have much difficulty in accounting for all the poisons, mineral, vegetable or venomous, that are in the world, nor find it difficult to conceive that they should have such direct ratio to the human frame, that they will carry over into it symptoms of disease and disorder.

Now apply your law of *Similia*. May we not say that the spirit which hides and works mischiefs in the organ and its disturbed function is the very same spirit whose malignities give potency to the drug which you find to be the *Similia* of that disease? And in obedience to a universal law of the spiritual world, that evil gravitates to the bottom of its own like, when you introduce that lower than human ultimate of its life, namely, the drug the malignity which disturbs what is of man, must pass into this *Similia* and be carried off with it in the draught. It is because all influx into the organs with man is a transference of his spirits, and the associated spirits of evil and mischief who do him harm, that their function is disordered and disturbed. If those spirits have their lower home in some poisonous substance of nature, its introduction into the realm of their mischief must constitute a restriction upon their efforts, and a compulsion upon their life, to enter into it, and come out of the man. This will remind you of that scriptural incident, where when the Lord of Life Incarnate confronted the legion who infested the man, and commanded them to come out of him, they sought first as their permission and their right, that they might be allowed to enter into the four footed breed of their own kind; and "straightway the herd of swine ran down into the sea."

If this seem to you far-fetched, I beg you to remember that it is not the first of things which have become naturalized in our philosophy, that at the first seemed impossible or at best useless. It is but a hint I know; but the hint of

to-day becomes the developed thought of to-morrow; the thought grows to theory and takes root in experience in the progress of humanity. I commend it to you as an egg which is worthy of culture and of fair treatment as possibly pregnant with a philosophy that may give assurance of faith, and understanding to facts. If this hint affects you as it does me, it will suggest two things which I desire to leave with you, as worthy of thought and careful cherishing: First, the supremacy of mental symptoms in the search of *Similia*; secondly, the absolute trustworthiness of the *Similia* when it stands forth clearly amid the totality of symptoms. If I were a practitioner, as you are about to be, holding this faith as I do, I should be ambitious to add to faith in God, and good will toward man, and to a well rounded common sense, this trust and contagious courage, —that having found the *Similia* in any case, we may watch and wait, while the confluent forces of Providence work out the Law in the orderly and progressive, but sure and unfailing processes of cure.

THE PRESENTATION OF THE PRIZES.

BY PROF. H. B. FELLOWS, DEAN OF THE FACULTY.

Prof. Fellows announced the prizes as follows: First prize, $50 in gold, to Dr. A. C. Halphide, Illinois; second prize, $25, to Paul Rose, Indiana. Prof. Leavitt's first prize, a pair of obstetrical forceps, for the best examination in obstetrics was awarded Dr. M. S. McNiff; the second prize, a curette, to Dr. E. G. Hunt. Honorable mention was also made of Drs. C. E. Prosser, R. P. Bennett, E. A. Caswell, H. J. Macomber, J. L. Alexander, G. S. Culver, E. M. Fowle, O. L. M. Wall and M. A. Davidson.

Hospital Physicians and Surgeons.—Dr. E. M. Spaulding, of Minnesota, received the appointment as House Physician, and Dr. G. S. Culver, of Michigan, House Surgeon; Lady Physician, Dr. C. M. Hendy, of Wisconsin: while Drs. J. M. Hicks, M. H. Brown and L. S. Brown were the appointees for next fall, when the new hospital is to be opened.

ANNUAL MEETING OF THE ALUMNI ASSOCIATION.

The tenth annual meeting of this flourishing Association was held in the club-room of the Lexington Hotel, Wednesday evening, March 22, 1893, the President, Dr. H. P. Holmes, of Omaha, Neb., in the chair. The session was a very interesting and agreeable one, the disposition and the increase of the Alumni fund for the new college and hospital claiming most attention. The following new members were elected:

Drs. W. M. Thompson, '92; J. Lloyd Alexander, '93; Chas. H. Lards, '93; J. B. Ellis, '92; H. A. Noyes, '93; A. C. Halphide, '93; Oel S. Misick, '93; Ina M. Mighell, '93; O. F. Pierce, '90; J. A. Kirkpatrick, Clara A. Hendy, '93; Irene Hunt, '93; Ella G. Hunt, '93.

Apropos of the early history of this flourishing society, we quote the following from the literary crumbs at the banquet:

Dr. L. A. Bishop, of Fond du Lac, Wis., responded to the toast, "The Alumni," and a part of what he said was as follows:

"In 1888, not yet ten years ago, after the close of a profitable session of the Wisconsin State Homœopathic Medical Society, while whiling away the time in social converse. in the parlors of the Palmer House, in the hospitable city of Fond du Lac, waiting for the arrival of the train which was to convey our Chicago guests homeward, the question was asked, Why has not the Hahnemann Medical College an Alumni Association? This was a "stunner" that no one could answer. But when the second question was asked, when will a better opportunity ever occur to take the initiative? every one present answered as with one mighty voice, "Never!" We then and there appointed a committee on organization, consisting of five alumni, one from each of the following States, viz., Wisconsin, Illinois, Michigan, Minnesota and Iowa. I had the honor of being appointed chairman, and my esteemed friend, the rapidly rising Professor of Theory and Practice, A. K. Crawford, Secretary. When we met the following spring ('84) at the Grand Pacific, to make our report, everything was complete for a perfect organization —even a constitution and by-laws, the honor of which was largely due to our efficient Secretary. At this meeting the work of the committee was ratified, and I had the honor of being elected its first President, and Prof. Crawford its first Secretary.

The Alumni Association of Hahnemann Medical College had its origin in the innate desire of its graduates to associate themselves together in a band or society, having for its primary object the perpetuation of fraternal relations together with remembrances of those happy college days ever to be kept green in the memory of the Alumni. Its secondary, yet most important object, was the medical and surgical growth and development of its members together. We have not yet reached the close of the first decade of our existence as an Association,

yet our work has borne its fruit; the $2,000 that has been so cheerfully contributed by its different members is but the beginning. It is the leaven which in time will leaven the whole lump."

After speaking of the the objects yet to be accomplished by the Association, the doctor concluded by saying:

"God hasten the day when Old Hahnemann will become the mecca of yet many more students. *This can be done.* How? By good management, the best of professors, and plenty of money to back it. We must enthusiastically interest ourselves in her behalf, for we are 'bone of her bone and flesh of her flesh.' No student of medicine should ever find it necessary to turn away from her portals for information in any of the principal branches, or to the polyclinic for post-graduate instruction. So long as our alma mater is true to her children, her children should be true to her. In conclusion, I am constrained to class in the same catagory, the alumnus who is wholly indifferent to the welfare of his alma mater and who refuses to identify himself with his fellow students of the Alumni Association, with that son, who at the annual thanksgivieg dinner, finds neither time nor inclination to return to the old homestead, the old hearth-stone, to the associations of his early childhood, to the scenes of the springtime of his life, where were planted the seeds that germinated and developed into his stature of manhcod and success in later life."

ADDRESS TO THE ALUMNI ASSOCIATION.

By E. J. ABELL, M. D., of Joliet, Ill.

Mr. President, Ladies and Gentlemen:

When I was invited to make a few remarks before this Association my first impulse was to decline, not because I did not consider such a privilege an honor, but a guilty conscience whispered to me: "You are not worthy; what have you done in aiding the Alumni Association to promote the interests of your alma mater to enhance her welfare?" Nothing. These thoughts brought repentance, not of the death-bed kind either, nor the repentance of Judas, for I resolved to lay the thirty pieces of silver in the old dame's lap with, "God bless you, mother, I will neglect you no longer, I will retrieve the past and will avail myself of this opportunity afforded to meet your progeny represented by this Association and make a public confession, hoping thereby to receive absolution, and at the same time to be the instrument in bringing some other alumnus to the mourner's bench with his contribution." Graduates of Old Hahnemann, our mother has not passed the climacteric and we, the older children, should see that she is sufficiently supplied with material that she can feed the brothers and sisters that are yet to come with such food that they will grow to that full medical stature the day and age de-

mand, and also be in a position to fully appease the medical appetite of any of her numerous family who might choose to visit the maternal roof in quest of medical refreshment. It is of vital importance to us that our alma mater should be so well equipped with laboratory and clinical facilities that her graduates can maintain the standard demanded of physicians to-day, and take such rank in the professional world as will demonstrate to all and especially to those knowing and clever gentlemen who continuously do chant: "Homœopathy is slowly and surely dying," that Old Hahnemann has not only kept up with the procession but that she leads it.

Do not misunderstand me, please. In speaking of the need of increased facilities for the present and the future, I do not wish to depreciate the Chicago Hahnemann Medical College of the past, nor the noble efforts of her corps of teachers who have given their time and brains in the lecture room, in the amphitheatre and in the wards of the hospital without any remuneration or hope of reward. The didactic lectures in the old days could not have been excelled, but now medical teachers are recognizing the necessity of more laboratory and clinical work. The medical profession in the interest of themselves especially and mankind generally, ably seconded by the public, are demanding a higher standard of medical education. It is of vital interest to every individual member of the community that Doctors of Medicine should be thoroughly qualified for their profession by having a sound, complete and practical medical education. To secure such an education there must of necessity be increased facilities in our medical schools. The number of subjects taught must be increased. The time devoted to those branches must be extended over a longer period. A proper time must be spent by the student in the different laboratories in the study of chemistry, hygiene, physiology, pathology, histology, bacteriology, microscopy, etc.; and the student cannot understandingly, with profit to himself and honor to his school, be drilled in these different and important branches of medical science unless he has properly equipped laboratories in which to carry on these studies. Likewise the aspirant for a sheepskin cannot have a practical knowledge of disease without an opportunity of observing the objective and subjective manifestation of morbid forces at the bedside of the sick. No student should be graduated without first having received ample bedside instructions so that he or she can

see with "vision clear," with nose, ears, the tips of the fingers as well as the eyes. This means good and extensive hospital facilities. At this date, Anno Domini, 1893, the medical college that cannot offer students these very important facilities for acquiring a thorough medical education and training by actual work in the laboratory and hospital as well as in the lecture room will be on record as not in sympathy with the movement for the general elevation of the medical profession and thereby for promoting the true interests of the public.

The faculty of the Hahnemann have at all times shown a remarkable devotion and courage in their endeavor to raise the standard of medical education in this school we love, and have exhibited a marked degree of energy in planning and arranging to give her students increased opportunities and facilities for qualifying themselves in the noblest of all professions. The new college and hospital buildings when completed will be a fitting monument to the indefatigable efforts and zeal of the present faculty and management. They need the hearty coöperation of all friends of homœopathy, and especially of each alumnus. We should give it willingly and gladly.

We must not pattern after a congregation I know of; all of the members climb into the band-wagon and expect the poor parson not only to pull the entire load but to strike a two-forty clip straight for glory, and they yell and hurl epithets (I don't mean curse words) at him if he shows signs of getting winded on the road.

Each alumnus should demonstrate in an unequivocal way his staunch loyalty to his alma mater, and should unhesitatingly avail himself of the blessed privilege of assisting in this noble and glorious work. A small contribution, say $25, annually for four consecutive years, from each of the 1,500 graduates of Old Hahnemann, who is still engaged or interested in the practice of medicine, would aggregate a handsome sum, $150,000. Just think of it! How much that would add to the prosperity and efficiency of our college, and what a record for the Alumni Association.

Every graduate of "Old Hahnemann" is a debtor to the college. All honest people should meet their obligations. We therefore ought to render unto our alma mater that which is due her from us. I have mentioned a part of our obligations, the contribution of money to the building and equipment fund. Of course we are anxious to meet that

claim, but there is another obligation, and it is a greater and more important one. A tree is judged by its fruit, the fertility of the soil by the grade of the produce. So, also, an educational institution by the attainments, ability and success of its graduates. This brings me to some of the things that concern the reputation and success of every physician, and if the graduates of Hahnemann, both old and recent, will look well to them, such credit will be reflected on our college that medical aspirants will be anxious and proud to be numbered among her matriculates. Candidates for admission as students in medical colleges recognizing the public demand for a higher standard of medical education and the keen competition in the profession, no longer will seek the school that will rush them through the easiest, in the shortest period of time, but will knock at the portals of the one that will give them the best training, qualifying them to meet that demand and to successfully compete in the strife for patronage and preferment.

See to it, graduates of Hahnemann, that your standing in the profession is such that the would-be doctors will become possessed with a fixed determination of being made in the same mould. You will thereby assist to increase the number of students calling upon the registrar of Hahnemann College and at the same time will be meeting that other obligation.

Now to those things that concern the reputation and success of a physician. Physicians when starting in the practice of their chosen profession should found their expectation of success on their personal as well as their scientific qualifications, and keep purity, honesty and truth to the front in their minds and be governed by them. Look well to your companionship. Avoid loafers and loafing places. Unfortunate associations have been the stumbling block in the way of many a physician. Never try to hold down the counter inside nor the dry goods box outside of any store. Physicians are regarded as public property, and the public consider that they have a right to closely observe and criticise their conduct, and if any Æsculapian disciple does not show himself socially, mentally, morally, worthy the esteem of that public, woe unto him, for success cannot crown his labors any more than a ringboned and spavined horse can win the race. The public takes cognizance of every detail regarding a doctor's life, his dress, manners, speech, habits, his going

and coming, therefore it behooves him to dress well, cultivate courtly, courteous and refined speech and his habits should always be above reproach. The doctor who is afraid of soap and water, who is indifferent to his personal appearance and is not acquainted with "Lookie Cleanie," the laundryman, even though he possesses a scientific and well-stored mind, must not blame Dame Fortune if some brother with less attainment and ability outstrips him in the race. Our worthy surgical professors insist that absolute cleanliness must be adopted in their work in order to have successful results. The surgeon or accoucheur in preparing his patient should never forget his own toilet. You have probably noticed that in speaking of some of the requirements necessary to make a successful physician I have used the masculine gender. Do not think I have forgotten the ladies in the profession. It would be ungallant even to insinuate that they could at any time be guilty of actions or conduct or addicted to habits unworthy of their sex and of their noble calling. To each graduate of Hahnemann allow me to say: By your life let people know that you possess a soul, that you are cognizant of the fact and are afraid to sully it. By leading an unblemished, useful and industrious life, true to yourselves, your profession and your God, you will meet another obligation to the college that gave you birth into the medical world.

"Wisdom is the sunlight of the soul." If advantage is taken of opportunities for a wider and more thorough medical education, it not only will increase our usefulness as physicians, our power to do good in relieving distressed humanity, but the intellectuality developed thereby will prepare us for a keener appreciation of the good things of life and an abhorrence of the evil. The thought that humanity reposes confidence in the physician's ability to heal its wounds and cure its diseases should be a strong incentive for him to acquire the requisite knowledge that confidence may not be misplaced nor abased. The physician, to keep abreast with the times, must be a thinker and a close student. He should be a subscriber to several good medical journals, and should know that unless he releases them from their wrappers he cannot absorb or assimilate their contents. He should have well-developed powers of discrimination, for there are some magazine articles that are indigestible and are apt to produce nausea if taken in too large quantities. He need not be afraid of the CLINIQUE however. It can be swallowed, scarlet cover

and all, and is warranted to agree. The assimilation thereof will produce nothing but healthy ideas and therefore truthful. You can always rely on them. Intolerance and bigotry can have no place in the composition of the intelligent and progressive physician. Faraday says: "Nothing is so opposed to accuracy of philosophical deduction as fixity of opinion." Another: "A man will never change his mind who has no mind to change." A physician, to be truly fitted for his noble profession, must be tolerant and liberal minded, and should not let prejudice prevent him from adding to his medical knowledge from any source. He should not be rabidly sectarian, but should seek truth for its own sake and accept it wherever found. Samuel Hahnemann discovered a grand truth. A system of therapeutics founded on it has made him the father of Homœopathy and the benefactor of mankind. We feel that it is an honor to be called disciples of Hahnemann. We receive Homœopathy as a truth, but in rejoicing over the possession of this truth, we must not forget that there may be other therapeutical truths which we should accept and use for the relief of distressed and suffering humanity. The doctor should not accept with unseemly haste every fad that may arise. Falsehood sometimes presents itself in the garb of truth, well vouched for. When the delusion is made manifest, how cheap and helpless he feels. Some of these products of fertile brains are discovered to be nothing but wind. Bergeron's rectal insufflation treatment for consumption is an example. I wonder if there is a single physician to-day who could acknowledge without blushing that he was ever the distinguished owner of one of the Frenchman's gas-bags?

Ladies and gentlemen of this Association: I have not tried to mount the heights of Parnassus, but I trust you can find a few grains of wheat in the chaff that I have given you, and I sincerely hope my appeal to you will take root and bring forth good fruit, and that our alma mater will reap a bountiful harvest through our united efforts as field workers. She needs our help, we must not fail her. Prof. Crawford has kindly furnished me facts and figures as to what has been done already by the faculty and Board of Trustees in the work of planning, erecting and equipping the new College and Hospital buildings, and by the alumni in contributing to the same. Please allow me to give them. The New College is now completed at a cost of $52,000, and contains a Museum: Medical, Chemical, Microscopical, Bacteriological and Physiological laboratories; three dis-

secting rooms, amphitheatre furnished with special chairs and working tables, elevators, café, dispensary, reception rooms, furnished throughout with electric wires for galvanic, faradic, cautery, and electric lights. The hospital which is nearly ready for the roof, will contain a kitchen on the top floor; six wards of twenty beds each, that can be increased by several beds in each ward; sterilizing room, a crematory for college refuse, forty private rooms, parlors, operating rooms, laundry, besides engines etc., in the basement.

It will be modern in every particular and will have an efficient interne corps of physicians, surgeons and nurses. It will cost $100,000, plus cost of college, making a total of $152,000. Money on hand and in sight, $68,000. Loan at 5 per cent $50,000. Total $118,000, leaving a balance of $34,000 to be raised. How much do you suppose the alumni of Old Hahnemahnn have contributed to the hospital fund? I am really ashamed to name the amount, $2,000, of which only $1,400 has been paid in, an average of about one dollar per alumnus. This will never do. I am a very penitent sinner; let me assure you that the repentance is genuine. I will not backslide. Those graduates who have been my companions in a Rip Van Winkle sleep must wake up, get a move on them, and come to the assistance of the faculty and management of our school. I have already stated what the alumni united could do. Don't call me a rainbow chaser. Each of the 1500 graduates of Old Hahneman ought to be able to at least give $100, twenty-five down and the balance in annual instaliments of $25. Contemplate for a moment where such a coutribution would place our school.

I am proud of the history of our college, proud of its advancement as an educational institution. A few days ago exspeaker Thomas B. Reed delivered an address in this city on "Progress and Leadership." If he had lectured on the development of our beloved college, the subject would have been practically the same, The history of Hahnemann Medical College of Chicago, can be told in those two words: "Progress and Leadership." At the end of another decade when that history is supplemented, let it be recorded that the alumni of Old Hahnemann have cheerfully, unhesitatingly and loyally done their part, have been no small factor in making it possible for our alma mater to keep abreast with the extraordinary advancement in medical teaching which will be sure to mark that period.

ALUMNI OFFICERS ELECT FOR 1893-4.

The following were elected officers for the ensuing year: *President*, E. J. ABELL, M. D., Joliet, Ill.; *First Vice President*, JULIA ORR, M. D., Chicago; *Second Vice President*, E. VINCENT, M. D., Springfield. Ill.; *Secretary*, F. H. HONBERGER, M. D., Chicago; *Treasurer*, JAMES P. COBB, M. D., Chicago; *Necrologist*, E. S. BAILEY, M. D., Chicago; *Executive Committee*, A. K. CRAWFORD, M. D., Chicago, M. J. MOTH, M. D., Chicago, L. A. BISHOP, M. D., Fond du Lac, Wis.

The advisability of holding a meeting of the alumni during the World's Congress, in May, was favorably considered, and the Association adjourned to meet at the call of the Executive Committee.

THE RECEPTION AND BANQUET.

The reception and banquet given by the faculty and alumni was held in the beautiful parlors of the new and magnificent Lexington Hotel, where every appointment was attractive and delightful. The guests numbered about three hundred and a more pleasantly social reunion of the loyal and thankful friends of the Old Hahnemann were never convened before. The toasts were very cleverly responded to by Drs. Bishop, of Fond du Lac, Spaulding, of Minneapolis, and O. W. Carlson, of Milwaukee, old alumni in excellent standing; by Mrs. Dr. N. V. Clarke, of Iowa, and Dr. E. S. Prindle, of Vermont, from the graduating class of '93; and by the Hon. E. M. Phelps, Treasurer of the Board of Trustees. Dr. C. Gurnee Fellows was toast-maker. The whole brilliant affair ended with a hop for the young people and leave-taking all around. And this closed the *thirty-third* year in the history of the Hahnemann Medical College and Hospital of Chicago.

CORRESPONDENCE.

OMAHA, Neb., April 3, 1893.

MR. EDITOR: I cannot forbear expressing my pleasure in reading Prof. Shears' article in the last CLINIQUE (p. 125) on Malignant Tumors of the Parotid. Your readers must have been gratified with that very practical report. The reference to the alleged impossibility of removing that gland, as it was held by Prof. Gibson, of Philadelphia, reminded me that, in his Autobiography, at Vol. II., p. 328, the late Prof. Gross tells the story as follows:

> Gibson was a non-believer in the feasibility of extirpating the parotid gland, and before his own class he openly accused McClellan of falsehood for having asserted that he had repeatedly performed the operation. For a long time there was a warm controversy on this subject between the rival schools, in which Pattison at length took an active part in favor of McClellan. Some ten years afterward Gibson and McClellan became partially reconciled; and after the latter had withdrawn from the Jefferson Medical College he was invited to witness an extirpation of the parotid, in the University of Pennsylvania, in the presence of the class and of many physicians who had come to see the "fun." The tumor was skillfully removed; and when the operation was over Gibson, turning toward the audience, remarked, "Gentlemen, I have performed what is generally called extirpation of the parotid gland; but it is not an extirpation of that gland. The mass I have removed is only a tumor overlying that gland, not the gland itself." "Gentlemen," said McClellan, "my distinguished friend has extirpated the parotid gland, but, unfortunately, he does not know it"—a remark which caused convulsions of laughter in the large assembly. McClellan is said to have performed this operation altogether eleven times.

Very Respectfully,
C. S. T.

Miscellaneous Items.

We are greatly pained to note the death of Prof. G. A. Hall, April 4, full particulars of which unfortunate event and the action taken upon it by the faculty and the profession must go over to our next issue.——Profs. Gilman and Vilas are at home again.——Dr. Boetcher has gone to Europe for six months in the interest of the Eye and Ear Clinic.——Dr. Anna C. Hardy was married April 12 to Mr. Jas. L. Bigelow.——The new Hahnemann Hospital is enclosed and the artists are hard at work inside the building.——Prof. Comstock, of St. Louis, has removed to his new and elegant residence, 3401 Washington Ave.—— The Hom. Hospital and Headquarters in the Columbian Exposition is almost ready for visitors, and the arrangements for the World Homœopathic Congress in Chicago, beginning May 29 and lasting one week, are about completed. Come and see us.——The usual complimentary dinner was given to the outgoing and incoming House Physicians and Surgeons of the old Hahnemann Hospital, March 27.——A number of clinical reviews and other papers will appear in our May issue.——The bureau of the Surgical Diseases of Women will report at the next meeting of the Clinical Society, April 29.——Dr. L. A. Shulz takes Dr. Boetcher's practice and Dr. Leffingwell, '93, goes with Prof. Shears.——We are satisfied that the portrait of the editor of the CLINIQUE contained in the *Pulse* for March was not intended for a caricature.——Send to Prof. Bailey, 3034 Michigan Ave., Chicago, for the Hahnemann Catalogue for 1893-94.——Dr. C. H. Evans has won golden opinions for his lectures on the Organon to our junior and middle classes.

THE LATE PROF. GEO. A. HALL, M. D.

THE CLINIQUE.

VOL. XIV.] CHICAGO, MAY 15, 1898. [No. 5.

Original Lectures.

SYPHILITIC DISEASES OF THE NOSE AND THROAT.

A CLINICAL LECTURE DELIVERED BY W. A. DUNN, M. D., PROFESSOR OF LARYNGOLOGY AND RHINOLOGY IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, CHICAGO.

The first case that I have to show you to-day is one suffering from necrosis of the hard palate, the result of secondary syphilis. This is one of the many unfortunates that you will meet from time to time who suffer from this dread disease. She does not seem to understand the primary condition, and it is impossible to ascertain from her the time of the primary lesion, but she says that about a year ago, after having the grippe, there came an ulcer in the roof of her mouth which has destroyed the tissue and the bony palate, the size of a pea.

When this case first came under my observation about six weeks ago, the surrounding soft tissue an inch in diameter, was very much infiltrated, and appeared to be on the verge of sloughing, but under the influence of the potassium iodide and a daily spray with the mercurial solution, and iodoform insufflation it has rapidly improved and appears healthy to the border of the ulcer.

As you see, the bottom of the ulcer is the bony surface

which does not appear to be in a normal condition, but is quite irregular and has the appearance of being necrosed. How far this destruction of bone extends I am not able to say, but usually we find the destruction far more than appears on the surface. It is probably destroyed at least the diameter of the original inflammation of the surface, and the destructive process is gradually softening and transforming this dead bone into pus. The intra-nasal condition does not show an ulceration, however; the base of the septum seems puffy and infiltrated as if the bone beneath the mucous membrane were diseased, which I believe to be the case, as the diseased bone we see is immediately beneath this portion of the nose. The odor is extremely fetid, even though the parts are thoroughly and frequently sprayed with the most powerful antiseptic solution. The general health of the patient is fairly good and I believe with proper treatment in this case she will be restored to good health with the loss of the diseased bone.

We shall proceed to-day to remove all the diseased bone possible with the desire of cutting short the long and disagreeable process of suppuration that is going on.

The chances are that this sequestrum will not be exfoliated for a year or more, during which time the patient is not only a nuisance to herself but to all about her. We can, at a single operation, do for her what nature will require very much time to do, therefore I propose to operate through the tissues of the mouth for the removal of this diseased bone.

As she is now under the influence of chloroform, I shall make a vertical incision an inch long in the median line, through the soft tissues covering the hard palate, beginning well anteriorally and ending when I find solid bone beneath my knife. As I insert my knife, I find that the destructive process has extended to the anterior portion of the alveolus, and as I proceed backward I find the bone is softened for about an inch and a quarter. Now I shall separate the soft tissue from the bone, and while the assistants hold back the tissue on each side with the double

tenaculum, I shall take this scoop and cut out all the softened bone. We find it gives way easily under the sharp curette, and a large portion is rapidly broken off, which I shall remove with these forceps.

We have here a section of the alveolar process, and by feeling the gums in the median line you can appreciate the amount of bone removed. I shall remove a second piece from the posterior portion of the wound which will probably bring with it, as you see, the base of the septum.

By inserting the curette into the wound I am able to scrape away the edges of the bone which might still be diseased, but I find that the portions are firm, smooth, and I believe in a healthy condition. We shall close the wound with silk-worm sutures and treat it exactly as a cleft palate.

The wound will be sprayed frequently with sublimate, 1.2500, and all precautions taken to keep it as aseptic as possible. As the tissues are naturally in a very septic condition and extremely liable to ulceration, it is possible the wound will not heal kindly and may be sometime in restoring itself; but I believe that, with extreme care and a continued influence of iodide of potassium we shall be able to record good results. However, we cannot possibly have as much risk of wide destruction and serious constitutional results as if this bone remained to slough away by gradual destruction. There will probably be a small hole through the palate which can be restored after the patient is in a thoroughly healthly state, and in the meantime she may wear a rubber plate to cover the opening into the nose.

While this subject is fresh in our minds I will give you the history of certain other cases that have come under my observation which show the deep-seated and far-reaching effect of the specific virus, especially on the nose and throat. You will often be told that with careful treatment for three years, under the influence of mercury and the iodide of potash, patients are perfectly cured and that no symptoms will recur. This, I believe to be an improper statement, as I have repeatedly found cases after years of

apparent relief have undoubted symptoms of specific disease develop in the nose or throat.

I believe a disease that may be transmitted from the parent to the child must contain a specific element which permeates the system so thoroughly, that even though it be reduced in its action by the hereditary transmission, is yet so virulent that the destructive ulceration takes place from the slightest cause, and has such power of penetration and destruction of the tissue, that it is impossible for a remedy to thoroughly eliminate it.

There must be in these cases, a small portion of virus hidden away in the trophic centres,or in the glandular system,or in some portion of the economy which the system with its normal reactive power is able to withstand ; but in after years the patient's general health becomes reduced from some cause, and we find the natural resisting power of the tissues reduced, or in other words depressed vitality enables the virus to become more active, and it shows its power by destruction of the softer tissues. A gumma shows itself on the mucous membrane that rapidly extends to the tissues about, causing a destructive suppuration, which attacks everything in its path. It may attack the mucous membrane, the periosteum, the brain, the spinal cord, the liver, or any organ of the body, being more liable, however, to seize upon the softer and more vascular tissues than others.

You should bear in mind the different stages of the disease with which you must contend. The most frequent pharyngeal complications you will find in the so-called secondary stage ; or in that time when the disease is yet in an active condition in the system, and frequently the early secondary symptoms are first observed in the pharynx or the glands of the throat. The patient appears with a very large swelling on the side of the throat, involving not only the tonsil but the peri-tonsular tissue and the lymphatic glands of the submaxillary region. The appearance of the throat in such cases is peculiar, and can readily be recognized by the practiced eye.

You will observe upon examination a peculiar deep red, appearance of the whole tissue that has been gradual in its progress as compared to an acute tonsilitis, which is free from deposit but is attended by more or less salivation. The invasion has perhaps occupied a week or a month, the patient has frequently left his first physician, who has not observed the cause, and sought aid elsewhere. Such patients are, as a rule, extremely anxious if they know the cause, and if they do not appreciate it cannot understand why the throat does not heal more rapidly. There is but slight tendency to suppuration, but sometimes an abscess accompanies it. The swollen tissue is extremely hard, inelastic and seems to be massed together. As a rule, this condition does not ulcerate if properly treated, and finally is reabsorbed and the throat is left in a good condition.

Usually attending this condition in the throat you find eruptions and other symptoms of the early stage of the syphilitic history. It frequently happens that the throat symptoms are but moderate, attended by a few socalled "canker sores" in the mouth or throat, which rapidly disappear.

You should be careful of the diagnosis in this class of cases, as a physician is often put to his skill in their proper management. It frequently happens that patients are unaware of the septic lesion behind the throat trouble. It sometimes occurs under such circumstances that the most delicate care is required on the part of the physician not to produce serious social complications, or to offend the patient.

It is sometimes best not to give the diagnosis, and it is under such circumstances that the skillful diagnostician is at the best advantage. He is able to treat with success because of his intuitive diagnostic skill.

Manifestation of the after years seem to increase in intensity as time goes on. Gummata appear on the soft palate, causing destruction of the uvula, the soft palate and posterior pharyngeal wall with its well-known plastic cica-

tricial adhesions of this reformed tissue. The soft palate is frequently adherent to the posterior wall. The disease may attack the hard palate, rapidly destroying the soft tissue and the bone beneath, which has the appearance of having been shot through the roof of the mouth. Ulcerative patches within the nose rapidly destroy the septum, frequently allowing the terrible deformity produced by destruction of all the bones of the nose, causing the nose to fall inward and to destroy the external contour of the face.

Specific ulcerations within the nose usually show their well defined border, their destructive tendency and the cicatricial contraction by healing. A very unfortunate series of cases are those that attack the naso-pharynx. These cases occur late in the disease and are extremely unpleasant to the patients themselves, their friends and the physician.

The following case will illustrate the severity of such a condition and will show you the symptoms developed thereby:

Case. W. L. C. was sent to me by a personal friend and was suffering with what he supposed was chronic catarrh. His history showed him to have had primary syphilis some fifteen years before. About nine months ago he suffered from an attack of the grippe which left him with what he supposed to be a nasal catarrh, with difficulty of breathing, increased secretion and fœtid odor from the nose. This had increased from that time, and when he applied for treatment I found the nose to be almost perfectly occluded, the post-nasal region filled with irregular, nodular granulations coming almost to the level of the soft palate. These tissues would bleed from slight irritation. The odor of the breath was extremely bad, and the discharge very fœtid. He suffered from reflex neuralgia of the head which at times was extremely severe, making it absolutely impossible to sleep or rest. His general health had been fairly good, but at this time he was considerably reduced from loss of sleep and a septic condition of his system. Under the influence of the usual antiseptic treatment, consisting of 1,2000 sublimate solution, of per-oxide of hydrogen, iodoform and such remedies he made but slight progress.

I removed the granulations with cutting forceps, but they rapidly returned. Applications in the nose of the aristol cerate, which is usually of great service in such cases, were also of no avail, and after two months of unsuccessful treatment he ceased his visits to the office, and tried various cures and physicians until his death occurred two months later.

This is the history of an extreme case, the like of which does not frequently happen, but it shows the severity and the deeply penetrating activity of this violent virus, even after years of suppression and of supposed cure. The treatment in all these cases must be local as well as medical; and there are two methods of prescribing for this condition, one of which is followed by the ultra homœopaths and the other by those who are not so extreme in their views. The former believe that the septic change involves only the vital or nerve centres, and that a highly potentized remedy prescribed on the totality of the symptoms, will restore these centres with sufficient power to eliminate the poison from the system.

I have not been able in many cases to compete with the ever-spreading and devitalizing influence of this virus by aiding the vital centres and allowing the virus to deplete the various tissues of the body. I have found best results by destruction and elimination of the septic germs by the use of the iodide of potass in five to ten grain doses three times a day. After a course of such medication the indicated homœopathic remedy will restore the depressed vitality and eliminate the remaining virulent elements.

Clinical Society Transactions.

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

APRIL MEETING, 1893.

The regular monthly meeting of this Society was held in the Great Northern Hotel, Saturday evening, April 29, the President, Dr. W. A. Dunn, in the chair.

REPORT OF THE BUREAU OF GYNÆCOLOGICAL SURGERY.

R. LUDLAM, M. D., CHAIRMAN.

XII. THE PHYSIOLOGICAL AND MORBID RELATIONS EXISTING BETWEEN THE UTERUS AND THE EYE. BY DR. R. LUDLAM.—One of the fruits of legitimate and honest work in special lines of medical and surgical practice is to develop their mutual relations; to show where these lines merge or intersect each other; and to furnish curative resources that no single school of specialists could have discovered and made available. If this fact were remembered there would be less friction, for not only would the pursuit of one branch of study and practice be a check upon the crazy and exclusive reliance upon another, but the interest of one would become the interest of all alike.

There is, perhaps, no better illustration of what I shall venture to style an inter-special reciprocity than is to be found in what has recently come in a clinical way of the associate work of the gynæcologist and the ophthalmologist. Every observing physician has seen cases in which for some unknown reason the eyes and the vision have become involved in the various uterine and ovarian disorders. In former times we first treated such cases in a general way, then, when they had drifted into an unman-

ageable state, sent them to the oculist or to the gynæcologist, according as either set of symptoms predominated; or to whichever of these two specialists was most convenient, friendly or experienced. After which, if they happened to work in harmony, as men who are aware of their mutual relations and responsibilities should do, all might be well, but if not, whatever benefit accrued to the patient was purely accidental.

Fifteen years ago an arrangement was entered into between my worthy colleague, Prof. Vilas, and myself, for the mutual study of such compound cases as came within the range of our observation. Occasional reference has already been made in this society to the result of our labors, and, at this time we have thought best to call especial attention to the subject as one that is likely to interest the general practitioner. The time is all the more propitious because of the recent appearance of two extensive monographs upon this subject.* It is a pleasure to state that in the main the conclusions arrived at by the two authors corroborate our own. The exceptions will be given you by Dr. Vilas, and it only remains for me to summarize and to emphasize the clinical contents of these two books.

Concerning the morbid relations that exist between the eye and the uterus, Dr. Janot bases his work upon the following conclusions, each of which should be carefully considered:

1. *Certain ocular troubles exist in relation with different physiological and pathological conditions of the uterus.*

2. *In order to institute an efficacious treatment it is important to establish their origin.*

3. *These ocular lesions are much more tenacious when the uterine troubles have persisted for a long time.*

4. *In a large share of cases they are attributable to infection.*

5. *The treatment should be addressed to the local condi-*

Contribution a l'etude des Rapports Morbides de l'Œil et de L'Uterus. Œil Uterine. Par le Dr. CHARLES JANOT, Paris, 1892; et *Les manifestations Oculaires de l'Hysterie—Oeil Hysterique.*—Par le Dr. P. PANSIER, Paris, 1892.

tion of the uterus and the vagina, to the local state of the eye, and to the general condition of the patient.

After stating that this publication was supplementary to that of S. Cohn (1890), the only separate work that has been published upon this subject until now; and that it would be limited to the direct relation between the eye and the uterus, omitting such special diseases as albuminuria, Graves' disease, hysteria, etc.; as well as that it would especially consider the *role* of infection in this form of ocular troubles, the author proceeds to develop his thesis in a very careful and practical way. The points are illustrated by detailed cases, of which there are *eighty-seven*, that are derived from various authentic sources. The bibliography furnishes a list of 104 papers, reports of cases, etc., that have already been published in various languages.

During Menstruation.—Frankenstein based these conclusions upon the study of twenty healthy women during menstruation whose ages ranged from 19 to 33:

(*a*) During the period there was a narrowing of the visual field; (*b*) this diminution began two or three days in advance of the flow, attained its maximum at the third or the fourth day, and diminished little by little until the seventh or eighth day of the period; (*c*) this narrowing of the field of vision varied in different persons, being more decided in those who had malaise, headache, palpitation and other nervous symptoms, or in whom the loss of blood was considerable; (*d*) it existed not only for white but also for green, red and yellow; (*e*) in twenty per cent of these cases the sense of color was deranged during the whole period for green, which was designated as yellow; (*f*) the central acuteness of vision was only slightly affected and became normal with the cessation of the flow; (*g*) the refraction remained intact.

It is not rare for the return of menstruation in otherwise healthy subjects to be accompanied by eczematous and herpetic eruptions upon various parts of the body, hordeolum, blepharitis, and kerato-conjunctivitis. Raus-

ohoff reports the case of a woman, æt. 28, who suffered at each menstrual period from an affection resembling herpes of the cornea of a tropho-neurotic nature. Although normal menstruation seldom affects the retina or the optic nerve, Leber reports a case of acute papillitis with hæmorrhage of the retina which was directly related to the catamenia. Inflammations of the uveal tract are more frequent because the iris and the choroid are most intimately related with the uterus. This latter fact is emphasized by the increased tendency to eye affections in dysmenorrhœa and other menstrual disorders. Numerous cases are cited to show that existing lesions of the eye and of vision may be greatly aggravated by the return of menstruation. In the case of iritis this monthly aggravation is sometimes very pronounced. Trousseau was the first to describe the catamenial form of irido-choroiditis and to demonstrate its relation with the menstrual infection. Indeed until his thesis was published in 1890, the etiology of ocular affections of all kinds was ascribed to congestion and anæmia, or to one of the diatheses, as rheumatism, scrofula, syphilis, etc. DeWecker (1891) first described the metritic iritis.

At Puberty.—The ocular lesions incident to puberty are numerous and varied. For six weeks prior to the first appearance of the menses a young girl was blind every morning, but the trouble disappeared entirely with the coming on of the flow (de Boismont). Ourset reports a case of hydrophthalmia that was induced by precocious menstruation. Under such circumstances the loss of vision may occur insidiously, without orbital pain or any evident sign of inflammation, and yet the ophthalmoscope may detect a serious lesion. Dor cites the case of a young girl who at the beginning of her menstrual life had double hæmorrhages into the vitreous humor, which came and went at intervals until the menses were regularly established, when the intra-ocular hæmorrhage and the amblyopia disappeared entirely and did not recur.

DeWecker is of opinion that when the iris only is affected the inflammation takes on the serous form; and Galezowski attributes the atrophic choroiditis of these subjects to the lymphatic and strumous diatheses.

The optic nerve is rarely involved at puberty. Our author has been able to find but two cases of optic neuritis in this class of subjects. In one of them, published by Leber, the nerve was atrophied, and in the other, reported by Oursel, the patient recovered. The conjunctiva, the cornea, and the uveal tract are most often implicated. But, occurring at this important epoch in the life of woman, these lesions have different degrees of severity, and are tenacious in proportion to the difficulty and the delay in the establishment of the normal menstrual function. They are either very much relieved or entirely disappear when that crisis is past.

At the Climacteric.—The eye symptoms and suffering incident to the menopause are better known, but are not always thoroughly appreciated. They include orbital pains, photophobia and lachrymation; while the accompanying inflammation is limited to the uveal tract. Again the eye becomes glaucomatous, with a strong and painful tension that necessitates prompt intervention. The crystalline lens is cataractous; the painful crises are very tenacious and recur periodically. (Dehenne). Sometimes the glaucoma develops without concurrent symptoms, takes an acute form and is quickly remedied. Pargoire cites a case that yielded promptly to a collryrium of eserine.

Next to the uveal tract the optic nerve is most often affected. The lesion presents itself in the form of optic neuritis which may either disappear without leaving a trace behind, or terminate in atrophy of the papillæ. Galezowski holds that we may have it under three forms: (*a*) of neuroretinitis either mono-or binocular, but followed by an obliteration of one or more retinal vessels; (*b*) of neuritis, with inflammation that is limited to the optic nerve of one eye; (*c*) double optic neuritis that may end in atrophy of the papillæ.

During Pregnancy.—Beside albuminous retinitis, the significance of which in connection with pregnancy is appreciated by the accoucheur and by the profession generally, there are other ocular troubles of this period that should not be overlooked. Santesson reports a case of amaurosis which repeated itself in several pregnancies; and Portal, one in which a woman became blind in her first pregnancy, deaf in her second, and mute in her third. Several authors have quoted cases of temporary blindness during gestation. Jobert cites five varieties of polyopia in each of which, except one, the woman had twins, and in the exceptional one, triplets. Bloding notes a case in which strabismus came and went with such regularity as to constitute a sure sign of pregnancy.

Hæmeralopia toward the end of gestation, hæmorrhage into the crystalline lens, and detachment of the retina without retinitis or albuminuria are not infrequent. T. Metaxas gives the following list of the eye lesions possible during gestation: (*a*) Ulcers of the cornea, which are usually central, develop slowly, and are painful but not dangerous. There is very often chemosis and hypopion; (*b*) accommodative asthenopia, which occurs in those who are hypermetropic; (*c*) hæmorrhagic glaucoma; (*d*) miliary aneurisms (Galezowski); (*e*) amblyopia and amaurosis without appreciable lesions; (*f*) scotomes and hemiopic symptoms that are purely nervous, without alteration of the ocular membranes. To this list Janot would add polyopia, strabismus and hemeralopia.

We see, therefore, that, in addition to the lesions caused by albuminuria, ocular troubles are frequent among those who are pregnant. They may be very slight and disappear with delivery, but they sometimes end with complete and permanent loss of vision. In view of this latter possibility, Lor is of opinion that the induction of premature delivery may sometimes be justifiable, as it is in case of serious albuminuria.

In the Puerperal State.—The eye troubles incident to labor are referable to the cerebral congestion that is caused

by the struggle and the strain of delivery. When not associated with confirmed Brights' disease they are usually self-limited. But the opposite is true, however, of the early post-partum period, in which this class of troubles are developed some hours after the expulsion of the placenta, directly after a severe hœmorrhage, or possibly some days after delivery. All parts of the eye are liable to be affected, and the lesions are various. Amaurosis, which may be entailed from pregnancy, or which may happen after successive labors, and which is not always associated with renal disorder, is frequent. Szily reports a case in which four days after labor, on having the window of her darkened room opened suddenly, a woman became blind. The ophthalmoscope showed no lesion; the trouble lasted for six weeks and disappeared, the patient's room being darkened and she gradually accustomed to the light again. Where blindness is incomplete, hemiopia from embolism of the central retinal artery, or one of its branches is not uncommon. Sometimes this lesion is preceded by a violent fever, partial aphasia with loss of memory for the names of objects, and other cerebral symptoms, which symptoms may disappear although the eye mischief remains.

These puerperal eye troubles are remarkable for their persistency. Not only may we fail to cure them, but often there is no relief for them; and sometimes they become very complicated. Nagel found a lying-in woman who became blind four days after delivery with characteristic signs of embolism of the central retinal artery. There was contraction of the arteries, palor of the papillæ and a cherry red spot, without any cardiac lesion. Later on there was detachment of the retina. Retinal hæmorrhages often accompany this embolism, and their cause is confirmed (as it was by Litten in six of his cases) by finding bacterial infarctus and abscess in the lungs and other organs.

This propagation of pathogenic germs, which penetrate the uterine wound and are carried to the eye, may cause an inflammation of the uveal tract, which, in fact is the part of the eye that is most susceptible to uterine involvment from the entrance of septic germs into the organism.

Iritis, irido-choroiditis and sclero-choroiditis are also common.

The characteristic of all of the diseases of the eye in childbed, including optic neuritis, is that they are septic, infectious, and secondary upon the uterine lesions and accidents that follow labor, whether premature or at term, and whether normal or abnormal.

In puerperal pyæmia it may happen that secondary abscess shall form in one or both eyes and the organ be thereby destroyed. A few years ago I saw a case in consultation with Prof. Vilas and the late Dr. Hall, a very sad case of the kind, in a primipara in which the globe of the eye burst and was discharged.

In lying-in women who are a prey to the worst consequences of the purulent diathesis one or both the eyes may be attacked with hyperæmia, which does not result from the ordinary causes of ophthalmia, but from a general cause. First there will be a blepharo-conjunctivitis to which the sinking of the eyes and their being buried in the orbit gives a peculiar appearance. The look is troubled, but without expression, and the patient rarely has any idea of ocular disturbance. Sometimes the cornea is sunken, faded, loses its tension and its usual brilliancy. In certain cases there is photophobia and lachrymation. Like the cornea, the iris may have a changed look, in which case it may partly lose its habitual color. I have several times seen a hypopion form, and the level of the purulent liquid would reach to a considerable height in the anterior chamber. (Hervieux. *Traite clinique et pratique des Maladies Puerperales.*)

Disturbances of vision are also frequent among nursing women. An amaurosis, more or less complete, at times accompanied by hyperæmia of the conjunctiva, is especially common. Eastlake observed this amaurosis in eight successive confinements of the same woman, attended in each instance with total loss of vision supervening on the third day. This patient was subjected to the examination of skillful ophthalmologists who were unable to demonstrate any alteration whatsoever in the transparent media or upon the retina. The sight generally returned in from three to five weeks. Cuvier and Sichel have observed the sudden appearance of amaurosis during delivery and a second case

in which no improvement took place during childbed. (Winckel *On Childbed.*)

In Amenorrhœa.—Of the pathological states of the uterus as distinguished from the physiological, the disorders of menstruation have a most decided influence upon the eye. Thus amenorrhœa is a frequent cause of amaurosis, which usually ceases when the flow is regularly established (Demours.) One of the forms of vicarious menstruation is the shedding of tears of blood. Cohn reports a case in which the menstrual hæmorrhage came from the angles of the eye, and sometimes from the jaws, the nipple, the hand, and even the ear, the stomach and the nose. Intra-ocular hæmorrhage, and hæmorrhage into the anterior chamber may also be due to menstrual retention. Amblyopia from amenorrhœa is rare, but a case is reported by Kohn. Oursel relates a striking case of myopia that was aggravated by a suppression of the menses.

Inflammatory affections of the eye from this cause are, however, more common, especially in scrofulous subjects. Phlyctenular and granular conjunctivitis, with or without eczema and glandular swellings, are familiar incidents in amenorrhœa. Daguenet cites a case of keratitis of the two cornea following a brusque arrest of the menses that ended in suppuration. Mooren reports an interstitial keratitis of both eyes that did not suppurate, but which persisted despite the treatment. When his patient was examined she had already had the trouble for thirteen years with a marked exacerbation every four weeks. Some improvement followed the bringing on of a slight flow by the use of emmenagogues, but there was no cure for it. The deeper parts of the eye do not always escape this secondary mischief, for the uveal tract, the retina and the optic nerve may also suffer.

The hæmorrhage into the retina may take on different forms; sometimes it is in spots and again it spreads. It often provokes a sanguineous effusion into the vitreous body. This more or less severe effusion interferes with the

use of the ophthalmoscope and prevents a recognition of the retinal hæmorrhage until after its absorption. Then we may find hæmorrhagic spots that are seated about the macula without changing it, and without invading the optic papillus. So far as vision is concerned it causes amblyopia, which, if the effusion of blood into the vitreous body is considerable, may finally result in total blindness. When the effusion is lacking, or has been absorbed, there are scotomes. An interesting peculiarity of this retinal hæmorrhage is that it usually involves but one eye.

The detachment of the retina under these conditions is so rare that but two cases are cited, one by Parrgoire and the other by Pflüger. Optic neuritis is accompanied by violent headache from the beginning, and the vision usually disappears rapidly. In one of Christensen's cases the blindness was complete in an hour. The prognosis, however, is not always unfavorable, for the atrophy may be only partial and the remaining vision may be sufficient. In Meyer's case, although the visual acuteness was reduced one-third, it returned to the normal and the fundus of the eye showed no trace of a lesion. Machek observed one case in which there was a complication of retinitis and of disseminated choroiditis that was followed by a complete cure when the menses were reëstablished.

Thus far we realize that the lesion may be seen, for it extends as far as the papilla where, by the aid of the ophthalmoscope, we can recognize the hyperæmia, the œdema and the change of color. But we may infer that it is possible for the inflammation to be limited to the intracranial portion of the optic nerve, and even to cause amblyopia or perfect blindness. This affords the best explanation of some cases which certain authors have mistaken for amaurosis. Such a passing inflammation does not result in atrophy of the optic nerve, and disappears when the menses return.

In a case noted by Skorowski and Kofminski the amaurosis lasted for six days. Both eyes are not always seized. Brown reports one in which the left eye was af-

fected along with hemiplegia. After six months vision was completely restored.

In Dysmenorrhœa.—The most important ophthalmic lesions that are secondary upon dysmenorrhœa are subconjunctival ecchymosis, which is very rare; conjunctivitis; choroiditis; scleratitis; keratitis, ulcerative or vascular; iritis, serous, cachectic single and double; inflammation of the uveal tract; asthenopia, accommodative or muscular; oculo-motor paralysis (Joachim), and retinal hemorrhage.

The retinal congestion may be the sole morbid symptom resulting from the dysmenorrhœa and subsiding without any serious consequences; but it may happen that hæmorrhage will result from a lack of resistance on the part of the vessels. We shall see that the septic germs may so alter the vascular walls as to facilitate their rupture. It is in this way that infectious materials brought by the blood current from the uterus to the eye may, if their influence is feeble, provoke a congestion only; while if it is very strong, may cause a rupture of the vessels and a consequent hæmorrhage. The most frequent eye effections associated with dysmenorrhœa, however, are iritis and choroiditis.

In Abortion.—In abortion the eye involvment is almost certain to be the result of infection.

Not only is the introduction of septic germs into the current of the circulation favored by the uterine wound, but also by the atony of the uterine muscular fibres. These contract less firmly and more slowly than after delivery at term, and the open mouths of the vessels offer an easy ingress to the microörganisms.

Admitting the possibility of infection as a cause of certain diseases of the eye, as for example, iritis and iridochoroiditis, in a given case, where could these germs have originated? In spite of the fact that women sometimes have an interest in concealing the truth, it will not be difficult to refer the lesion to its proper source. It is therefore necessary that the physician should be aware of their etiology if he would treat these diseases successfully.

Chronic Uterine Affections.—The neck of the uterus is continually in contact with the vaginal secretions, a condition that is quite favorable to the development of certain microörganisms. Through its erosion, or ulceration, the septic germs very readily find entrance into the blood current. The same is true of epithelial exfoliations of the cervical and corporeal endometrium.

Retinal hyperæsthesia is often induced in a reflex manner by dragging, pressure and displacement of the uterus. Cohn and Moren report cases of the kind in some of which repeated pregnancies aggravated the lesion through increasing the uterine deviation. We have noticed the same condition as a concomitant of old perineal ruptures. Rouquette cites instances in which photophobia was dependent upon metritis, anteversion and retroversion. Mooren had a case of retroversion in which after coitus the eye-suffering was always aggravated.

The optic nerve may be inflamed but is not likely to become atrophied. The chief ocular lesions in chronic uterine cases are those which are incident to the menstrual disorders, as amenorrhœa and dysmenorrhœa, which have already been considered. According to Litten the most frequent of those which accompany uterine cancer is retinal hæmorrhage. It may happen that the eye will be attacked although the cancerous lesion is limited to the cervix, while if it invades the body of the womb the eye may possibly escape. He ascribes this ocular involvement to the anæmia of advanced cases, but it is doubtless true that uræmia and malignant infection should also be added to the list of causes.

Concerning the infectious source of the diseases under review this book is full of suggestions. Trousseau, to whom we have referred, first described the catamenial iritis. He reports other cases in which the patient's eyes were healthy after labor so long as the vaginal irrigations were continued, but when their use was suspended the eyes soon became infected. At the moment of menstruation there is a true uterine wound which, being in constant con-

tact with the germs, may excite a metritis and their transference to the eye. Truc calls attention to similar conditions incident to abortion which will not respond to treatment until the uterine wound is healed. De Wecker is very emphatic: "In fact, "he says, "we may conclude without fear of contradiction, that all cases of iritis of whatever kind are of infectious origin, and that every person who suffers from it should be guarded as if he had an infectious disease."

This is too sweeping a statement, no doubt, and our friends the oculists will correct it by showing that, while iritis and other utero-ocular lesions are often, and more often than has generally been supposed, of infectious origin, the old theories of their causation should not be altogether rejected. For they are, and will always be deserving of consideration.

As already stated, I have long been satisfied of the clinical importance of the relation between chronic diseases of the uterus and the eye, and that the most sensible and successful way of curing them was to take both sets of factors into account. Here is an extract from one of my hospital lectures delivered some years ago:

A considerable proportion of cases of endo-cervicitis are characterized by impaired vision, or rather by weariness of the eyes and inability to use them. This is true not alone of inflammation of the cervical mucous membrane, but of other diseases of the neck of the womb, and perhaps of the ovaries also. For there is an inexplicable sympathy between the inferior segment of the uterus and the eyes. I have treated a case of incipient amaurosis which was entirely and promptly relieved by the removal of a small mucous polypus that was found hanging from the external os-uteri. Women have in almost numberless instances complained to me of pain, aching and weakness of the eyes immediately after the application of even the mildest lotions directly to the cervix. It is not at all unusual for this symptom to follow copulation temporarily, and in case of immoderate indulgence of the sexual appetite, to become chronic and perhaps incurable. The patient before you, had these symptoms in a marked degree, and just in

proportion as the uterine irritation and inflammation have been relieved in her case, have the weakness of vision and its attendant symptoms improved.*

What is said of the diagnosis of these allied affections is so very practical and expressive that we cannot forbear another quotation from Janot:

In the great majority of cases it is easy to find the original cause. The patients themselves direct our attention to the condition of the womb; for they are often struck by the periodicity of these affections and their relation to the menstrual return. This periodicity is often significant at puberty as well, and even when the flow has not yet appeared.

But these signs are sometimes lacking. The ocular lesion may persist in the intervals with aggravation at the month, in which case we must verify the uterine involvment by a local examination. Thus we may often find that the womb is concerned in the difficulty when it had not been suspected that such was the case. With young women who are free from syphilitic and rheumatic antecedents we may find an excoriation with suppuration of the lips of the cervix uteri.

If the patient desires to conceal the true state of the genital organs the diagnosis is more difficult. The case reported by Prof. Truc was one of plastic irido-choroiditis following an induced abortion. He was forced to push his inquiries to the end of obtaining all the facts because he was satisfied that the iritis was related to a uterine lesion.

It is comparatively easy to distinguish these troubles from such as are caused by syphilis and rheumatism. The patient's antecedents and the coincident suffering are suggestive, but since both sets of causes may be in operation they do not always absolve us from the necessity for a vaginal examination. We have often seen cases in which patients had iritis and irido-choroiditis with rheumatic pains that were complicated with menstrual troubles, and which could not be relieved until the menses were regulated.

When the eye ailments result from blenorrhagic infection the diagnosis is more difficult. That this cause may induce iritis is shown by Prof. Truc who has reported an

*Lectures Clinical and Didactic on the Diseases of Women. Sixth edition, page 458.

irido-choroiditis in a young man with subacute rheumatism and acute gonorrhœa. We should therefore remember the presence of the gynococci in the genital organs. In some cases only the bacteriological examination of the vaginal discharges could settle the diagnosis, but usually there can be no doubt of the presence of the infectious element. In the case of virgins the result may be charged to the microbe of ordinary suppuration.

The prognosis turns upon the diagnosis. Having determined the uterine origin of the eye trouble, the nature and clinical significance of the cause is an essential factor in foretelling the course and result of the secondary affection. The ease and facility with which the disordered menstrual function can be remedied and its healthy performance restored; the possibility of curing an accompanying disorder of place or of structure in the uterus itself; the time of life, the limited condition of puberty, gestation, puerperality, lactation and the menopause, are qualifying conditions that need to be studied very carefully. Briefly, however, the prognosis of ocular lesions of uterine origin is serious, for it often happens that they do not disappear when their peculiar cause has been removed.

Finally, the local treatment for the eye and that for the uterus should in many cases be the same as if each affection was single and primitive. When, however, there is reason to believe that the double mischief depends upon some form of uterine infection, the indication is for intrapelvic antisepsis, the technique of which is familiar to the members of this society. Menstrual arrest and derangement, as well as uterine deviations, laceration, congestion and ulceration should be regulated and remedied by medical and surgical means, the eye being treated meanwhile as local circumstances may require. The constitutional remedies in our school of therapeutics especially, can very often and indeed usually be suited to both sets of symptoms at one and the same time. But this opens so vast and important a subject that I must close with the hope that one of our number will favor us with its development, and also

with the remark that the review of the second book on my list must be deferred.

DISCUSSION.—DR. VILAS.—Those of us who are familiar with the labors of Dr. Ludlam in his specialty will not be surprised at this remarkable paper. This is a most difficult subject to write upon. Any one who has heard the names of diseases alone which have been given would feel very much as students often do when first they attend lectures on the eye. Those who have listened to lectures from me may have noticed that I always begin the initial lecture with the statement that in the eye and its appendages may be found a portion of every component of the human body; and for that reason it becomes a most important study of the course.

I am sure you will agree with me, after this paper, on the importance of such study; and I surely hope that its author will give a review of the other book at an early date. A paper of this sort is so complete that it is impossible for any one to speak upon it without a thorough and careful study of its detail. There might be some points which could be elaborated by the ophthalmologist were time given. When Dr. Ludlam spoke of the asthenopia found in connection with the displacements of the uterus, I thought it a good time to emphasize the fact that this relation does not receive sufficient attention from the general practitioner.

We might also speak particularly about the metastatic choroidal abscess which was touched upon. When the Doctor reviews the other book with his next paper, which I hope will be very soon, I think the whole should be published in pamphlet form; it would be most useful to all branches of the profession.

Patients are sometimes a little surprised if questions are asked by the oculist that refer to the organs remote, and seemingly not connected, but for a number of years I have put great emphasis on the fact that no man could be a good oculist unless he was a good general practitioner as

well. I would like very much indeed to have more time, and would like to study this and its companion paper. I am sure that our records can add more and similar cases that have been seen during our joint service of the last fifteen years. I hope we may have some suggestions from some others. I feel abundantly repaid for coming this evening, and thank Dr. Ludlam for all the labor he has taken in our behalf.

Dr. E. S. BAILEY: I have been very much interested in the reading of this paper, for I have known of some instances in which the lower segment of the cervix seemed to have a very marked influence on the vision of the patient.

I have in mind a class of cases that I think have a large influence upon the general system, sympathetic system largely, and secondly the cerebro-spinal system and following that the nerves, the spinal sense, and that is the class of cases of hyperplasia of the uterine tissues; and the second the uterine displacements. A case that is fresh in my mind to-day illustrates the latter part of it, and that is a patient suffering first with a severe form of retroversion in which the fundus rests upon the rectum. I noticed that with the beginning of her uterine trouble she had a failing vision. She suffered from this for twelve years and has had a number of physicians during the time. Repositing the uterus relieved a good many of the pelvic symptoms and finally the eye symptoms. Following the condition of retroversion, came on the condition of acute anteversion with the cervix resting upon the rectum to a very large extent, interfering with the vision, so much so that the oculist thought it a case of amaurosis and performed two operations for its relief. The patient drew attention to the fact, that always when she was suffering from the severe form of uterine displacement the eye symptom was prominent.

I think this a good time to insist that the subject be ventilated further. I believe it of very great importance that the eye symptoms be studied with those from the uterine lesions, and I have learned a good deal from the reading of this paper.

DR. SKILES: I have listened with a great deal of satisfaction to the reading of the paper. For several years it has been my habit the first thing when I saw a patient, to examine her eyes and often I have found the cause of the eye trouble in the uterus and by relieving this, the eye trouble was also relieved. I recollect one case which I sent to Prof. Vilas. When she was fourteen, he fitted the eyes with glasses for hypermetropia, and before she was eighteen he changed her glasses three times, making them stronger every time. At eighteen the father reported that she could not see; she could not tell whether it was her mother or some one else's mother in the room. I asked for an interview and upon questioning her, I found that, ever since she could remember, she had had a continued leucorrhea. I told them it was due to endometritis, and when that was relieved her eyes would be all right. I dilated the uterus and wiped it out with cotton and to my delight in the morning she could see her mother. This has been my habit for several years, that when these cases are treated I place them in a dark room. Whether this is correct or not, we had the result. The way that I came to do this: I had a friend who treated a case of this kind and the patient was so delighted that the eyes were cured and acute inflammation of the eyes disappeared.

I do not know how I can emphasize the value of this paper; I do not believe that we can fully appreciate it until we have read it carefully.

Dr. C. J. SWAN: I quite agree with those who have previously spoken in regard to the value of this paper, especially in regard to having it printed, as I believe it will be the first pamphlet published on this subject in the English language. I was informed beforehand that this essay was to be read, and have made an effort to find something upon the subject. I looked over my own books and spent several hours in the Newberry Library for this purpose; but the meagreness of the literature upon this topic is something to cause surprise.

In looking over my notes taken last winter in the clinic

of Prof. Fuchs, of Vienna, I found a case of amenorrhea, with hæmorrhagic retinitis that will come under this head. A young woman, twenty-four years of age, came to the clinic complaining of a periodic amblyopia. Ophthalmoscopic examination showed bilateral hæmorrhages. It was found that these hæmorrhages would be reabsorbed in three or four weeks, but would recur at every menstrual period. The outcome of the case I was unable to learn, as she was sent to another clinic.

There was also a case of trachoma with pannus, in a young peasant girl, that seemed to do well under treatment until the menses came on, when the disease would again assume all its former virulence.

Dr. W. H. BURT: I have been very much delighted with the paper this evening, and find that it opens an entirely new field for us. I would like to relate one case in point, for in my practice I have had many confirmations of these cases. I had one patient who gave me great trouble, a young lady, about eighteen years of age, with deep, heavy pains in the eyes all the time, and during the menstrual period always having a sick headache. I felt satisfied in my mind that I had a case of some optic trouble, and therefore sent her to Prof. Vilas, but the result was that the doctor said there was nothing wrong with her eyes. She had female trouble, and not being willing for a man to treat her she went to Mrs. Dr. ———, and was treated in the old school way for about two years, but remained a physical wreck all the while. Then she had to give up school, and I commenced treating her. A man then came along and married her, and I felt very sorry for him at the time, thinking that he had ruined his life forever, as well as hers. In a short time she became pregnant and was delivered of a nice child, and is now a perfectly healthy woman. Now I see that Dr. Vilas was right. He could not find any optic trouble, and it was probably reflex from the uterus.

Another woman had terrible convulsions, and remained partially blind for nearly six months. If she could have a

light in the room she was all right, but if the light was out she would go insane. In about six months she got over that entirely.

Only yesterday I had a case similar to Dr. Bailey's. She had had this for about six years and one eye was almost lost. I replaced the uterus yesterday, and of course have not heard the result. I have been more than paid in hearing the essay of the evening and am sure that it will bear a great deal of study.

Dr. SKILES: I would like to ask Dr. Vilas if, in these reflex cases he can see anything abnormal with the opthalmoscope?

Dr. VILAS: Yes, in some of the cases, but generally not.

Dr. SKILES: A case that I treated about a week ago of almost complete blindness, except that at the right side there was just a ray of light in the right eye, and now she can see an object at about forty-five degrees. She had been thoroughly examined by oculists, and they pronounced the eye perfect. I would like to ask Dr. Vilas if the deeper part of the eye showed anything by which the trouble could be diagnosticated?

Dr. VILAS: I could not say without examining the case, whether they did or not. That could be answered only with the ophthalmoscope.

People are apt to think and speak of the eye as a separate thing, entirely disconnected, as though it could be mailed by express, treated and sent home. They do not seem to think of it as connected with the body. I have been working a number of years on the subject of the relation of the eye to the general system and some day I hope to publish a monograph on this important subject.

Dr. WESLEY A. DUNN: This is a pet subject of mine, and is a matter of the relation of the organs to the body. I chose for the subject of my inaugural address as President of this society, "Is a Specialty Possible?" and took the ground the special study of an organ alone is not possible. I believe that, to be a good specialist you must be at first

a good general diagnostician. I started out with the idea, that I would treat nothing but the nose and throat, and thought I could tell all about the nose and throat by looking into them. But I soon learned, that often I was treating the wrong end of the body and in many cases saw only the tail end of the symptoms, when I observed the nose and throat.

So it is with all the organs and the specialities. One cannot be a specialist without first being skilled in general diagnosis. This is a foundation of all things, and without making a general diagnosis it is impossible to effect a cure. This is true in every specialty and those who say they will not look beyond the eye, nose or throat, are the ones who are getting left.

Dr. LUDLAM closed the discussion with thanking the members for their expression of interest in his report. It was designed to bring their attention to something useful, not alone in a diagnostic, but also in a curative way; and not only to a specialist, or to two sets of them, but also to the general practitioner. The frequency of utero-ocular troubles will be conceded, and I am sure that many of our physicians have seen them and treated them more or less skillfully and successfully, but unwittingly, without having recognized their clinical kinship. And, what is true of the lesson in this case as between the oculist and the gynecologist is, I take it, true of the mutual relationship of all the other specialties that really deserve the name. When rightly practiced they are not independent but interdependent; and I have no sympathy with those who doubt if their cultivation will do us any real good.

Taking the clinical hints as to causation contained in our paper, supported as they are by objective and tangible facts, as a starting point, and turning to our materia medica, what confirmation do we not find of the morbid relation between the eye and the uterus. The provings of belladonna and pulsatilla and many other remedies are exceedingly suggestive in this regard. Dr. Evans has promised to develop this side of the question for the ben-

efit of the Society; and I hope that others will resurrect and bring hither a report of the cases which they have had that are in line with this inquiry.

Dr. VILAS offered resolutions concerning the death of Prof. Geo. A. Hall. (See page 260.)

THE LICENSE TO PRACTICE MEDICINE.—In a recent address to the Minnesota Academy of Medicine, after extolling the plan followed in Canada, Prof. Osler said:

"Difficulties have, of course, been encountered in the development of this plan. The first came when the homœopaths demanded representation on the boards. This was bitterly opposed, but the legislature refused to grant any privilege in which all schools did not have an opportunity to share. I do not think that this issue with the homœopathic school is a real one to-day. Men are brimful of prejudices. But, after all, the homœopaths only differ from the regulars in therapeutics. There is no homœopathic anatomy or physiology; no homœopathic surgery; no homœopathic midwifery; no homœopathic pathology; no homœopathic practice; there is only in therapeutics a special difference, and I do not differ more from my erring homœopathic brethren in the matter of therapeutics than I do from many of my regular brethren, who write shot-gun prescriptions a yard long, and fire them indiscriminately at their suffering patients. The way to sift out any medical error is to pass all candidates through the same portals of the profession. Mistakes will be minimized when men are taught alike in the essentials of anatomy, physiology and pathology."—*Northwestern Lancet.*

Hospital Notes.

THE PHYSICIAL DIAGNOSIS CLINIC.

SERVICE OF PROF. A. K. CRAWFORD.

Case No. 17,000.—MITRAL INSUFFICIENCY AND HYPERTROPHY.—This little school girl, about seven years of age, short of stature, thin and of a bilious temperament, came to me from the children's clinic for examination and treatment.

Eight months prior to her presenting herself, she had been taken sick with her second attack of measles. Three years before that she had an attack of rheumatism in the ankles and wrists, which lasted for two months. She had never felt well since the last attack of measles; complains of headache over the eyes; pain in the cervical region; palpitation of the heart, especially upon walking, and under excitement and the bowels are inclined to be loose.

Upon examination she was found to have a small compressible pulse, the sphygmographic tracing of which is

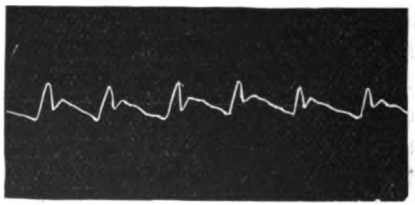

FIG. 11.

here exhibited. This tracing presents the features of a fairly good apex, a too sharp descent into the aortic notch and considerable over rapidity. It looks well enough on paper, but under the finger it lacks both volume and sustaining force. The general impression is, upon only slight digital pressure, that the artery has little blood in it. There was marked throbbing noticed of the carotids, and when oscultated these vessels were found to give forth a hæmic murmur, especially marked on the right side.

On account of the combination in the history already given, of illness following an exanthem and of the rheumatism which had preceded it, the cardiac area took up our attention next.

The apex beat of the heart was found to be displaced downward and to the left, with a larger area than normal of cardiac dullness upon percussion. A slight, but constant mitral systolic mumur was quite readily distinguished over a considerable surface.

Arsenicum jod. 3 x was prescribed three times a day, and as the patient reported much better at the next visit, this prescription was continued for three months.

In how far the lesion itself was affected by the remedy the clerk has failed to note.

Case No. 17,001. FATTY DEGENERATION OF THE HEART.—This man, a laborer, 64 years of age, sanguine temperament and medium weight, comes to us because he is too sick and miserable to be able to work, and not sick enough to go to bed. A year previous to his reporting to my clinic he suffered from an attack of the grippe, since which time he has not been well a day. At present he complains mostly of a smothering sensation and tightness across the upper part of his chest. Occasionally he has a pain in the small of the back, and, not long since, he was troubled with pains also in the region of the heart. He tells us that about fifteen years ago he had an attack of rheumatism affecting the limbs and head, and even now is what we call a rheumatic subject, for he has more or less flitting rheumatic pains bothering him. Twice he has had regular inflammatory rheumatism which confined him to his bed for some days. His pulse is an entirely different one from the last

FIG. 12.

case as can be seen by the tracing. It is rather a delicate, ill defined and thready pulse under the finger. It will be

observed that the apex is not nearly so high and that the pulse remains at its point of distension for quite a period. This gives the tracing the flattened top characteristic of either atheroma of the artery or fatty degeneration of the heart.

For the purpose of gaining corroborative evidence, the sclerotic is examined under the lid and the arcus senilis is discovered. Besides this we find the condition present of abdominal plethora which goes so commonly with vasomotor stasis.

In auscultating over the præcordia no murmur is discoverable, but at the same time there is a marked lack of normal systolic force. The valvular sounds are heard, and little else, which, together with the fact that there is no special enlargement of the organ, leaves the diagnosis tolerably certain.

Arsenicum alb. was given to this case part of the time in the 2x trituration and part of the time in the 3x, because it is undoubtedly the best "antifat" remedy, in so far as the cardiac muscle is concerned, which we possess.

Case No. 17,004.—AORTIC STENOSIS.—This girl, fourteen years of age, has been in the care of the eye and ear department, on account of an aural discharge, but there was evidently something more wrong with her than that and she was sent in for a physical examination.

It was elicited from her, that about five years ago she had a bad attack of diphtheria to which she ascribes her subsequent ill-health. When the cardiac area was examined,

FIG. 13.

we had the evidence of a former inflammation of the endocardium. The action of the organ was quite intense and more rapid than normal. The frequency is seen in the tracing, but the force of the heart's action is out of proportion to the pulse beat. No murmur was heard in the

apex region, but one was discovered at the base of the heart and systolic in rhythm.

Later in the treatment of the case, rheumatic pains appeared and disappeared and palpitations were frequent, especially upon exercising, but the symptom which was most persistent and provoking was that of a slight rise of temperature above the normal. Moreover, this peculiarity was not confined to this special case, for we had several boys and girls, their ages running possibly ten to eighteen, who exhibited this same symptom. Whether it was due to the old aural condition or to the endo-cardial inflammation running a latent course, or to some occult state of the system or season, I never clearly determined.

Under naja her general condition and special symptoms improved considerably, bnt there was always the tendency to relapses and new features cropping out, which demanded such other drugs as spigelia, aconite, ferrum phos., etc.

In this case there was so much pain, ill defined and flitting, referable to the underside of the manubrium that I was convinced that the inflammation which had started within the ventricle, involving the aortic orifice, had extended into the lining of the aorta itself and I think this position was sustained by the fact that spigelia and aconite had both a very marked controlling influence over it.

Case No. 17,006. CHRONIC ASTHMA.—This patient, who is now 55 years of age, has been sick for seven or eight years, the chief complaint being constant wheezing with cough. She says the cough is worse in the morning and in damp weather. When severe a coughing spell brings on headache. Cannot lie down at night on account of suffocation. During the winter previous, for three months, she suffered from successive attacks of what she termed lung fever. Undoubtedly it was acute exacerbations of her chronic bronchial condition. She reports that the bowels move only every second day and that the stools are dry and hard. The urine is very dark with slight sediment.

The physical examination brings out the usual signs in such cases. No areas of marked dullness, but rather an impairment of percussion resonance particularly over the bases of the lungs. The sibilant and sonorous rales, with wheezing, are of course the prominent auscultatory signs, with lessened vesicular action posterially.

She was given Arsenicum alb. for one week with slight improvement reported at the end of that time, when the prescription was changed to ammonia carb. 3 x every two hours.

When such a case as this, after having run through the gauntlet of a severe winter, and laboring under the bad effects of repeated colds, and presenting some of the ordinary symptoms of tartar emetic, I have found that the ammonium carb. is the preferable remedy. To be able to limit the mucus secretion and aid in its expulsion either one of these remedies answers well, but the preference comes for the carbonate of ammonia in old people who possess little vitality and poor reactionary power.

Case No. 17,007. CHRONIC BRONCHITIS.—A male patient, 45 years of age He has been sick for nearly four years. At that time he was working in a brick yard. When he stopped working one day he was very warm and lay down on the ground and went to sleep. When he wakened he felt very stiff and found that he had contracted a severe cold, and following this had a cough for two years.

He complains now of severe pain in the right chest and back which has been troubling him constantly for the past four months. He coughs and expectorates thick yellow mucus. The throat is dry. The nose stuffy. There is a heavy white coating on the tongue in the morning, with a slimy taste in the mouth. His appetite is poor. The food lies like a stone on his stomach; the bowels are constipated and the urine is generally dark.

On stripping the chest the signs discovered were very largely negative. There was impaired expansion and impaired respiratory murmur pretty evenly distributed over both sides. By forced respiration some mucous rales were found toward the bases.

Mercurius bi-jod. was prescribed for this patient with the expectation that it would not only reach the catarrhal condition of the bronchial tubes, but also the catarrhal state which exists from the nostrils down through the alimentary tract. He is a poor subject for a rapid cure no matter what remedy may be chosen for him, because there is nothing that will hold a bronchial subject down so long and so persistently as the one whose alimentation is poor. While his chief complaint is in regard to his chest and his cough, the point for the physician to direct his attention to and eliminate as quickly as possible

is the catarrh of the stomach which accompanies the other condition.

Such a one would do well in a warm, moist climate through the winter months, and this change alone would do him more good than all the remedies that could be fired at him while he remains in a northern latitude.

Case No. 17,010. CARDIAC DILATATION.—This Irishman, 53 years of age, says he has been sick for six months and has been unable to do any work during that time. For twenty years he has been employed in a neighboring brewery, loading and unloading the wagons with heavy beer kegs. He certainly looks sick and not only unfit for work, but apparently unfit to be out of bed. His eyes are sunken, his lips blue, and a marginal blue line is seen on the gums. By percussion the liver is found to be greatly enlarged. The apex beat of the heart, as well as it can be determined, is three and one-half inches below the nipple. By the stethoscope no murmur can be discerned. The pulse

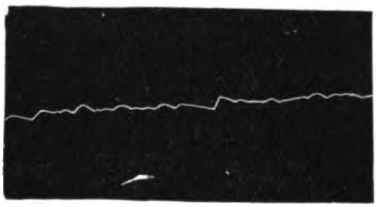

FIG. 14.

as a mere waver. Thus far, the physical examination shows that we have an enlarged heart with diminished power, and a lar ge liver and stasis of the general circulation. This is sufficient to make out the diagnosis of dilatation of the heart. But the question arises—what has brought about this condition of dilatation? We have in the history one item to give us a clue to the forerunner of this state, and that is the patient's having done much heavy lifting. Therefore, I argued before the class, that hypertrophy was consequent upon this heavy work, and that in all probability a valvular lesion had also existed.

My first prescription in this case was the tincture of digitalis, two drops every three hours, to be continued for one week for diagnostic purpose alone. The two points which I wished to determine were, first: Does there exist

any latent strength in the cardiac muscle? And second, does a valvular lesion coexist with all the other troubles? In one week when he returned to the clinic, the proof of the hypothesis was forthcoming. The patient said that he had felt better for the past three days. There is less cyanosis apparent upon inspection. There is more strength in the

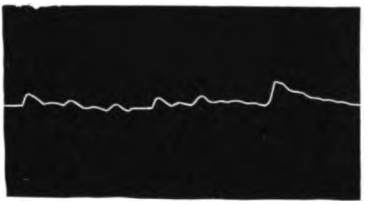

FIG. 15.

heart beat, there is improvement in the pulse tracing, and a mitral systolic murmur can now be heard.

Now, the question faced us, whether or not to continue the digitalis tincture, because of the general improvement manifested. But we should not forget that digitalis in drug doses, if persisted in, is a dangerous remedy, and even if he did not suddenly drop dead under its action, it might only rouse up and tire out all the unused force which the organ was possessed of.

It was not discovered until after he had come many times to the clinic that he was a rheumatic subject, and it is frequently the case with these chronic subjects that they forget about influences and conditions which have a strong bearing upon their case.

One day in midsummer when thunder storms were prevalent it came into his mind that such atmospheric conditions always had made him feel worse and gave him pains in the chest. Of course rhus tox. incidentally prescribed removed the bad effects. He told us also that he frequently had a faint feeling and dizzy spells when up and about. This simply meant that there was a tendency to syncope, resulting from cardiac debility. For a time he was put upon cactus grand, 1 x four times a day and was given a vial of digitalis, with instructions to take a dose occasionally, if he felt faint.

No improvement being noticed from the administration of cactus, he was ordered an infusion of the digitalis leaves in desertspoonful doses three or four times per day.

It is only a year since the first examination was made, and "Jimmy" still comes around occasionally to our clinic not because he needs anything particularly, but simply to show "the Professor" how well he is getting along. He will never be cured nor restored to his former strength, but the case is an evidence of what can be done with an old worn-out heart, and for the comfort of its owner.

Case No. 17,013. ACUTE ENDOCARDITIS.—This boy, 15 years of age, was taken sick three years ago with rheumatism. He has had hæmorrhages from the lungs. He attended this clinic a year ago, with what complaint is not stated, but he was then sent to the country.

At present he has a severe cough day and night, which is much worse upon lying down. There is shortness of breath, with pain in the left chest through to the back, but no headache. He has a whitish expectoration streaked with light green. His temperature is 103° and the pulse 125° per minute. The examination of the heart shows rapidity and excess of action, and emits a mitral regurgitant murmur.

Under spigelia and bryonia alb. in alternation every hour, he reported in one week's time much improved. The temperature had abated to 101, the pains in the chest were relieved and the pulse was less frequent. A few days later the temperature had dropped to 99¼, but the cardiac excitation still continued, as well as the murmur. He did not return to the clinic, so we cannot give subsequent history; but the outlook was, that if he recovered from the acute inflammatory attack, the valvular impairment would remain, and he would gradually drift into chronic mitral disease.

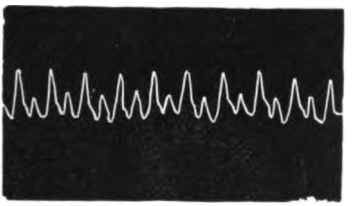

FIG. 16.

The tracing which I took on one of these visits shows extreme frequency, sharp systolic action followed by collapse of the artery, and a well-marked dicrotism.

On account of the leak through the already injured mitral orifice, the blood current in the artery could not be sustained. Hence its almost constant empty condition.

Such a pulse would convey to a light touch a throb which appears to be strong, but under even slight pressure could be entirely obliterated.

Case No. 17,015.—SUB-ACUTE ENDOCARDITIS WITH HYPERTROPHY.—This lad, æt., sixteen years, was taken sick in November, 1891, with pain in the back, knees and ankles inflamed and swollen, and was confined to his bed for three months. He evidently suffered from an attack of acute articular rheumatism.

About Christmas he says the heart became involved. He noticed palpitation from the least exertion. He has no rheumatic pains now excepting before a storm. He has bad night sweats and is wasting in flesh. His general appearance is bad.

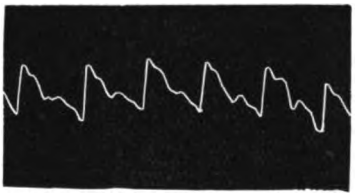

FIG. 17.

Examining the præcordia discloses the apex beat in the sixth interspace, below and to the left of the left nipple. The hand receives the sensation of purring thrill quite distinctly,and, of course, upon auscultation a mitral murmur is only too evident.

His first report at our clinic was on June 3d, 1892, which was fully six months after the acute inflammatory onset.

The reason for calling it a case of subacute endocarditis rests on the facts that his pulse is continuously high, most of the time being over 100. His temperature is likewise above normal, ranging from 99⅘ to 100⅘, in several consecutive examinations, and the night sweats have not yet ceased.

Under rhus tox this last named symptom first abated and then disappeared. He was given the two potencies of the 3d and 30th in alternation. But this peculiarity of

abnormal temperature refused to be affected by any and all the remedies prescribed.

At different times he was given aconite, spigelia, naja, tuberculinum, arsenicum jod., and digitalis.

With the exception of tuberculinum, of which he had but two doses, all the other remedies were continued a sufficient length of time to test their curative influence.

The tracings were taken three months apart. They both show evidence of hypertrophy, but in the last the tone of the circulation is lower, the tendency being to dicrotism.

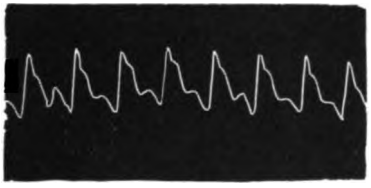

FIG. 18.

Occasionally resort had to be made to one or two other remedies on account of stomach or bowel trouble during the summer, but while he reported feeling better and more comfortable the physical signs of the case remained in *statu-quo*.

Case No. 17,017. AORTIC STENOSIS.—Woman, aged 52. She gives a history of having had rheumatism when about eighteen years of age. Afterward she caught cold and then for the first time felt pain in the heart which came on suddenly and as age advances the pain becomes more severe.

She passed the change of life about six years ago, but she could not see that it made any difference in her heart symptoms.

She complains of not being able to sleep on account of smothering spells. She must rise up in bed to catch her breath. She has dizzy turns and is afraid that she will die. Sometimes has vertigo when lying down.

The physical examination brings out the points that the apex beat is decidedly weak, that a murmur is heard at the second interspace close to the sternum and its rhythm goes with the first sound of the heart.

By exposing the upper section of the sclerotic the arcus

senilis is visible. This case differs in one or two particulars from another case of aortic stenosis already cited.

The former is in a young person, and this in an aged one. The former has a strong heart muscle with intense action of that organ and gives a corresponding sphygmographic tracing. In the latter case we note that the heart muscle is weak, and the arcus senilis leads us to the conclusion that it has undergone impairment through fatty degeneration.

Bearing out this view are the symptoms of dizziness, vertigo and smothering sensation during sleep.

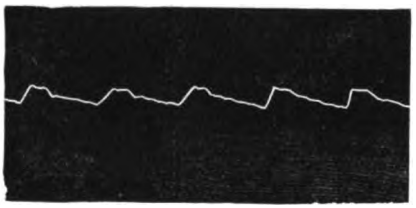

FIG. 19.

The pulse gives a tracing of that drift toward a flattened top which goes with vascular tissue changes so often referred to.

From the symptoms she has given, the remedy prescribed was necessarily spongia, and she reported better from it use. This lesion has been of such long standing that if we succeed in simply giving the patient some comfort it will be all that can be looked for.

Case No. 17,018.—MITRAL REGURGITATION. The mother brings this school boy of thirteen years of age to us because she thinks he has heart disease. The record is, that four years ago he had a severe attack of rheumatism, followed by malarial fever. He has no pain in the joints now, but complains of severe frontal headache. He tires out easily, gets short of breath and has palpitation. The examination confirms the mother's guess for he has a leak of the mitral valve, no doubt the result of rheumatic endocarditis four years ago.

He is unquestionably a chronic mitral patient, notwithstanding his tender years. There is no sign of any acute or subacute symptoms in his case. His pulse is 66 per minute and his temperature is normal.

The necessary hypertrophy to compensate for the incompetent valve has attained its development and is apparently stationary.

FIG. 20.

He may continue in this way an indefinite period, but if the damage to the valve segments is not very extensive there is a hope for his recovery by the time he has matured into manhood.

Arsen. 30, was prescribed for him four times a day. In two weeks the murmur had so diminished that it was scarcely preceptible.

The reason for this prescription was simply to sustain the cardiac muscle and prevent the tendency to fatty metamorphosis.

If great care is exercised over his diet and mode of life, with occasional remedies as his case may suggest, there is good reason to hope for the boy's recovery.

Case No. 17,033.—CHRONIC PNEUMONIC CONSOLIDATION. —This is a unique case and ought to be reported by a materia medica crank instead of by a medical diagnostician.

The boy, aged twelve, reported on Sept. 2, 1892, when a thorough physical examination was made. On Oct. the 24th following, he was again as thoroughly examined. On Sept. 2d, he was sick enough to have been confined to bed. On Oct. the 14th, he was perfectly well.

He received but one dose of tuberculinum on his first visit and absolutely nothing thereafter.

The history is, that in the month of June previous, the boy had an attack of pneumonia. He had been well prior to that time, with the exception of the usual infantile complaints of mumps, chicken-pox, colds, etc. Since June he has not had a well day.

Among others, his complaints have been attacks of nosebleed, night sweats and thick yellowish expectoration. We

found the base of his left lung consolidated, with tense tubular quality of breathing and bronchophony, the same signs locally, which we find during the second stage of acute croupous pneumonia.

On Oct. 14th the consolidation had given way to moderate clearness of percussion, and instead of the bronchial breathing, the respiratory murmur had returned and the only rough spot remaining was under the angle of the left scapula.

By that time the night sweats were gone, the cough had ceased, there was no more nosebleed or expectoration. In fact, the cough and sputum had disappeared two weeks before.

If the boy had been allowed to run along with this solid plaque in the base of his left lung, the mucous expectoration would soon have turned to purulent. The lung tissue would have become involved and broken down. Tubercular deposition would have soon made its appearance in the apex of the same lung and he would have by that time formed a perfect picture of phthisis in its third stage.

The one dose of a potent remedy, with proper care, obviated all this and the lad was discharged cured.

IN MEMORIAM.

PROFESSOR GEORGE A. HALL, M. D.—As briefly announced in our last issue, the death of Dr. George A. Hall occurred at his home in this city, on Tuesday, April 4th, 1893, in the fifty-eighth year of his age. Dr. Hall was born in Chautauqua County, New York; studied medicine with the late Dr. L. M. Kenyon, at Westfield, N. Y., and graduated in the Homœopathic Medical College of Pennsylvania, in 1856. He practiced his profession in Westfield until 1872, when he removed to Chicago, where two years later, he became identified with the "Old Hahnemann" which he served so faithfully for almost twenty years. He was its senior professor of surgery for thirteen years. The estimation in which he was held is shown in the following record of the action taken by the Faculty and the local profession after his death. His funeral services were held in Christ Church, Bishop Cheney officiating.

MEMORIAL SERVICES.

On Sunday afternoon, April 9, a Memorial Service under the auspices of the Trustees and Faculty of the Hahnemann Medical College and Hospital was held in the old hospital amphitheater. The members of his family, many friends, old patients, physicians and students were present to pay a last tribute of respect to his memory.

PROF. A. K. CRAWFORD. We have met this afternoon, as you all know, to do honor to the name and memory of Dr. Geo. A. Hall, who passed from this life on Tuesday last, the fourth day of April. I am one of those fortunate ones who studied under his tutorage, who sat on the benches of this college and hospital whilst he instructed in the art of surgery, and who holds, and highly prizes the diploma of this institution signed by his hand. Later, it was my privilege to know him more intimately as a fellow-practitioner in medicine, and to be a colleague of his in the Hahnemann faculty, and lastly, it fell to me to be called

upon to attend him through his final illness, an honor, sad though it be.

Some here present have known Dr. Hall a much longer time than I have, and others have been more intimately associated with him. They will speak of his character and attributes, but it devolves upon me to relate more particularly what I am familiar with of his physical downfall.

A peculiar bond has existed between us of late years through the chance coincidences of our illnesses. We were both "attended" when the ebb of life was low by one whose strength and ability we equally admired and relied upon. Months later, when we had rallied, our first meeting was at the grave of Dr. Gee who had been taken ill almost simultaneously with ourselves.

A year later another severe trial befell us both, and again that fair young giant gave us comfort. But, anon, we, the crippled ones stood by his bedside the night long trying to divert from him the relentless hand of death, but without avail.

It is more than three years since the first pronounced break in the doctor's health occurred. He was then stricken with hemiplegia, and lay some months in this helpless and critical condition. There were many who feared he could never again return to his place among men and in medicine. But, gradually, he gained in strength until the paralyzed side resumed its normal function, and he was welcomed back to the field of his wonted work.

Herein lay, in part at least, the trap through which he fell again. His friends thronged to him, and after his enforced idleness he could not withstand the temptation to overwork, for he seemed desirous of doing double duty to make up for the time lost in bed.

Then, being tired out, he hailed with delight the opportunity which presented itself to take a trip to California. Totally unlooked for, this proved fraught with evil to him. The grippe seized him while out on the Pacific coast, and he was brought back more dead than alive. The disease had assumed the enteric form, and he wasted away to almost a skeleton. After a hard battle his inherent tenacity gained the victory, and he once more returned to his home and his labors. But he was a changed man physically. His mind was alert as ever, but he no longer possessed the power of endurance which, his life long, had been a marked trait of his being. And, not-

withstanding his good intentions to have a care, and limit his tasks, he forged along as though the impulse was irresistible to do more than his strength would warrant.

So more months, under the stimulus of coffee and lycopus, he worked with all the ardor that was in him. In the natural order of things this could not continue indefinitely. The end of his labors for his fellow men came just four weeks before he died.

He gave up because he could go no longer, and there was no reactive power remaining on which a new life could be build. An irregular form of Basedow's disease which had existed ever since his attack of la grippe, now reached its culminating point. The enlarged and rapidly acting heart, together with the prominent eyeballs, had given place to right cardiac dilatation, an intra-cardiac murmur and pulmonary congestion. Following in rapid succession came albuminuria, œdema of the extremities, and uræmia.

During these last four weeks he never lay down because of the extreme orphopnœa, and his suffering was pitiful to witness. He bore it all with the pluck accredited to the martyrts. The end came peacefully, and we were all thankful that it was ordered so. Uræmic coma came on Monday night, and after fifteen hours' slumber, the thread was severed which had held Dr. George A. Hall to the shore of the living.

The combined efforts of Drs. R. Ludlam, H. B. Fellows and J. S. Mitchell, with myself, had not been enough to prolong the life of this noble surgeon,and I now mourn with them and you, his frien ds, the loss of him who was my teacher, brother physician, fellow professor, companion and friend.

PROF. SHEARS said: It was my fortune to know Dr. Hall intimately in several ways: as a teacher, when I a pupil listened to his instruction; as a member of the board of management of the Hahnemann Hospital, when I was its resident surgeon; as a man when I lived in his household and was associated with him in the enterprise known as the Chicago Surgical Institute; and still more recently as a colleague and associate in the surgical field, and I can truthfully say that in every one of these activities I knew him only to his credit. As a teacher he was to me most impressive. Gifted in speech he conveyed instruction in terms so clear, and by illustration so apt that no one could fail to understand. In this latter respect, the

power of illustration, homely, forcible, pointed, he had no peer in the faculty. Much of this wealth of illustration was due to the great development of his perceptive faculties. To see was for him to retain the entire picture in his mind in all of its details. He never committed a story or a description to memory. He simply saw the picture and described it in forcible, trenchant language. Many a time have I seen him in this lecture room with eyes half closed, telling his story, or describing his picture to the great delight of his hearers. Many of his favorite illustrations were the creatures of his imagination; for he had the power of creating characters and situations to point his remarks, and to them he usually gave a local habitation in York State, or Westfield, until that little town became quite famous No lecturer was respected and esteemed more highly by the students than Dr. Hall. His lectures were always eagerly looked forward to, and religiously attended. He demanded and always received the respectful and courteous attention of his hearers. He not only impressed the students but every one with whom he came into contact. As an expert witness he was dignified, self-possessed, positive and possessed an alertness of mind and dryness of wit that made him much desired. I remember upon one occasion when he was testifying in behalf of a patient whom he had examined and had expressed the opinion that the man would never again be able to do manual labor, he was asked by the opposing counsel: "What, then, would you say if I were to tell you that he had been seen only a few weeks after your examination carrying a hod of coal up three flights of stairs?" Dr. Hall innocently remarked, "I should say that he was trying to make himself useful as well as ornamental," which so amused the court and disconcerted the counsel that the force of the question was lost.

As a surgeon, Dr. Hall made himself the most prominent man in our school in the West; and this was not due to any bolstering up from authority, but from his own inherent ability. Celsus, the great Roman, said, and it is as true to-day as it was two thousand years ago: "The surgeon should possess a firm, steady hand, a keen eye, and the most unflinching courage." Dr. Hall possessed all of these. In addition he possessed a fertility of invention in emergency which few men are blessed; a manual dexterity which few possess, and a capacity for seeing all of the points of a case, which made his diagnosis

often seem like intuition. His self-confidence, courage and hopefulness led him to take many extreme cases, yet he never lost his self-command, or failed to meet the most unlooked for complication. He always did something.

As a man Dr. Hall was respected and admired, and loved by his friends and patients. No man ever had more loyal, devoted friends than he. They believed in him, stood by him, and were his earnest supporters under all circumstances. Among his most marked qualities were his strict honesty in financial matters, his inspiring enthusiasm and his lavish generosity. For more than thirteen years our paths have crossed in a business way, and *never* during that time has there been cause for a single doubt as to his integrity. Dr. Hall never knowingly imposed upon any man. His generosity all recognized. "Generous to a fault" is a common saying. In Dr. Hall it was a true one. How many young men and women, students, nurses, doctors and poor patients owe their start in life to him? Many were ungrateful, many were undeserving, for he was often more generous than discriminating. A sad story was enough to excite his sympathy, and to excite his sympathy meant that something must be done and done speedily. How many loved him for this quality; and no one will ever know the number who profited by his generosity and were a credit to it.

One of his most enticing qualities was his enthusiasm. Enthusiasm for homœopathy; for the future of surgery; for the college and for the hospital. It is this quality which makes all things possible, builds institutions of learning, encourages the weak and stimulates the laggard, in other words puts life into what was before only matter. By it his patients were made hopeful, his associates were convinced, and many doubtful projects were made successful. Opposition did not discourage him, it only excited him to greater exertion. He would drop his business, spend his money and time and ask no recompense if it seemed for the best interests of the matter in hand. His motto was, "He aims too low who aims beneath the skies." He failed often in the accomplishment of his projects, but until his health gave way he never was despairing, and his hopefulness made him ever the one to whom the doubtful and hesitating applied.

Death came to him at a time when he was in the fullness of his power, and when he was just gathering into form the rich treasurers of his mature experience. I have

not been informed as to whether the book upon which he was employed has reached such a state of progress that his experience will be retained in permanent form for the benefit of the profession; but I do know that the impetus which he gave to surgery in the homœopathic profession can never be recalled, and that the memory of his good deeds will ever be cherished by his friends. What better can any one do than,

"So to live that when the sun
Of our existence sinks in night,
Memorials sweet of mercies done
May shrine our names in memories' light
And the blest seeds we scatter'd, bloom
A hundred fold in days to come."

PROF. E. S. BAILEY paid the following tribute: Twenty years more of life should have been allotted to him. Then his life-work would have seemed rounded out and perfected; now it must remain incomplete. Although cut short in years, his life gave evidence of great activity while he lived; and in laying down the burden, there are very few of the great men whose labors have been so varied and so successful.

Dr. Hall was one of those men who seemed born into rather than graduated into the medical profession. His tastes and tact, his emotional nature, his personal magnetism, his quick perception, and great powers of physical endurance, very early and materially aided him in obtaining a large *clientelle;* and I am told that wherever he located his was always a busy life.

In many parts of the earth the divine right for kings to rule is never questioned. The individual right accorded our deceased friend to be a leader among his professional friends is never referred to save to accord it to him as one who was worthy and capable of leadership. Ambition is no crime, and in attaining the ends to which his ambition led him, he committed no crimes, he violated no confidences. His colleagues knew where to find him every time. His positivism stamped the man and his works.

I do not know how in a few moments to condense so much as comes to me concerning his personality or his professional life. For three years and a half I lived in his home, and withdrew as a partner in his business at the end of that time.

To me as I look back upon those years I cannot tell which interests me most, whether it be Dr. Hall as the

man, genial, warm-hearted, generous, thoughtful, humorous, sympathetic, enthusiastic, æsthetic; or Dr. Hall as a physician and surgeon, skillful, artful, of countless resources, swift in judgment, tireless, attentive, compassionate and sympathetic.

As a physician he was very positive; he had supreme confidence in his remedies, and in his methods. One day while riding with him from the home of one of his patients, supposed to be mortally ill, in a feeling manner he said to me "I think I have saved a life.', How, said I, in eagerness to know all about the method used? In reply, still very thoughtful, he said "I simply assured the patient the danger had passed, and that there was more hope than at any time during the long and weary days and nights, and I made her believe it too; and although the family had said the last farewells just as I entered the room, I fanned the spark of life with hope, and I shall be greatly suprised if she does not get well. To my mind, he continued, the medicines, the bottles, the glasses, the whole paraphernalia of the sick room are a mockery at such times, unless there is a stronger element back of it and that is the personality of the doctor. I tell you, you have to get right under these patients, and the whole family too, sometimes, and lift them all right up, and carry them, and you have to do it by your own firmness. To have mingled my tears with theirs would have cut off every chance for the patient." She recovered, and tearfully thanked her deliverer, dimly remembering that a single thought of hope came to her when all else was passed. That lesson was impressive, it was true. It was his characteristic way of closely uniting himself with the highest interests of his patrons.

As a physician he had keen intuition and his perceptive faculties were fully as marked as his reasoning, if not more so. He lived in the realm of nature as he found it, rather than in the records of books. He seized and appropriated from every source. He knew the signs of disease.

As a teacher no one to my knowledge ever commanded respect and admiration equal to that accorded him. His lectures were models oftentimes; having concise statements, ample illustrations, and an impressive manner, in description and expression; judgment, precedent and common sense as the guide in treatment. "The workman dies but his work goes on." In hundreds of homes unknown to

the teacher his methods have been used with large success.

It was in the class of '78 that admiration ran so high that he was named "Uncle George," by the students, a name he afterward told me gave him exceedingly great pleasure.

In public medical meetings and conventions, Dr. Hall always commanded attention in debate and in reports. He was always a welcome delegate and a great favorite in public councils. To have known him intimately was to have been fortunate; to have shared his confidence was to have made and kept a friend. He was to me a model of industry and perseverance. In him fidelity to the cause and to his profession was a marked virtue. He labored to build up, he was progressive. If there was any littleness in his make-up, his daily life never revealed it; he worked for his profession, not for it entirely, but for the great cause, his heart being near to humanity. The last service was from his great heart. He enjoyed the luxuries of life, clubs, and the exchange of social hospitalities. No host could excell him. He will live through the generations that knew him as a man of rare gifts, and a thousand eyes will dim with tears in secret, as memory touches the cords of sympathy between patient and physician, friend and neighbor.

PROF. W. J. HAWKES: I cannot express in words my sorrow for the loss of a dear friend and esteemed colleague. For no member of our profession had I warmer affection as a friend, and respect as a surgeon and teacher. The friendly relations between him and me and our respective families had been exceptionally warm. While we had decided and freely expressed differences of opinion on professional matters, natural between one whose specialty was surgery and another whose specialty was therapeutics and symptomatology, we were always in hearty accord socially and as friends.

As is so often the case with strong natures, his greatest strength was his greatest weakness. He was intense and entheusiastic in whatever he undertook to perform; to this allied with a broad intelligence and sound common sense is due his great success. But to this is due also his premature and lamentable taking off. *He worked himself to death.* And his work was not always for selfish ends. The last straw in the breaking of his strong back was, I believe,

the intense and enthusiastic labor he gave to the furtherance of the project of establishing the Columbian Homœopathic Hospital and Headquarters. Had it not been for Dr. Geo. A. Hall this great work, now assured of success, and which was projected solely for the honor of our school, would never have been accomplished.

How often have I earnestly urged upon him the danger to his life of excessive work, especially since his severe and protracted illness two years ago. But so often would he smile in his confident way and go right on.

I can never forget the last time I gave him this warning. He was performing a delicate surgical operation before the class, and had run over into my hour, so that I had an opportunity of witnessing a part of the operation. He was pale, perspiring and tired-looking, but cheerful and confident, quick, energetic and accurate, explaining the various surgical points as he worked in his own clear-headed way, but with every evidence of overstrained nervous tension.

I feel, as I am sure we all feel, the deepest sorrow for the great loss we have sustained in the premature death of our genial and beloved friend and colleague, and with you extend to his bereaved family my most profound and heartfelt sympathy.

MR. S.W. ALLERTON said: Dr. Hall has been my family physician for years, and I always found him faithful and tireless in the performance of his duties as a physician. In my experience I never met another man who so entirely forgot self in serving his fellowmen. I believe he never let an opportunity pass unnoticed where it was possible to ease suffering or to gladden the heart of some poor and less fortunate human being.

PROF. LUDLAM spoke feelingly as follows: This occasion is a peculiarly sad one for me because it adds another to the list of our co-workers who have been called hence. Since this College and Hospital were established in 1860, no less than seventeen men, who were counted among its teachers, have died; and six of the Trustees have also passed away. So far as I know, of all the instructors who were connected with the school at the beginning and in its early days, I am the sole survivor.

My relations with Dr. Hall in the College and Hospital work were very intimate. After my first return from

Europe in 1875, at the urgent request of my good friend Dr. Carroll Dunham, I had accepted a chair in the Faculty of the New York Homœopathic Medical College, and had promised to remove to that city. But at the meeting of the Homœopathic Congress in Philadelphia, in June, 1876, we had the first assurance that fourteen members of the Faculty in the Old Hahnemann had deserted, leaving only three of us behind. Dr. Hall, who at that time was my assistant, holding the position of Lecturer on Obstetrics, with Dr. D. S. Smith and Dr. Small, then President of the College, came to my hotel and begged me to change my determination and to remain in Chicago. Now all three of those men have gone hence. Dr. Hall finally said that, if I would join him, he would give ten years of his most earnest effort to sustain the College, to develop its interests, and to demonstrate that it still deserved to hold its place at the head of the column. On this assurance, and the expressed sympathy and good will of many of the alumni who were present at the Convention, I resolved to accede to their very urgent request. The consequences are known to the profession, and the results of that conference are certified to by our new College and Hospital buildings, by what we have done for medical literature meanwhile, and by the reputation of the school that has grown in a compound ratio ever since.

I have entered into this history, "all of which I saw and part of which I was," not for personal reasons, but simply to say what I most emphatically believe that, but for Dr. Hall's prompt action, his pluck and indomitable courage, this institution would have suffered the fate that its intimate enemies had prayed for and prophesied.

Dr. Hall's characteristics as a teacher have been set forth by my colleagues. They are known and will be recalled by all the students who have been here for the past twenty years. His enthusiasm was contagious; his earnest spirit never flagged; the clearness of his ideas was matched by the clearness of his statements, and both were clarified. He said what he meant, and meant what he said. In all his appointments with the class and the profession he had the interest and the character that go with punctuality. He was not an afternoon-man, and no one could say of him that he was "punctually half an hour late." He had a largeness and breadth of view that is unusual in the medical profession, which made it impossible for him to become a bigot, and which always kept him on

the alert for new truths and new developments in the line of his chosen work.

His memory will be enshrined in the hearts of his pupils, his professional associates, and his patients, who will naturally feel as if no one can fill his place. And, after all, this is the most touching and tender way of being remembered, for

> "Praises on tombs are trifles vainly spent,
> A man's good deeds are his best monument."

HON. ERSKINE M. PHELPS, Treasurer of the Board of Trustees, also paid a glowing tribute to the good name and qualities of Dr. Hall, after which the following remarks were made by

PROF. LEAVITT: During the winters of 1875–6 and 1876–7 I listened to obstetrical lectures by Dr. Hall, who filled the chair of Obstetrics and Diseases of Children. These lectures were the only obstetrical lectures to which I ever listened, save one which I heard in New York and one in London. I had the honor and the task to succeed Dr. Hall as a lecturer in this department, where for sixteen years I have continued.

As I look upon the shining characteristics of our deceased brother, prominent among them, and that one which especially endeared him to many, was his heartfelt sympathy. He was a man who truly carried his heart in his hand.

Meditating upon the truths concerning Dr. Hall, which have been brought out here to-day, I have prepared the following resolutions, the adoption of which I now move:

WHEREAS, In the order of Providence, our beloved friend and brother, Dr. George A. Hall, has been removed by the hand of death,

Resolved, That as a Faculty we mourn the loss of an earnest, energetic, able and loyal coadjutor; as associates we grieve over the departure of a faithful and genial friend and a brother; and as student we miss a capable, enthusiastic, and impressive instructor.

Resolved, That in this hour of sorrow over Dr. Hall's departure, we recall with pleasure as foremost among his qualities of mind and heart his warm sympathy with those suffering in mind, body or estate, and his deep grief over the loss of associates; and trusting that from so noble an example we may draw an inspiration which shall move us to more cheerful sacrifice of personal ease and sordid ambition in the interest of suffering humanity about us.

Resolved, That to the bereaved friends of our brother we hereby offer our profound condolence.

ACTION TAKEN BY THE CLINICAL SOCIETY.

At its regular meeting, April 29th. the following resolutions offered by DR. C. H. VILAS, were unanimously adopted:

Inasmuch as this Society has lately lost by death one of its members, DR. GEO. A. HALL, be it

Resolved, That this Society deeply deplores the loss of one who was ever its friend and counselor, and one of its honored members.

Resolved. That this resolution, with the remarks made thereon upon this occasion by the Members of this Society be spread upon the Society records, and a copy thereof be sent to the widow of the deceased and published in THE CLINIQUE, the organ of this Society.

In presenting the resolution, Dr. Vilas said:

Mr. President: It is with feelings of sadness that the time has come when the duty falls upon us of appropriate respect to the memory of one who so lately left us.

As a fellow-founder of this Society, Dr. Hall was associated with us who were then present. From that time to his death he was one of our most enthusiastic members and promoters. With zest he wrought for our Society good always; there never was any uncertainty in his labors, and his earnestness was a common theme.

I have not labored to express in stilted phrase a feeling too genuine for such verbiage. You will all agree with me, I believe, that the simple record of our appreciation of his work and respect for his memory can derive no weight from oft-repeated regret.

The motion to adopt these resolutions was ably and kindly seconded by DR. W. H. BURT, and they were ordered to be spread upon the records.

ACTION BY THE DIRECTORS OF THE HOMŒOPATHIC HOSPITAL IN THE WORLD'S COLUMBIAN EXPOSITION.

At a meeting of the Directors of the Homœopathic Headquarters and Hospital of the Columbian Exposition, held on the evening April 10, the following resolutions were adopted:

WHEREAS, Divine Providence has called from us our associate, DR. GEORGE A. HALL, late President of the Columbian Headquarters and Hospital,

Resolved, That in his death the Directors have lost a most efficient and energetic worker and genial friend, who had entered with great enthusiasm in furtherance of the enterprise;

Resolved, That we cannot sufficiently regret the dispensation that has deprived us and the whole profession of our most worthy colleague and that we tender his family our most heartfelt sympathy.

J. S. MITCHELL, M. D.
W. J. HAWKES, M. D.
W. S. HARVEY, M. D.

IMPORTANT ALUMNI NOTICE.

It has been arranged to have a meeting of the Alumni of the "Old Hahnemann," during the World's Homœopathic Congress, which opens in Chicago, May 29. Every graduate of this school who can possibly do so, is therefore invited and urged to be present at 8 P. M., of Tuesday, May 30, at the new Art Institute building, on the Lake Front, Michigan Avenue and Adams Street. Under graduates, preceptors and friends of the school from all quarters are also invited to come and participate in the festivities.

BY ORDER OF THE COMMITTEE.

THE HOSPITAL BUILDING FUND.

The Treasurer of the Alumni Association acknowledges the following subscriptions received since his last report: Dr. H. W. Van Doren, '88, Bird City, Kan., $10; Dr. A. C. Hall, '89, Grand Crossing, Ill., $10; Dr. H. A. Noyes, '91, Mt. Carroll, Ill., $10; Dr. N. P. S. Smith, '81, Paris, Ill., $10; Dr. E. D. W. Benthall, '84, Spencer, Ia., $10; Dr. E. J. Abell, '81, Joliet, Ill., $100; Dr. S. M. Spaulding, '79, Minneapolis, Minn, $10; Dr. Otto Poppe, Chicago, $10; Dr. O. A. Palmer, Warren, O., $10. Already reported, $1,696.60. Total, $1,876.60.

JOS. P. COBB, *Treasurer.*

Miscellaneous Items.

The World's Congress of Homœopathic Physicians and Surgeons, a department of the great Columbian Exposition, convenes in this city May 29 to June 3. A very large and influential meeting is confidently expected.——Dr. A. K. Hills has removed to 669, Fifth Avenue, New York; Prof. Hawkes changes his residence to the Salerno, La Salle Avenue and Locust Street, city; Dr. H. H. Schumann, to the Columbus Memorial building; Dr. W. A. Dunn, with his new partner, Dr. Robert C. Block, to the Marshall Field Building, and the *Medical Current* to the Quincy Building.——Dr. Asa S. Couch, of Fredonia, N. Y., has been invited to deliver a Memorial Address on the late Prof. Hall at the dedication of the Homœopathic Hospital and Headquarters in the Columbian Exposition, Dr. Hall having been the President and chief promoter of that excellent organization.——*Erratum:* On line 19, page 171, of our last issue for "seventeen" read twenty-seven.——Dr. John L. Kellogg, who was the first Professor of Obstetrics in the "Old Hahnemann," died at Washington Heights, April 27 at the advanced age of 82.——Dr. C. L. Crandall, 78, died of apoplexy at Salt Lake City, March 22. The following resolutions were adopted by the Utah Hom. Med. Association:

WHEREAS, Death has taken from us our esteemed colleague and friend, Dr. Casper L. Crandall, we, as a Society, in expression of our deep sorrow, and our appreciation of his sterling worth and lofty character do hereby adopt the following resolutions:

Resolved, That we consider the loss irreparable to the profession, in which as a representative of our school of practice in this locality, his undaunted energy, his marked ability, and his zealous devotion to truth, was ever an incentive to honest endeavor and gave to us all the inspiration of hope. What he honestly believed he was ever ready to bravely and manfully defend. What he knew to be right he unerringly performed.

Resolved, That as President of our Association we shall miss his guiding spirit and his encouraging presence. In all our deliberations he was ever a willing helper and an able counsellor. His life was consecrated to his profession and the pride of his heart was to perform nobly and well all the duties it entailed.

Resolved, That we admire the manly quality and Christian character of his life. His modest dignity will ever be a pleasing recollection. As we prized his ennobling qualities. so shall we forever honor his memory.

Resolved, That to his bereaved family in their hour of deepest sorrow, we tender our sincere sympathy and offer this token of love for our departed friend and associate.

THE CLINIQUE.

VOL. XIV.] CHICAGO, JUNE 15, 1893. [No. 6.

Original Lectures.

AN ADDRESS ON HOMŒOPATHY AND THE PUBLIC HEALTH.

BY R. LUDLAM, M. D., CHICAGO.

VICE PRESIDENT OF THE WORLD'S HOMŒOPATHIC CONGRESS.*

The public health is the counterpart of the commonwealth. That a system of medicine which has sustained itself independently and grown in a compound ratio for a hundred years; which has its own literature and its schools, its clinics, societies and hospitals, as well as its pupils and practitioners in every civilized community, is closely related to the health of the people is self-evident. To doubt this proposition would be like questioning whether protestantism is related to Christianity, charity to benevolence, or the sunlight to the evolution of plants and flowers. If its recognition were commensurate with its deserts, and if its representatives had not been the victims of a class-bias that so far as possible has excluded them from the army and the navy, the hospitals and the eleemosynary institutions of this and of other lands, I should have a more grateful theme, and a better prospect of pleasing you in what I have to say on this occasion.

Toleration has been defined as "the dogma of the

* Delivered before the Congress, Chicago, May 31, 1893.

weaker party." If the reformer did not insist upon it he would never have a hearing. When he comes to be tolerated within certain galling limits, he has already gained a foothold. From that time forward his success will depend upon the merits of his cause, his own and his comrades' tact and persistency, and the conduct of its followers when its claims have received the popular indorsement.

I shall speak upon this latter point, for the "incomputable perils of success," as Lowell styles them, are not the least among those which beset our school of medicine at the present time. Our cause was a good one; there was need for a change in the harsh and harmful methods of treatment that were in vogue in Hahnemann's time. He was a man of science, as science went in those days, but what was infinitely more important, he was imbued with the spirit of scientific doubt. He saw the defects of the ancient system and set to work to remedy them. To gain a hearing he must be aggressive. He characterized certain therapeutical abuses in such a way that some of his phrases fit and stick like the nicknames that school boys give each other. He had the faith and firmness which are moral weapons of an invincible sort. With a just and benevolent cause he felt it no crime to be a dissenter from the established church in medicine. He knew that "while the animosities are mortal the humanities are eternal," and so, through a terrible opposition, he went forward in his chosen work. The merit of his cause is conceded and confirmed by thousands of physicians and by millions of patients in our day. If "the sweetest happiness that we ever know, the very wine of human life comes from sacrifice—from the effort to make others happy," what shall we not say for our hero, who, greater than Columbus, opened up a new world in therapeutics!

"Necessity," says Herder, "is the clock-weight that keeps all the wheels in motion." The early followers of Hahnemann were forced to be on the alert to defend their cause and at the same time to develop its resources. Its great qualities and small defects had to be looked after as one

would take care of a legacy. It was a legacy, but not for an individual or even for a family. It was a bequest for the benefit of humanity at large, and for the public health and welfare. The abuse poured upon the early homœopathists, like that which was showered upon the early ovariotomists, is fast becoming ancient history. It is so much easier to accuse than to excuse them that the fashion is to revive the old bitterness whenever their methods or their writings are mentioned. We forget that, being placed on a frontier post of medical knowledge they must hold their ground and, if need be, fight in its defense. Beset by furious and unscrupulous critics they were forced to charge their ink with gunpowder. In those days the controversial papers and the professional intercourse of parties on both sides abounded in brotherly throat-cutting. Almost every doctor, regular, irregular and defective, insisted upon giving his neighbor "a piece of his mind," notwithstanding the fact that nobody had any peace of mind. Old doctors and medical students especially, looked at homœopathy through the prism of their own prejudices. The medical journals became like Punch, "a refuge for destitute wit," and almost every old-school medical society took up the contemptible business of running a partisan search-light for the detection and discipline of heretics.

Under these circumstances, when their belief had to be kept up as a police force, it is no marvel that our brethren did and said some very unwise things. Like the lower brain centres that never sleep they had always to be vigilant, even at the expense of being sometimes vindictive. And some one has said that everybody has a little speck of fight underneath his peace and good will which he keeps for revolutions and great emergencies. In such a medical upheaval one must either fight for the supremacy of a faction or for a principle; and in this case it was not merely a matter of medical labels and liveries, but of deciding so important a question as the best means of relieving human suffering and of curing disease.

How well our predecessors did their work; what kind

of fiber was in their faith, and how they defended it; how, as time went on, they were emancipated from controversy and left to cultivate their views and their peculiar resources; how the medical world, or the best part of it, has learned to treat them with a decent spirit of toleration that has finally soaked through the old rocks of prejudice, are matters of common knowledge in our day. As their antagonisms faded their resources were economized; as the radical and uncompromising spirit was torn down, the clinical quality took its place in their affections, their teachings, and their practice.

After the enthusiasm with which each discovery is received come the difficulties of application, doubts and reactions. It is a false philosophy which thinks more of methods than of results; as it is a spurious Christianity which puts a creed concerning the insoluble matters of faith above the mutual duties and interests of mankind.

I think it was Goethe who said that: "whatever emancipates our minds without giving us the mastery of ourselves is destructive." We are no longer engaged in an uncertain contest. Faith and works, and fighting and waiting have secured us a hearing, an opportunity, position and popularity. But there is the rub. Considering what the outcome of all sorts of antagonisms, moral and medical, has been; that those who gain power and influence almost always become intolerant and thereby cripple their cause and compromise their position; and considering that doctors are subject to the same infirmities as statesmen, soldiers and politicians; that in this instance, especially, the the interests at stake are of vital consequence to the welfare of mankind, why should we not cultivate a larger measure of professional toleration? Surely we are unfit for such an endowment, if we fail to appreciate the responsibility that it brings, or to make the best possible use of it toward keeping our place in the line of the liberal professions.

In the far away Northwest, they sometimes have hailstorms that thresh the grain in the field just before the

harvest. There are some over-zealous disciples who act like a Dakota "twister" when it comes a few days too soon for the unlucky farmer. They have a passion for a label that amounts to an infirmity. Like a vulgar relation in good society, they invariably say the wrong thing at the wrong time; fancy that they are still living in a debatable and not in a progressive age; are always looking for the routes and resorts of an enemy; and cannot understand why the asperities of medicine should yield to the mellowing influence of time more rapidly than those of theology have done. You remember the old saying that "an honest man who lacks judgment is more dangerous than a thief who has discretion;" for so long as you watch the discreet wretch he cannot injure you, while there is no escape from the fool-friend.

In the glorious emergency in which we are placed there are duties that draw like the invisible chains of gravitation. These duties pertain to our fitness and qualification as physicians, and to our tolerance of those whose professional views and opinions differ from our own. The greatly improved facilities for obtaining a sound and thorough medical education are filling the first of these requirements in a most satisfactory manner; while the dissipation of the fog and mist of distance and Pharisaism among the fraternity is doing the rest.

It is true that in certain quarters we still are the victims of class-bias and of class-legislation. For there are those who continue to regard the representatives of the new school of practice with a muffled animosity against which our only shelter is the satisfaction of being in the right. But what concerns us, and those who believe with us, is of such exquisite importance and interest that, whatever the provocation, we cannot afford to quarrel with them any longer merely for the *theoretical* defense of our faith. We must use our own *clinical* spade, and we cannot answer for what will turn up. If some of the old roots of error, tradition, envy and unreason are thrown out of the medical field altogether, so much the better

for the coming doctors and their patients, for our literature, and for the general reputation of what used to be styled, and should really become, a *liberal* profession.

The position of homœopathy in our charitable institutions is not what it would have been but for the opposition that it has encountered from those who assume to monopolize all medical knowledge. Nor is it what it will become if we are fit and worthy for the places and the responsibilities that are rapidly falling into our hands as a simple matter of right and of justice.

From those who will follow me with special reports, you will have the detailed proof of this growing freedom of medical opinion. You will gather the most encouraging facts, showing that those who had dug a moat around our school of medicine to shut it in to itself, and to shut it off from all practical relation to the public health, have signally failed. The whole world of thought and action is permeated, but not saturated, with the principle of tolerance, and if we continue to watch and pray, to work and wait, a full share of recognition will yet be accorded to us. For it is a lucky thing that the universal law of change can so modify our views of liberty and of justice that the right may finally triumph. The powers that be are a shifting quantity, and this is an age of progress.

The repression of thought and the stifling of medical investigation, except on certain prescribed lines, is an antiquated abuse against which the spirit of this age is in open revolt. There is no toleration in the holding of those who differ from us in contempt; but there is an undercurrent of sympathy with what is new and noble, magnanimous and merciful of which we can take advantage. We have had a cycle, or better perhaps, a cyclone of that intellectual agitation which is the first step toward reform; and now, if our professional views are not twisted or too narrow; if we do not in turn become intolerant and egotistical; if we can learn to forget all but the ultimate end of our mission to mankind, and take advantage of the

ripening harvest, there is no reason why all that is good and true in homœopathy should not be fully appreciated by the public at large as well as by the profession.

The three factors in the stupendous reform that homœopathy has wrought were its intrinsic and relative utility, the faith and fidelity of its early apostles, and the persistent political intrigue of its opponents, which was the daily bread of the inquisition. It is enough to say that from the foundation of the world these are the precise conditions upon which every reform that was worthy of the name has depended for its evolution and establishment.

Although the persecution that we have suffered in times past has been a grievous burden, and has put us sometimes at a great disadvantage, it really has been a blessing in disguise. For while, as every Christian must know, the professional disabilities to which we have been subjected were indefensible at the bar of the Golden Rule, they were indispensable to our sturdy growth and development. The winds of opposition have rooted our tree of knowledge. Left to our own resources, we were compelled to do our best for our patients, and for our branch of the healing art at all points of the medical compass. Hence the all-around growth of our school, and the impossibility, except here and there, that we should become and remain mere fanciful and factional doctors.

Show us a form of quackery that can stand the clinical test of object lessons in all the practical branches of medicine and surgery, every day in the year, and before thousands of earnest and intelligent pupils and physicians; or one that has ever done first-class work in surgery, or in any of the various specialties. They have not even given the world that modern product of spontaneous generation, a decent gynæcologist!

But this Congress in which we are met comprises a host of representative men and women, who in many lands work as teachers, authors, and practitioners in every department of the medical calling; whose scientific attainments and professional probity, scope, popularity and use-

fulness are equal to those of a like number of physicians from any other school of practice. Judged by this standard and by the fruit of their labor, as it is preserved in our literature and noted by the Recording Angel, we surely do not deserve to be classed as outlaws and charlatans.

Twenty-three years ago and within a stone's throw of this spot, an address was made before our National Society which in the light of recent development reads like a prophecy. It sounded a clear note from the warm and loyal spirit of our dear departed friend, Dr. Carroll Dunham. *Liberty of medical opinion and action; a vital necessity and a great responsibility*, was a theme that was worthy of the speaker and of his cause.

As the one man among us best fitted to appreciate the peculiar position in which we were about to be placed; whose love for humanity and for his own calling was boundless; whose loyalty could not be questioned; whose regard for the opinions of others was always respectful and generous, giving every one credit for the good that was in him; whose faith was firm and steady, not fickle and foolish; whose opinion was worth more than anybody's else argument; whose writings are neither fierce and feeble nor shallow and worthless, the text of that discourse reads like the Sermon on the Mount.

The time, then, is passed which called for defenses and expositions of Homœopathy, appeals for equal privileges and protests against oppression. We stand henceforth on equal ground as members of the great body of the medical profession, in which we shall take rank *according to the worth of our work in the broad field of medical science.*

After a clear statement of his individual position on points of doctrine that were mooted then, are now, and always will be, he says:

Notwithstanding this belief, I advocate entire liberty of opinion and practice. Nay, *because* of this belief, I plead for liberty; for I am sure that perfect liberty will the sooner bring knowledge of the truth and that purity of practice which we all desire.

So long as we are a body of physicians characterized by

a distinctive name derived from the law of cure which we profess, I suppose that none will seek membership in the Institute, who do not substantially accept the law. This granted, I would have no exclusive creed, no restrictions relating to theory and practice, but would receive into membership of the Institute every applicant of suitable educational and moral standing. I deprecate any attempt to regulate or prescribe the opinion and practice of members of our school for two principal reasons. We *cannot* do it if we *would*, and we *ought* not if we *could*.

We *cannot*. We are not a body claiming to possess infallibility. It belongs not to us to utter denunciations of what we may believe to be errors of faith and practice; nor to put forth an index of the allowed and the forbidden. We are a voluntary association of laborers; simply from the love of knowledge, as is the case with all workers in science; and we have no power to enforce any restrictions upon which we might determine.

We *ought not*. Not until we have reached the absolute truth should we be justified in establishing a standard of faith and practice. How far we are from that position need not be argued here. Let us remember the wise course of the Bureau of Direction of the Paris Hospitals, when, in 1850, Tessier, of Ste. Marguerite, made known his conversion to Homœopathy, and it was proposed to deprive him, on that account, of his position as hospital physician. The wise Chomel opposed the proposition, saying that every physician, who is thoroughly qualified to practice, has the right to select his own mode of treatment, and to judge what is best for his patients, and may not be interfered with, unless his results are notoriously bad or he commit some act of unquestionable malpractice. "For," said he, "it is only by the exercise of this freedom that changes and improvements have ever been introduced in practice; and herein lies the only hope of further improvements. Tessier, in practicing Homœopathy, has only exercised the same freedom of selection which Bouillaud and Rayer and Louis and I have enjoyed, and as his results are as good as ours, we may not interfere with him." * * *

Do we demand liberty of opinion? Then must we take care that our opinions rest on a foundation of study and acquirements which embraces the entire circuit of medical knowledge, and takes in and honestly estimates every new contribution to it, no prejudice of place or person giving a bias to our reason. Then must we act in the

spirit of Hahnemann's noble admonition: "In a science in which the welfare of mankind is concerned, any neglect to make ourselves masters of it becomes a crime." * *

But, touching the open questions of medical opinion and practice—while each of us earnestly proclaims the opinions he has espoused, and zealously puts them in practice, let us cultivate the catholic and noble spirit of Chillingworth: "I will take no man's liberty of judgment from him, nor shall any man take mine from me. I will think no man the worse man, * * * I will love no man the less for differing in opinion from me, and what measure I meet to others I expect from them again."

In the light of his leadership and wise counsel; in the light of what we have learned since he left this precious legacy; and because of the great and growing influence of our branch of the Healing Art, I plead for toleration; for increased breadth of culture and acquirement; for the careful fostering of the specialties; and for the thorough and adequate fitness of our physicians for their all-around duties and responsibilities. These are the industrial conditions of success and stability; and if properly and persistently applied, they will surely demonstrate the vital relation that exists between Homœopathy and the Public Health.

RACHITIS.

A CLINICAL LECTURE DELIVERED BY JOS. P. COBB, M. D., PROFESSOR OF PÆDIATRICS IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, CHICAGO.

This little child whom I show you to-day, is a very pronounced example of rickets; she has been before our subclass several times, and has been examined personally by each one of you. We can well afford, however, to devote a little more study to her case as she presents you an object lesson in nearly all the possibilities of her class. She is a twin, twenty months old; is mentally bright and even precocious; physically she is far behind her twin brother in development. She has never made any attempt to walk, and cannot even sit up straight alone. She

has always been considered a delicate child, though she has never suffered from any of the ordinary children's diseases other than those due to malnutrition. She usually has several loose, painless, foul evacuations daily; the color varies between green, yellow and brown, sometimes containing a large amount of mucus; when not too loose, the movements are very much constipated. She sleeps very well, but sweats a great deal about the head while sleeping. She is unwilling to lie on either side either when asleep or awake. She is still nursed by her mother, though she eats in addition a very varied diet. We learn that the father's health is good, but that the mother has always suffered from indigestion and constipation.

Let us now turn our attention to the objective conditions presented by our little patient. First, notice this head, characteristic in itself, broad, nearly flat on top, with very prominent frontal bossa; a large anterior fontanelle nearly square and opening out into wide unclosed sutures; the edges of the fontanelle showing an irregular bone development with thin, notched, membranous edges which yield to pressure.

While the head seems flat on top as if it had been subjected to pressure from above, a closer observance shows a marked depression running antero-posterior. This is due to the parietal bossa or thickenings. Notice also that the shape is not at all the round or circular head of hydrocephalic development, but on the contrary markedly rectangular. The teeth are late in putting in an appearance; this child is twenty months old and has but six teeth.

Now, with body stripped you notice, first, the lack of proper symmetry of the body; the upper part of the thorax seems constricted, while the abdomen is very much enlarged. You can see and still better feel, the beads or knobs where the ribs and costal cartilages join, known as the "rickety rosary." Outside of this row of beads you notice a depression extending obliquely from above downward while an increased convexity of the costal cartilages

throws the sternum forward somewhat similar to a pigeon breast. "Harrison's sulcus," or the transverse grove extending around the chest on a level with the lower margin of the body of the sternum is very apparent. This grove is due partly to depression of the thorax by atmospheric pressure, but more to the bulging outward of the lower part of the thorax from the upward encroachment of the enlarged abdominal organs.

There is no very marked enlargement of the ends of the long bones of the limbs, nor any sharp curvatures; the legs are more bowed than normal and the bones give the impression of being very small in their diameters. The muscles of the limbs are soft and poorly developed, and those on the body hardly cover the bony skeleton.

Notice that when we try to have the child sit up there is a bowing forward of the back, not the sharp bend which you find in caries of the spine, but just such a bending as you would expect in a flexible column when trying to carry too heavy a superimposed load.

The pulse is weak, easily compressed, and beats one hundred and sixty times per minute; the apex of the heart is felt at the sixth intercostal space and outside of the nipple line; this is partly due to the malformation of the chest wall, and partly to the dilatation of the heart itself. Respirations are short, catchy, and number sixty to the minute; you will remember that we found evidence of collapsed lung tissue under the depressed parts of the thorax, and a condition of compensatory emphysema under the rounded cartilages and sternum. In the abdomen we find the lower line of the liver but an inch above the crest of the ilium and its upper part reaching across nearly to the margin of the spleen. The lower end of the spleen extends nearly as far downward as the liver, and you will remember how you could put your fingers under its edges and feel it between your hands.

These enlarged abdominal organs, more particularly the spleen, are a very constant feature in well-marked cases of rickets. Your knowledge of the physiological functions

of these glands teaches you that this cannot be simply a result, but must play a very important causative part in the leading feature of the disease, viz., impaired nutrition.

This state of impaired nutrition explains why these little patients are very prone to catarrhal diseases. Why a simple cold is so liable to develop broncho-pneumonia in one case or follicular enteritis in another. Rickety children are particularly liable to convulsive seizures, not so much those of the first months of infancy, as those which come in the last half of the first year and later on. It is in rickety children especially that the irritation of dentition serves to produce eclamptic seizures. Laryngismus stridulus, sometimes called internal convulsion, is a very common complication.

The etiological factors of rickets are numerous; the chemical explanations, viz., deficiency of mineral constituents, especially lime salts in the food, and the theory that there was some acid in the blood which dissolved the lime salts in those cases where the mineral constituents were known to be present are not accepted to-day as sufficient explanations of its development.

It is found that climate has an effect on its prevalence, it being more frequent in cold and damp climates, becoming rarer and less intense as we go south. Open air life in the southern climates probably has an influence, as we find the disease more common in crowded cities and in those parts of cities where sunlight and ventilation are not appreciated.

Again as we go farther south fruit becomes a more common article of food, and by its influence on the digestion, both of the child and the parents is prophylactic. Improper food is certainly an important factor in its development, as we find a large proportion of cases in children who are not nursed, and who have been fed upon starchy foods during early infancy.

It is a matter of common notice that rickets frequently seems to be the sequel of an acute infantile disease, as broncho-pneumonia or one of the exanthemata. In a large

number of cases its first obvious signs are preceded by chronic gastro-intestinal catarrh. There is no proof that rickets is transmitted from parents to children; there is, however, positive evidence that the ill health of the mother during gestation, lack of or improper food, confinement in unventilated abodes, and paucity of out-of-door air during this period are important elements in its intra-uterine development.

In its course rickets show great variations; the cases which begin during intra-uterine existence are rapid; the later the disease begins to develop, the slower usually will its progress be and the greater the probability that it can be arrested. Many of the cases of severe and early intra-uterine rickets die soon after birth, but other cases, in which the process probably began at a later period, show signs at birth and while some of these are going on to involution, other and more definite signs develop in remote parts of the body. The difference in these intra-uterine cases depends upon two factors—the period of initiation and the activity of the irritation which gives rise to the disease.

The great variation in the development of extra-uterine rickets, both as to period, rapidity, extent and site of lesions, and amount of local and constitutional distress, has always been recognized. Cases have been divided into those which begin abruptly and those which begin insidiously. The term "late rickets" is applied to those cases which develop after two years of age. These are comparatively rare, and the probability is that they were the subjects of mild infantile attacks which had been overlooked and had subsided to be awakened by some vicious habit or condition of life or by continued improper diet.

The term "acute rickets" is used to define a class of cases which have many characteristics separating them from ordinary rickets. The lower limbs are most severely affected; they are tense, shiny, often immobile, and exceedingly tender. There is often a sheath of cylindrical swelling extending along the shafts. Post-mortem examinations have shown extensive sub-periosteal hemorrhages

most marked in the limbs. In these cases the anæmia is profound and the majority present more or less sponginess of the gums.

There is a great variation in the course of rachitis in reference to its bony lesions; different portions of the skeleton become progressively involved, and as there is a constant tendency to the involution of bone lesions, the disease may be subsiding in one part while it is developing in another part. The cranial lesions may approach the end of their cycle before any change appears in the bones of the limbs.

Again, the lesions may be very pronounced in one part and only slightly noticeable in others. The cranial lesions may go through their cycle and have their characteristic bossa and configuration and little change appear in the limbs. Slight beading and bending of the ribs may be entirely effaced in time. Our little subject exhibits very marked lesions of the cranium and thorax, and very slight lesions of the limbs and pelvis.

Curvatures of the limbs tend to right themselves if the disease process is brought to an early end; if the process is violent and lasting there is apt to be an arrest of growth in the long bones, which produces stunting or dwarfing. It is not uncommon to observe subjects of rickets with a fair development of head and trunk, with very marked shortening of the limbs, more frequently the lower.

Rickets in itself is not necessarily a fatal disease, yet a large proportion of rickety children die because of their lowered vitality, and their consequent inability to cope with the ordinary ailments of childhood; this is particularly true of all diseases of the respiratory tract.

The treatment for rickets and the treatment to prevent rickets differ so little that they can advantageously be considered together. They involve the complete dietary and hygienic care of infancy. In the first place, the maintenance of the mother's nutrition is an essential factor for good. Two other conditions of the mother also influence the development and are to be avoided, viz: Frequent

child-bearing and the continuance of nursing during the period of pregnancy.

The proper food for the infant is its mother's milk, and your best efforts should be elicited to maintain that food in its proper quantitative and qualitative standard. The practice of weaning a child, so common to-day among the better classes, because of a slight failure of its mother's nutrition is vicious, and should receive your emphatic disapproval. Look for the cause of the mother's failure and you will usually find potent reasons entirely apart from the child. If, after some time of vigorous efforts to bring the mother to the proper standard, you are obliged to add some artificial food to the child's diet, do not discontinue the nursing, but interpolate additional food at proper intervals.

If you are obliged to give directions for raising a rachitic baby on artificial food remember that if God meant that a healthy infant should live on milk we shall be following a good example in feeding as well these little sufferers on milk. Study the composition of the individual milk you select, and prepare it so that it shall approximate the standard of good human milk.

In their life, both out of doors and in doors, at night and during the day, while asleep and while awake, see to it that they have good air and plenty of sunshine.

The safest clothing for these children is warm, well-fitting woolen undergarments varying in weight to suit the seasons, with light loose outer garments varying in number and thickness to suit the temperature they are in. The process of "hardening," either by exposure of parts of the body or by refusing to suit the garments to temperature and season, is always pernicious, and for these little sufferers is fatal.

It is in just such cases as these that Homœopathy, with its deep acting constitutional remedies, leaves its rivals far behind. Here as elsewhere, however, routine prescribing will not do; you must differentiate your individual case on its merits and know why you choose your remedy.

To return to our little patient, we shall advise the mother to keep the child out of doors all that the weather will permit; to see that the rooms she lives and sleeps in are well ventilated and lighted; to keep her properly clad to prevent chilling of the surface of the body and to have her well fed; we shall advise her to gradually wean the child because at this period of lactation, "twenty months," it is not probable that the mother's milk affords her very much nourishment. She may have some starchy food like potatoes, but we must remember that she is not advanced physically farther than a child of nine or ten months and should have only a comparatively small amount of starchy food. Milk should be her main article of food; this with cereal gruels and a small amount of well-ripened fruit will make a sufficiently comprehensive diet for her.

We shall prescribe calc. carb. for her and advise its administration three times daily. We shall expect, if no intercurrent ailment develops, to continue this medicine for some time to come.

THE ÆRO-THERMAL BATH.

A LECTURE DELIVERED IN THE HAHNEMANN HOSPITAL, OF CHICAGO, DURING THE SESSION OF 1892-93.

By Prof. B. S. Arnulphy, M. D.

I desire to acquaint you to-day with a simple and practical apparatus, which I consider as a precious accession to general therapeutics, and to the workings and the philosophy of which I would like to call your attention. I also take pleasure in introducing to you Mr. Victor Noël, who has imported the device from France, and is really the pioneer in this country of this valuable contrivance. Mr. Noël has kindly consented to bring his apparatus here to-day for your inspection, and will be pleased, after the lecture, to give you any supplementary information concerning its mode of application, which any of you may desire. He knows his business thoroughly, has always been very successful with it, and I am glad to be able to endorse his good work before an intelligent and appreciative audience.

The object of the apparatus is to bring about an abundant perspiration. How it is used, and what are its main indications I shall explain in a few moments with some detail. But before we proceed to that part of our subject, let us indulge in a few general remarks.

The extreme importance of the functions of the skin has been recognized by the human race all the world over; as far back as history will allow us to retrace our steps we find that the most ancient people knew something of the virtues of the sweat bath. The priests of India and Egypt, who certainly were better posted in medical lore than we generally suppose, thought they would best subserve the hygienic needs of the people by raising the sweat bath to the dignity of a religious rite, and so they did.

At the opposite extreme of civilization, and in our own times, we find that the mere instinct of the savage may lead him to an adequate conception of the services that the sweat bath may confer. The Aztec Indian, and the native of New Caledonia use a sort of oven in which they perspire freely. Those people know of no better panacea against all ailments.

It is also well known that the Russian peasant keeps up his magnificent strength and endurance through the toils of summer and the rigors of winter by means of the sweat bath which he gets in a sort of oven that he builds near his izba, issuing from which he rushes into the frigid water of the nearest pond or brook, an ordeal after which he takes up his wonted yoke with a braver heart.

Without going out of this continent I may refer you to a similar custom that has been in vogue among the northern tribes of Indians for untold generations.

The Greeks and the Romans used the hot-air bath for purposes of cleanliness and refreshment. At the present time, the custom prevails all through the Orient, but our occidental civilization seems to have forgotten the use of the hot-air bath, and it certainly is a great pity.

It is an instrument of public hygiene not to be disdained; and until our people know better, it is the province of the physician to appreciate and prescribe those simple and beneficent appliances of which the general public seems to have lost track.

If we only reflect for one moment on the philosophy of the cutaneous functions we shall understand the benefit that can be derived from the sweat bath. No other organ of the body has more numerous and varied functions than

those of the skin. It forms a protective covering for the underlying structures; it prevents the too rapid escape and evaporation of the water of the tissues; it assists in maintaining the temperature of the body at the normal standard; it acts as an organ of sensation, of secretion, of excretion, of absorption, and last but not least, of respiration. It is at the same time, a papillus, a sponge, a varnish, a cushion, a shield, a gland, a lung, and a kidney. It is all that and much more. For instance, it is an important part of that peripheral heart we have been studying together. Also the broad avenue through which a thousand and one impressions, a thousand and one stimuli reach the nervous centres.

Of these functions, it is the secretory function of the sebaceous glands, and the excretory function of the sudoriparous glands, as well as the respiratory role of the cutaneous surface that interest us the most with reference to the hot-air bath. You know what the sebaceous secretion consists of. Free fat, fat cells, epithelial *débris*. If you bear in mind the role of the fats in the system, such as we have reviewed it together, you may perceive the importance of this natural outlet, as a means of disposing of the superfluous fat of the system. As to the perspiratory function of the skin, it is of the utmost importance. It is the favorite emunctory through which the effete materials of the body are eliminated.

Perspiration in health is a colorless fluid, saltish in taste, and slightly acid in reaction. It is composed of 990 parts of water, and ten parts of organic and inorganic solids. The inorganic are mainly sodium chloride, potassium chloride, traces of iron and earthy phosphates. The chief organic constituents are: urea, fat, fatty acids.

You remember that a noticeable increase of the volatile fatty acids eliminated through the skin is a constant symptom of the state of slackened nutrition known as the "acid dyscrasia."

We also know that the skin absorbs some oxygen and exhales some carbon dioxide, it fact that it breathes. I shall now remind you of a fact which physiologists have never explained to their own satisfaction. If you take an animal and cover the surface of its body with an impenetrable coating, death occurs in a few hours, No other phenomena take place apparently before death except a steady downfall of the temperature; when it reaches 70° the end comes.

The same result is observed on man after a large superficial burn affecting about two-thirds of the surface of the body. Such burns are always fatal, even when no great damage is done the skin, from the above mechanism.

Now, this steady fall of temperature is unexplained to this day. I am inclined to attribute it to a lack of elimination and consequent retention of some eminently volatile and poisonous by-product of metabolism, of some of the ptomaines of the system; this subtle product would then exert an inhibitory action on the calorific centres.

The fact is established that not only ptomaines, but microörganisms as well are discharged through the perspiration. Dr. Konrad Brunner, of the University of Zurich, has demonstrated that various bacterial forms can be seen in drops of perspiration by means of the microscope.

FIGURE 21.

Now here is the apparatus, the invention of a distinguished chemist of Paris (France), Mr. Auguste Dubois. It consists of three wooden boxes, the inside of which is lined with tin. Each box measures fifty centimeters in length and fifteen centimeters both in width and depth, and contains three porous bricks enameled on all their faces but one. A movable, metallic crib is fastened over the bricks and keeps them in place. It also serves to graduate the heat as it issues from the heated bricks. (See Figs. 21 and 22.)

In order to heat the bricks a plain cooking-stove will do.

When the bricks are hot and the apparatus ready, the patient is put to bed. As a matter of precaution a rubber cloth had better be stretched under the sheet upon which the patient is to lie. The patient being covered with sheet and blankets as usual, the boxes are placed on the bed under the upper sheet; one of the boxes resting at the feet, the other two one on each side of the patient, on a level with the hips. The head must remain free and uncovered. Flexible reeds may be adapted to the boxes so as to keep the coverings from the body, allowing a circulation of air, much to the comfort of the patient.

When it is judged that the perspiration is sufficient, the boxes are first removed, then the lower sheet together with

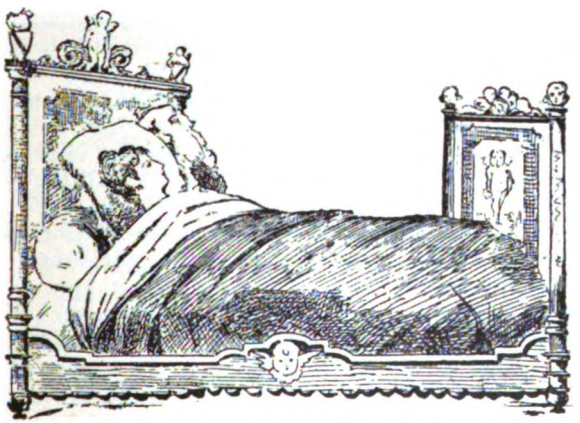

FIGURE 22.

the rubber one; then the upper sheet is also withdrawn and deftly replaced with a clean one, and the patient finds himself in a dry, comfortable bed, resting easily. In the course of fifteen or twenty minutes the perspiration ceases of its own accord, when massage can be proceeded with if indicated.

From the heated bricks a temperature varying from 110° to 200° may easily be developed and graduated according to the requisites of the case at hand. Not only is there no danger, but all who have gone through the process testify to the pleasant feeling experienced.

I have taken a number of these baths and can only describe the effect produced on myself as one of relaxation and exhilaration combined in a highly pleasurable way.

The physiological reason for this sensation of well-being is easily conceived when we think of the phenomena superinduced by the gentle application of dry heat to the surface of the body, the latter being in a state of muscular relaxation. First, the peripheral capillaries are dilated, allowing a more generous afflux of blood to the surface, to the relief of the visceral circulation; an abundance of fluids is exhaled in the deep cells of the epidermis; a general stimulus is imparted to the whole system, the elementary acts of nutrition in the anatomical elements are increased; the exchanges of matter in the tissues are favored; a mass of waste material is eliminated, thus rendering the play of all the organs easier and more effective.

A considerable quantity of fluid being lost through perspiration, the thirst is sometimes very pronounced, and therefore a liberal supply of cold water ought to be allowed during the bath.

When the bath causes a slight headache, compresses of cold water on the forehead will give immediate relief.

In order to avoid any unpleasant surprise in the course of the bath, you will watch the circulation and the respiration.

As I told you before the first notable effect of the dry heat applied to the body is to dilate the peripheral capillaries; the heart thus relieved will quicken its pace; therefore if you keep track of the pulse you will notice that it slowly and gradually rises from normal to 100 and 120 pulsations. Should the pulse rise rapidly in the course of a few minutes, and at the same time any dyspnœa become apparent, the bath should be discontinued.

As a rule, the respiration shapes its rhythm to the pace of the heart, rising from eighteen or twenty per minute to twenty-five, seldom above, except in diseased conditions of the thoracic organs.

When you can follow the bath with massage, it will be highly beneficial and gratifying to the patient; but lacking massage, an alcohol rub or friction with sedative water (Raspail's formula) will do very well.

One thing is certain that the activity of the skin is considerably increased by the process; also the receptivity of the system for any remedial agency that may be indicated, You will notice that remedies which had little or no effect on your patient, however decidedly indicated, will display their virtue after the bath. It has been my practice for a number of years to give one dose of sulphur to my patients

during the bath, in order to increase the stimulating effects of the bath, and to further sharpen the receptivity.

The æro-thermal bath, or brick bath is widely used in the Paris hospitals, and is advocated by the highest medical authorities. Such men as Profs. Bouchard, Germain Sée, Vulpian, Lassigne, Hérard, Laboulbéne, Pajot, etc., have testified to the excellent results derived from this mode of treatment in a variety of pathological conditions.

I shall now try to define for you the sphere of usefulness of this powerful means of treatment, and to point out its indications and its contra-indications.

[TO BE CONTINUED.]

HAHNEMANN MEDICAL COLLEGE, CHICAGO.—Final examination in Sanitary Science. Session 1892–3. By Prof. J. E. Gilman.—1. Under what general divisions are bacteria classified?

2. What are the necessary steps to be taken to prove the bacterial origin of any disease?

3. How would you sterilize any substance so that it would be absolutely free from any bacterial life?

4. State the methods in which bacteria develop and grow.

5. What is meant by a culture soil, and what is generally used for this purpose?

6. What is the cholera miasm, and how is it generated and spread?

7. What must the physician do to prevent the spread of the disease from any given case of cholera?

8 How would you disinfect an apartment after a case of scarlet fever or diphtheria?

9. When is the infection strongest in scarlet fever?

10. What steps would you take to prevent the spread of diphtheria from any given case?

Clinical Society Transactions.

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

MAY MEETING, 1893.

The Fifteenth Annual meeting of this Society was held in the Great Northern Hotel, Saturday evening, May 27, the President, Dr. W. A. Dunn, in the chair.

The attendance was unusually large, and a number of distinguished visitors, including Drs. J. P. Dake, W. P. Dake, C. F. Fischer, of Australia, and P. C. Majumdar, of Calcutta, were present.

ANNUAL ELECTION OF OFFICERS.

The following were duly elected as officers for the ensuing year: DR. R. LUDLAM, President; DR. AVERY MACCRACKEN, First Vice President; DR. A. K. CRAWFORD, Second Vice President; DR. MARY LANDRETH, Secretary; DR. W. P. MACCRACKEN, Treasurer. The same board of censors were reëlected.

The following papers were then presented:

XIII. UTERO-OCULAR THERAPEUTICS. By C. H. EVANS, M. D.—Those of you who were present at the last meeting of the Clinical Society and listened to the lengthy, learned and interesting review of Dr. Janot's monograph, must have been impressed with the thought how much it was in accordance with the truths of homœopathy. How close it was in conformity with the action of drugs as developed by Hahnemann, and proven in our daily use of them.* The organic body does not consist simply of an assemblage of physical instruments for the performance of special functions, and connected only by the circulation of blood. Instead, they are bound together in the most intimate relation by nerve supply and distribution; that parts

* See the *Clinique* for May 1893, page 214.

the most remote are in direct nerve communication with each other. This in the past has been vaguely designated as sympathetic, and latterly as reflex.

But it is more than either of these. Dissection in the near future will show the presence of nerve filaments in many organs that are now not supposed, or are only supposed to contain them. Anatomy has not yet reached its full measure; more, very much more remains to be revealed by the dissector's knife and lens, and this will be found to be especially true in the domain of nerve distribution. In the meantime the proving of drugs upon healthy persons, voluntary and involuntary, has shown us that remote parts of the body suffer in consequence of disturbance taking place in one or more organs or tissues. Clinical observation from collated facts demonstrates that disease in some prominent organ is followed or associated with disease in distant ones, between which there must be a physical relation. These latter, coming from the opposing school of medicine in such frequency of late are confirmatory, every one of them of the scientific basis upon which homœopathy rests. Thus it is that the proving of drugs is an interrogation of nature, the morbid force thus produced having penetrated where the scalpel has hitherto been unable, and possibly may never be able. Nerve fibres the most varied in dispersion are often included in the same nerve sheath, and before they reach their ultimate distribution have been included in the sheaths of two or three nerve trunks.

As diseases are produced and continued along these lines of network when once they are initiated by any morbid force, so it is that the influence of a drug acts in the same manner, along the same lines, through the same structures, in the same order, and producing like results, not only cures the patient of his ills, but also indicates the direction in which both morbid operations have proceeded.

Although the title of this paper has been chosen to emphasize the clinical side of the above mentioned monograph on utero-ocular disorders, yet the same truth holds

good in disease of each and every other organ of the body. The relation between hepatic disorder and the brain as evidenced by melancholia and hypochondriasis is well known. The association of deltoid and scapular pain with disease of the liver is an unquestioned fact. Pain about the knee belongs to the early stage of hip joint disease; and the intimate correspondence between the heart, lungs and stomach is such as to need no comment. The nerves which supply joints also send nerves to the skin covering them; thus it is that the skin becomes reddened and inflamed, while the structures composing the joint are vascular only to a small extent. These are but a few illustrations of what takes place in the course of acute or chronic disease, and it is due to this relationship through nerve filaments of remote organs that chronic diseases become so complicated. It is therefore a matter of fact that the specialist is especially adapted to our school as he is in a position to trace disease in all its ramifications guided by the light of pathogenesy. Furthermore, it is his province to show the close relation and interdependence of all parts of the body, and to develop the fact that disease is more than what is revealed by gross pathological tissue changes.

But to return to the especial topic of this paper; the therapeutic indications for utero-optic disorders are as numerous and varied as there are remedies in the materia medica, many of the reasons for preference often being found in the symptoms of a third organ.

The ones herewith submitted are suggestive and corroborative, and are submitted with reference to the observations of Janot's monograph on the descriptive side.

Belladonna.—The menses are too early and too profuse. Pale menses, the menstrual blood is bright in color. Offensive smelling menses, suppressed menses, painful menstruation, leucorrhœa of white mucus (with colic), heat and dryness of the vagina, pressure and bearing down of the genital organs as if everything would be forced out; sometimes relieved by standing. Pressure downward as if the contents of the abdomen would issue through the

vulva. Clutching or clawing pains, or transient stitching pains in the uterine region; the parts are sensitive and cannot bear the least jar. Pains coming on suddenly and ceasing as suddenly. Prolapsus and induration of the uterus. Prolapsus uteri following severe labor, or induced by getting up too soon afterward. The os uteri is rigid, hot and dry. Heat and dryness of the vagina. Ovaritis (of the right side). The (right) ovary is much enlarged. Stitching throbbing pains in the ovary. The pains in the ovary come suddenly and cease suddenly. Chronic ovarian pains.

Far sightedness. Vertical half-sightedness. Diplopia. Vision is obscured as if from a white vapor, with dilated pupils, photophobia; photophobia is worse from artificial light. At first there is photophobia which is followed by blunted and diminished vision; with dilated immovable pupils. Dimness of vision or actual blindness. Is blind on waking. Blindness following severe congestive headache. Night blindness. Objects are seen inverted. Double and triple vision. Objects appear as if framed with the colors of the rainbow (as if they were looked at through a glass prism). A halo appears around the lamplight, parti-colored, but red predominates. Everything seen looks red. Flashes of light occur. Bright sparks before the vision. Hyperæsthesia of the retina. Dilated pupils (paralysis of the circular fibres of the iris, and also of the optic nerve). Deep-seated dull pain at the back of the eye. Heat and burning in the eyes. Sensation of sand in the eyes. Shooting pains in the eyes. Orbital pains (at the climacteric) with photophobia and lachrymation. Neuralgia of the eyes, especially the right eye. Congestion of the eyes, with bright redness of the vessels. Ophthalmia developing itself suddenly, is worse in the right eye, and there is intense photophobia. Ophthalmia accompanied by severe headache. The eyes are red and protruded, staring and brilliant. Scrofulous ophthalmia, with discharge of acrid tears. Discharge of purulent mucous. Convulsive movements of the eyes when in the light, with severe pressive pain throughout the head, only relieved when in a dark room. Interstitial distension of the sclerotic. Specks thickening and ulcers on the cornea. Strabismus. The eyelids are puffy, red and congested. Erythema and erysipelas of the lids.

Pulsatilla.— The menses are scanty, late, and of too short duration, with cramp pains in the abdomen. The

menstrual discharge is thick, slimy, black and clotted, or thin and watery, or changeable in appearance; flows more during the day while walking, and is intermittent. Dysmenorrhœa so seveve in character that the patient tosses about in every direction, with cries and tears. Menses are dark and thick, or pale and watery; flows by fits and starts, and the patient is worse in a warm close room. Pressive constrictive pains in the uterus and hypogastrium, relieved by crouching forward. First menses are delayed. Delayed menstruation, with chilliness and a bad taste in the mouth in the morning. Delayed scanty, slimy menses. The menses are suppressed, or flow intermittently after patient has had her feet wet, or following upon nervous debility, or with chlorosis. Suppressed or intermittent menses, with evening chilliness, throbbing headache, pressure in the stomach, pain in the uterus, dysuria, dyspnœa, ophthalmia, and morning nausea. Metrorrhagia at the climaxis, during chlorosis, or following the continued use of quinine and iron; the flow is profuse at times, at others again is intermittent and mixed with clots, now ceasing and then profuse. The menses are changeable in appearance. Amenorrhœa. Leucorrhœa occurring before or during the menses, with cutting pain in the abdomen. Milky leucorrhœa with swelling of the labia, particularly so after menstruation. Acrid, burning, thick white leucorrhœa, with or without abdominal pain. Tensive cutting pain in the uterus, which latter is quite sensive to touch, and is tender during coitus. Prolapsus uteri, worse when lying down. Prolapsus uteri, with pressure on the abdomen and small of the back, attended with an inclination of the lower limbs 'to go to sleep;' there is also ineffectual urging to stool. Pain in the uterus, with amenorrhœa. Pain in the uterus caused by nervous debility, or by getting the feet wet. Crampy constriction of the vagina. Indurations, fistulæ or polypi of the vagina. Dimness of vision, with lachymation, in the open air. There is an appearance as if a fog were before the eyes, relieved by rubbing or wiping the eyes. Sensation as if a veil obscured vision, temporarily relieved by rubbing the eyes. Dimness of vision, especially when the patient becomes warm from exercise. Blackness appears before the eyes during menstruation. Transciently obscured sight. Dimness of sight following the suppression of any bloody discharge, or from metastasis of gout or rheumatism, or in consequence of gastric derangement. Obscured

vision when the person rises from a seat and commences to walk about. Dimness of vision consequent upon suppression of the menses. Seeming darkness before the eyes in the morning on rising from bed. Fiery circles and starry apparitions appear before the eyes. Photophobia. Hemeralopia. Diplopia. Flashes of light before the eyes, as if the patient had been struck in the face. Stitching pain in the eyes, especially from light and when in the sunshine. Burning and itching in the eyes inducing rubbing. Weak eyes, with frequent styes on the eyelids. Pressive burning pain in the eyes. Catarrhal ophthalmia. Purulent ophthalmia. Pustular comjunctivitis, with lachrymation worse when in the open air. Bland purulent discharge from the eyes. Ophthalmic fromamenorrhœa. Small ulcers on the cornea, without vascular supply. Phlyctenules on the cornea or conjunctiva. Prevents the ulceration of phlyctenules. The eyes always feel worse toward evening, and when the patient is in the wind. Lachrymation by day, followed by a purulent or muco-purulent whitish discharge at night. Lachrymation; blear-eyedness. Blepharitis with muco-purulent discharge.

Lilium tigrinum. The menses are scanty and flow only when the patient is walking about. Dark thick menses, smelling like the lochia. Delayed menses, with pain in the abdomen. Profuse bright yellow leucorrhœa following menstruation and excoriating the perinæum. Acrid excoriating leucorrhœa, producing an eruption on the labia and causing intense irritation in the vagina. Thin, acrid, excoriating leucorrhœa staining the linen brown and attended with intermittent labor-like pains in the lower part of the back. Bearing down in the uterine region as if everything would be pressed out; she must support the vulva with the hand to prevent the apparent protrusion of the contents of the abdomen. Bearing down of the uterus, with pain in the (left) ovary, and (left) mamma. The pains and bearing down sensation seems to extend and drag downward from the shoulders and chest. With this feeling of bearing down in the uterus, the patient is low-spirited, apprehensive and weeps, or is irritable, or has contradictory and opposite mental states, or has urgent desire for stool, or there is loss of appetite, or becomes faint in a close room and when standing, or there is a frequent discharge of scanty, burning urine or pain in the sacrum. Tenderness of the sexual organs internally and externally. Bloated sensation in the region of the uterus; the pelvic organs feel

swollen and there is an aching pain. Severe neuralgic pains in the uterus; the patient cannot bear to be touched, or even bear the weight of the bedclothing; is made worse by the slightest jar. The patient dates all her trouble from a miscarriage. Pressure and heaviness in the pelvis and rectum, with ineffectual efforts to stool. Burning, stinging, cutting or grasping pains in the (left) ovary, extending across the hypogastrium to the groin and down the leg. Delayed post-partum sub-involution of the uterus, with profuse excoriating lochia lasting too long; associated with dragging pain and smarting in the urethra after urinating. Many ovarian symptoms. Retroversion of the uterus. A large number of hysterical symptoms. Objects seem as if seen through a veil.

Asthenopia depending on spasm of the muscles of accommodation, asthenopia of astigmatism. Obscured vision, with prolapsus uteri. Blurred vision. Hypermetropia. Intense pain in the eyes, extending backward into the head, with dimness of sight. Burning heat in the eyes after reading or writing; the eyes feel very weak. Heat in the eyes and redness of the conjunctiva. Aching, tired feeling in the eyes, with a feeling as if the eyes must be closed and pressed upon with the fingers to enable the patient to see clearer. Lachrymation. The eyes are painful and sensitive to light. Redness of the conjunctiva. Dull reddish infection of the conjunctiva. The eyes are very sensitive to gaslight which causes intense burning pain. The late Dr. Woodyatt reports a case of asthenopia successfully treated with this remedy as follows:

Mrs. E., aged 37 years. Has sewed steadily for some time, until a gradually increasing pain in the eyes has compelled her to desist. What was at first periodic pain, has now become constant, and she is painfully conscious of her eyes all the time. All effort to see, causes pain, and in talking with friends she is obliged to close the eyes frequently and press the globes with her fingers. All light is painful, so that she remains in a darkened room. Headache frontal and occipital, and there is present a condition of general nervous irritation. Lilium 30th, four times a day. There can be little doubt that there was uterine disease in this case, but as the oculist is not expected to look farther than his own specialty, the examination for uterine symptoms was omitted, though the general nervous irritation pointed in that direction.

Sepia—The menses are early and profuse, too late and scanty, or are suppressed. Menorrhagia mentrorrhagia at the climaxis, chronic metrorrhagia excited by the least cause. Profuse menstruation, metrorrhagia, during pregnancy, especially at the fifth and seventh months, with disposition to abortion at those times; discharge of blood when walking, attended with a yellow, fœtid leucorrhœal discharge. The menses are always irregular and the patient perspires profusely when walking, is sensitive to cold air and there is frequent shuddering during the menstrual period; amenorrhœa in those of feeble constitution, always menstruating irregularly, and especially sensitive to cold air; amenorrhœa at puberty or later; the menstrual disorders are attended with the passage of fœtid urine which deposits a sediment on the bottom of the vessel like burnt clay, very difficult to remove; leucorrhœal discharge of yellowish or reddish green water, or of purulent offensive fluid; leucorrhœal discharge like pus or milk, excoriating the thighs and flowing only during the day. Profuse mucus or purulent fœtid leucorrhœa, pain in the back, with a bearing down sensation extending from the back to the abdomen and causing oppression of breathing. Prolapsus uteri with irritation of the bladder, leucorrhœa, flushes of heat and sympathetic affections of remote organs; sensation as if everything would be forced out of the vagina; burning, stitching, shooting or lancinating pains, mostly in the neck of the uterus and extending upward toward the umbilicus. Sense of constant tonic pressure in the uterine region, little darting pains shooting upward from the uterus. Painful stiffness in the uterine region. Prolapsus uteri and vagina. Induration of the neck of the uterus. Dropsy of the uterus.

Retinal anæmia with sudden vanishing of sight. Dimness of sight, sees only half of an object clearly, the other half seem obscured. Flickering appearance before the eyes like that of a thousand suns. Asthenopia with uterine complaints. Black or cloudy appearance before the eyes in the evening, during the menses, associated with great general weakness. Sees a green halo around the lamplight, sudden vanishing of sight during menstruation; sees a zigzag circle of colors, fiery sparks are perceived, obscured vision dependent upon hepatic derangement. Photophobia, pricking pain in the eyes in the evening from artificial light; the eyes are hot and dry, inflammation of the eyes, redness of the sclerotic, with stitching, pressive pains in the eye. Conjunctivitis with muco-purulent discharge

in the morning and excessive dryness in the evening. Pustules form on the cornea. Phlyctenular keratitis especially in women with uterine disturbances. Ophthalmic disorders dependent upon uterine troubles. Kopiopia hysterica and cataract, especially in women. Chronic ciliary blepharitis; a scaly condition of the margin of the eyelids, with the formation of small pustules on their ciliary border. Trachoma in "tea drinking" women. Ptosis, paralysis of the upper eyelids, with uterine disease.

Sulphur.—The menses are too soon and profuse and last too long. Menstruation is late and of short duration. Scanty menses, delayed menses, suppression of the menses, delayed first menstruation. The menstrual discharge is thick, dark and acrid, making the thighs sore. Pale menses, chronic hemorrhage, almost ceasing, then occurring again and again for weeks; attended with weak, faint spells. Previous to menstruation there is headache, cough in the evening, nosebleed and itching of the genitals. During menstruation there is congestion of blood to the head, headache, nosebleed and general pruritus. Abdominal pain during the menses, the patient has to take a sitting position for relief. Ichorous, acrid, offensive leucorrhœa, burning and smarting like salt, making the vulva and thighs sore. Yellow mucus, corrosive leucorrhœa, with pain in the abdomen bearing down on the pelvis toward the genitals. Labor-like pain above the symphisis pubis, various forms of uterine inflammation called for by general indications. Sense of burning in the vagina; she is scarcely able to keep still. Papular or vesicular eruption upon and around the external genitals.

Short-sightedness, weakness and dimness of vision; an appearnce as if a veil or mist were before the eyes, vision becomes obscured when the person is reading. Objects seem more distant than they really are. Incipient amaurosis, amaurosis following the suppression of an eruption. Sensitiveness of the eyes to daylight. Photophobia, optical illusions, gaslight causes more pain than sunlight, the gas or lamplight seem to be surrounded by a halo. Retinitis, caused by overuse of the eye, sharp, darting pains in the eyes, a feeling as if pins were sticking in the eyes, severe cutting pain in the(right) eye, shooting pains in the (left) eye when attempting to read. Shooting pain in the eyes and into the head, sensation as if sand were in the eye, pain in the eyes like splinters. Burning in the eyes, a feeling of dryness in the eyes when in the house, with

lachrymation in the open air. A sensation of dryness of the eyes as if they rubbed against the lids. Inflammation of the eyes (and lids) with itching, smarting and burning, and a feeling as if sand were in them. Inflammation of the eyes caused by the presence of a foreign body in them. Redness of the eyes near the angles, redness of the eyes during the day, with itching in the evening; discharge of purulent mucus, also in scrofulous patients. Lachrymation, profuse acrid lachymation. Pannus (in strumous patients) the conjunctiva looks like a piece of raw beef. The ophthalmias have a tendency to relapse. Pustular inflammation with great lachrymation, superficial or deep ulcers on the cornea, with intense redness of the eyes. Iritis, keratoiritis, hypopion, abscesses of the cornea. The eyes and eyelids are aggravated by bathing them in water. There is itching, smarting, dryness and burning in the eyes and eyelids. Successive crops of styes. Eczematous affections of the eyelids.

Phosphorus.—The menses occur too soon, and are too profuse and protracted, or they are early, scanty and watery. Very free menses, sometimes with sexual excitement. Menorrhagia in nursing women, membranous dysmenorrhœa, profuse hemorrhage ceasing for a time and then returning. During menstruation there is stitching headache, fermentation in the bowels, bloody expectoration, palpitation of the heart, pains in the small of the back, bruised and lame sensation in the small of the back, languor, fever and sleepiness. Amenorrhœa, with spitting of blood, rectal hemorrhage and hematuria. Suppressed menses, vicarious menstruation, mucous or milky lencorrhœal discharge, profuse watery, slimy, excoriating leucorrhœa causing blisters on the skin. Leucorrhœa, with chlorosis, metritis following upon frequent pregnancies; also with pyæmia and phlebitis, especially when occurring in fair, graceful women. Cancer uteri, with frequent and profuse hemorrhages, ceasing for a time and then recurring. Pain in the ovarian region and extending thence down the thigh. Stitching pains in the vagina extending upward into the pelvis.

Contracted pupils. Cloudiness or dimness of vision. All objects seem in a mist. The patient sees more distinctly in the morning and in the twilight than during the day. Day blindness; nyctalopia. Short-sighted. A cherry red color appears before the vision. Momentary blindness. Black floating points or dark objects pass

before the eyes. Sparks appear before the eyes in the dark. Flickering of vision, with roaring sound in the head. The eyes fill with tears, and are painful after reading. The letters look red when reading. Is worse when looking at bright objects or at the lamplight; the eyes are better by twilight. Functional amaurosis. Amaurosis following sexual excesses or from a continued loss of fluids from the body; also during the course of Bright's disease. The eyes ache when moving them. Aching pain in the eyes extending to the orbits and forehead. Relieves intra-ocular pressure in glaucoma. Cataract. Paralysis of the recti muscles. Weakness of the internal rectus. Retinitis albuminurica. Retinal apoplexy.

Gelsemium.—Suppression of the menses, with congestion of the head; sharp darting pains in the face and head, and convulsions (every evening). Suppressed menses, with pain extending upward and downward from the uterus. Dysmenorrhœa when the flow is scanty and painful, associated with vertigo and faintness at the stomach. Dysmenorrhœa with spasmodic, neuralgic pains and cramps in the uterus and legs, and general hysterical condition. Dysmenorrhœa preceded by sick headache, vomiting, congestion of the head, deep red face and a bearing down in the uterine region. Amenorrhœa with aching pain, sense of heavy fullness in the uterine region and leucorrhœa. The uterus feels as if it were being squeezed by a hand (in anteflexion). Sensation as if a wave passed from the uterus to the throat. Ovarian irritation and inflammation, accompanied by the characteristic headache.

Dimness of vision, also with vertigo. Smoky appearance of every object. Is unable to see anything. Complete blindness. Objects appear double. Diplopia which can be controlled by an effort of the will. Diplopia when the head is inclined toward the shoulder on either side, but vision is single when the head is held erect. Astigmatism. Hypermetropia. Asthenopia dependent upon weakness of the external recti muscles. Amaurosis of congestive origin. Confused vision. Sensitiveness of the eyes to light, with lachrymation. Photophobia either from sun or gas light. Serous choroiditis. Irido-choroiditis with detachment of the retina. Inter-occular inflammation. Dilated pupils, with blindness and vertigo. Retinitis. Extravasations into the retina of blood, with white patches. Traumatic detachment of the retina. Lateral oscillation of the eyes when using them. Drawing pain in and over the eyes.

Ptosis; the eyelids are drooping, half closed, and there is apparent inability to move them. The eyelids close whenever the patient looks steadily at anything; she cannot keep her eyes open.

Calcarea Carb.—The menses return too soon and last too long; there is only a short time in the month when she is not menstruating, and is more or less anæmic. The least excitement causes the menses to return. Profuse menses during lactation. Irregular menstruation. Membranous dysmenorrhœa. Metrorrhagia, with leucorrhœa during the climacteric. During menstruation there is cutting pain in the abdomen, griping pain in the back, heat and congestion to the head. Suppressed menses with plethora. Suppression of the menses in women of full habit and leucophlegmatic temperament. Suppressed menses in young girls with tendency to pulmonary consumption. Suppressed menstruation after the person has been working in water. Suppression following fright. Amenorrhœa, with dropsy of the uterus and adjacent parts. Milky leucorrhœa, worse before and after menstruation, attended with burning and itching. Albuminous leucorrhœa with burning pain in the cervix; with lassitude and debility. Stinging or stitching pain in the cervix. Prolapsus uteri. Bearing down pain in the uterine region. Prolapsus when the patient finds it difficult to stand on account of the downward pressure. Bearing down as if all the internal organs would be pressed out. Displacement of the uterus caused by lifting. Burning soreness in the genitals. Polypi.

Far-sightedness. Sensitiveness to light; photophobia. Photophobia worse in the morning after rising, and in the evening. Shadows or black spots appear before the eyes. Only one side of an object can be seen, as a shadow seems to obscure the other one. Dimness of vision as if she were looking through gauze. Halo is seen around the light. Flickering sparks or black spots appear before the eyes. Painful sensation in the eye, as if it were caused by the presence of a foreign body. Stinging pain in the eye, made worse by artificial light. Severe pain in the eyes when using them. Stitching pain in the inner canthus. Ophthalmia caused by "taking cold." Ophthalmia following the presence of a foreign body in the eye. Inflammation of the cornea caused by wet, or aggravated by damp weather. Ulcerative keratitis. Ulceration and disorganization of the cornea. Thickening of the cornea. Opacity

of the cornea. Chronic inflammation of the eyes and eyelids. Conjunctivitis and blepharitis, with a thick, purulent, excoriating discharge and falling out of the eyelashes. Discharge of muco-pus from the eyes. Excessive secretion of mucus in the eyes. During the day the eyes are full of mucus with heat, smarting pain and lachrymation, with agglutination of the eyelids at night.

Natrum Mur.—The menses are late and scanty, or early and profuse. Menstruation lasts too long at a time. Delay in the appearance of the first menses. Delayed menses, which are scanty for two or three days and then become copious. The menses delay and decrease more and more, and the patient wakens every morning with a severe headache. Previous to menstruation she is very sad and gloomy, is qualmish at the stomach, with sweetish risings and eructations, especially in the morning, headache, palpitation of the heart and disposition to faint. During menstruation the foregoing symptoms continue. Dysmenorrhœa, with convulsions. Discharge of transparent leucorrhœa (in the morning) preceded by colicky pains. Acrid, greenish leucorrhœa, with yellowness of the face. Leucorrhœa, with bearing down in the genital organs. Bearing down in the genital organs with so much pressure and pushing that the patient has to sit down in order to prevent prolapsus of the uterus. Prolapsus uteri, with aching pain in the lumbar region; is relieved when lying on the back, attended with cutting pain in the urethra after urination. Uterine cramps, with burning and cutting pain in the groins.

Double vision. Sees only one-half of an object. Muscular asthenopia and its results. Asthenopia caused by over use of the eyes. Unsteadiness of vision; objects seem confused. Misty vision. Sudden darkness passes before the eyes, when the patient is intently looking at any object, but especially when sewing (often associated with general muscular weakness or spinal irritation). The eyes give out while reading or writing; pressive pain extends into the head. Fiery zigzag light surrounds all objects. Amblyopia and amaurosis dependent upon menstrual disorders, especially in chlorotic patients. Continued use of the eyes induces heaviness and drooping of the eyelids, blurring of letters, and if long continued causes aching of the eyes. Burning and smarting of the eyes when attempting to use them, and after continued use of them. The eyes are painful when looking steadily at near or remote

objects. Photophobia. Smarting pain in the eyes. Sensation as if sand were in the eyes (in the morning). Burning heat in the eyes with photophobia with free secretion of mucus. Burning, itching and redness of the eyes, with lachrymation which induces redness and soreness of the eyelids. The discharges from the eyes are thin, watery and excoriating. Thin, watery excoriating discharges from the eyes after the misuse of nitrate of silver. Blear-eyedness. Ulcerative keratitis, with smarting, burning pain, sensation of sand in the eyes, secretion of acrid tears, photophobia and spasmodic closure of the eyelids. Chronic recurrence of ulcers, pustules upon the cornea. Chronic follicular inflammation of the conjunctiva, especially when confined to the oculo-palpebral folds. Affections of the eyes that have been excessively treated with nitrate of silver. Catarrhal inflammation of the margins of the eyelids, agglutinated in the morning. Weakness of the internal recti muscles (divergent strabismus).

Lachesis is often useful at the climacteric period when where is metrorrhagia, flashes of heat, faintness, heat in the vertex, pain in the ovaries, exhaustion from sleep. Is often adapted to women during the climacteric when the menses are profuse. The menses are scanty, delaying, or intermittent. The region of the uterus feels swollen and is sensitive to contact even of the clothing. Menses are scanty and feeble, but regular, and lumpy, black, acrid or offensive. Previous to the menses there is vertigo, nosebleed, pains in the (left) ovarian and uterine regions, bruised pain in the hips; all relieved by the appearance of the flow. Copious leucorrhœa (before the menses) smarting the skin and staining the linen greenish. During menstruation there are lacerating pains in the abdomen, throbbing of the head, labor-like pressure downward, followed by a slight flow from the vagina; uterine and ovarian pains relieved by a slight flow of blood, but in a few hours or days it recurs again. Swelling, induration, congestion, neuralgia and other anomalies of the (left) ovary. There is a history of ovarian affections and chronic constipation. The left ovary is swollen and there are tensive, pressive, stitching pains in it, with inability to lie upon the right side on account of a sensation as if something were rolling over toward that side; also worse in the morning and after sleeping.

Faintness and dimness of vision attendant on other disorders than the eyes. Misty vision. Asthenopia. Flick-

ering of vision. Colored rays or rings appear around the light. Pressure in the eyes as if they would be forced out. When the throat is pressed upon there is a feeling as if the eyes were being pressed out. Pain in the eyes from reading. Stinging, burning pains in the eyes. Inflammation of the eyes when there is a bundle of congested vessels passing from the inner canthus toward the corner. Retinitis, with hæmorrhage when no characteristic symptoms are present with the pathological change. Aching pain in the (left) eye. The pains in the eyes are worse after sleeping. Redness of the eyes. Sense of pressure in the eyes. Severe pain in and above the eyes. Ulcers on the cornea. Chronic recurrent phlyctenular keratitis. Cellulitis of the orbit.

XIV. AMAUROSIS COMPLICATING HEMORRHAGIC ENDOMETRITIS. By DR. C. F. FISCHER, OF SYDNEY, N. S. W.—In reply to the question "if I had known or seen any cases where affections of the eyes or deficient sight have accompanied uterine diseases or diseases of the generative organs?" the following case came to my recollection which I venture to quote in order to invite investigation in this direction.

Case.—Two years ago, when visiting Sydney, the place of my former activity, I was called to see an old patient of mine, whom for several years I treated for a variety of uterine affections, chiefly for a hæmorrhagic endometritis. She was always a very nervous, sensitive and delicate subject, the mother of four children and is now advancing to her climacteric period. It was a case of sudden spontaneous amaurosis caused by emotion, fright or terror in coming suddenly upon the body of a man who had shot himself at the door of her home, just as she was returning from a walk. She was struck blind. The medical treatment had been by specialists who diagnosticated the case as amaurosis, and who by careful opthalmic examination discovered no abnormal condition of the retina, or in the interior of the eyes. After months of treatment no result favorable to recovery had been made when I was requested to see my old friend in a friendly way. I found her in a very weak and emaciated condition in bed, totally blind, with no congested or injected conjunctiva and no abnormal condition of the exterior eye. The iris was insensitive to light, she suffered at the time with intense supra-orbital neuralgia, and was just recovering from painful and profuse menstruation.

She also complained much of a sensation of prolapsus and pain when moving.

I was called to do something for the neuralgia and, having frequently obtained relief from the application of the constant current of electricity, and having a galvanic battery in the house I applied a current of about ten bichromate of potash cells over the orbital and supra-orbital region. I was tempted to this to see also the effect on the optic nerve. It produced a marked relief in the neuralgia. I gave besides, gelsemium. The next day I was astonished in learning that the patient felt "not saw light" even through the closed eyelids. This gave me great encouragement and I decided to place her under the hand of a skillful masseuse who applied general treatment throughout her body and specific electrical massage over her eyes and the orbital region, in which she had already had experience and skill. This treatment was carried out with the result that in two months the sight was restored and the general state and strength of the patient much improved. The remedies which I gave besides were as I recollect, gelsemium, cimicifuga, helonias and phosphorus amongst others, according to the symptomatic indications, and also for her uterine troubles.

In quoting this remarkable and singular case of sudden or spontaneous loss of sight by emotion, fright or terror, may we not look for a remote cause to explain such state of things than a mere highly nervous, sensitive or exhausted condition, or weakness of the patient? Direct ophthalmic disturbances had not been found, and cerebral causes were not discernable. The existing weakness of sight and ultimate loss of it might lead us to the diagnosis of Bright's disease, but no albumin had been traced by her former medical attendants, nor by myself after careful examination of her urine. What conclusion can we come to except that to the state of her nervous susceptibility to cause blindness by sudden emotion or terror is attributable to a functional disturbance of the optic nerve caused by a sympathetic condition which coexists with the diseased state of her uterus, with which she had been afflicted for years.

We know of and recollect the many sympathetic and reflex nervous disturbances in the great variety of forms coexisting with various pathological and physiological conditions of the uterus—which we may easily trace to the nervous sympatheticus, we know of the sympathy of the vagus or the pneumogastric nerves—with diseases and vari-

ous conditions of the womb and the gastric disturbances and sickness of pregnancy which we can trace to the vagus.

We know of the various affections of the throat, of the pharynx and larynx coexisting with diseases of the womb. We are aware of the functional affections of the heart, of the spasmodic constrictions of the bronchial tubes, asthma, etc., in patients with uterine disease. Most of those are of nervous origin and traceable to the vagus, its branches and filaments which are merged and intersected with almost all other cerebral nerves that have their origin in the medulla oblongata. Why should the optic and the occuli motorii escape? Why should not a sympathy be traceable between the medulla oblongata and the uterus which would help to explain the various hysterical, functional and even organic disturbances that are constantly met with, divers physiological and pathological conditions of the uterine and generative organs? That this case which I have related was attributable to such uterine condition I have no donbt.

If I have been successful in adding to the list of cases and causes, and calling your attention to such probable existing sympathy between the medulla oblongata and cerebral nerves with the uterus, and have been clear and explicit enough to make myself understood my object has been obtained. I had not read the admirable, elaborate and instructive article of Dr. Ludlam before I decided to bring this case before you; had I done so I would not have added a theory to so many more efficient reasons for a connection of ocular disturbances with uterine disease among the most important mystic infections which, without doubt, would give rise to organic and functional diseases of the eyes, associated with uterine affections.

XV. TOTAL BLINDNESS DURING THE LYING-IN. By DR. O. W. CARLSON.—Briefly my patient's case is this. She was a healthy girl of twenty-three years when she was married, February 8, 1871, and her baby was born January 15, 1872. After becoming pregnant she became *very* plethoric, so much so that before confinement for several weeks she could not put on or take off her own shoes and stockings. She was taken suddenly sick on January 14, 1872, while at dinner. She says it seemed to her as if some one had struck her a severe blow upon the head with a heavy instrument, and she became immediately unconscious. Her father says her face, and in fact her whole

body, presented a mottled appearance. The baby was born early on the following morning, and during the day she regained consciousness, but could not see and did not see at all until January 20th, 1872, when the sight returned gradually. She made a good, but slow recovery, and has never suffered since from any eye or uterine trouble, in fact, has never had any sickness since. She has never been pregnant since; is now forty-six, and going through the change she finds herself obliged to wear glasses to read and sew with.

XVI. RARE CASES FROM PRACTICE. BY DR. G. H. MORRISON, Winnetka, Ill.—The following cases are submitted in the hope of getting light upon the diagnosis of something that I can find no description of in any of my text-books.

A Swedish family, husband and wife, rather dark complexioned, healthy, the husband a machinest, the wife as well as could be expected after having six children in seven years. Two of the boys were born before they came here, the second one having died at five weeks, after a week of convulsions, the only symptom noted before that was that "the stools never changed" (from the meconium). The first born died under my care at twenty-one months. He had an attack of cholera infantum of a few days, which seemed to have yielded, but after being apparently well for one day the diarrhœa returned, followed by symptoms of basilar meningitis, and he died in about six hours.

Then two girls were born, fifteen months apart, spindling, sickly little things, the second one apparently just escaped going with hydrocephalus at one year of age, but now both are comparatively quite rugged children.

But two boys who have been born since have puzzled me not a little. One about two years ago seemed all right at birth, but ten days after, I was called in as I was passing, and found him pale all over, apparently bloodless, though warm, pulse good, heart and lung sounds normal, had had a little colic in the morning, would not nurse; the stools had been green since the meconium ceased.

I could find nothing else abnormal, no tenderness anywhere. The palor continued and he died that afternoon.

The other, born this month, a particularly fine, large, healthy looking boy, I found on the eleventh day, in the same condition as the last case, only here there was distinct enlargement of the liver. He had some colic which dis-

appeared after taking chamomilla 6 x. He nursed well, and seemed clear mentally to the last; no apparent variation from normal temperature of surface. The mucous membranes were as pale as the skin, the gums looking like teeth. They had noticed some jaundice of the skin for a few days before the color left, but as he seemed well otherwise, no especial attention was paid to it. He lived about thirty hours after the palor was first observed.

I gave the cause of death as strangulation of the capillaries.

XVII. PROGRESSIVE PARALYSIS CURED BY NATRUM MUR. BY DR. M. HISLOP, OF WASHINGTON, D. C.—Mrs.—— æt. 45, the mother of four children, is of fair complexion, blue eyes and light hair, plump in figure and has always been in good health. Three years ago she was seized with an attack of what seemed to be acute rheumatism in the right arm and left leg; but as it steadily grew worse, in spite of all treatment, until the use of both members was entirely lost, and as there was a history of progressive paralysis in the family it was thought to be none other than that, by both patient and doctor. Phytolac., Acon., Rhus., Macrotin., Staph. and many other remedies were faithfully tried, but without the least effect. Massage, too, was given a fair trial but without relief. Discouraged and disheartened, I determined to try what some of the higher potencies might do for the case; so upon the recommendation of a high dilutionist, and upon the one indication of "consolation aggravates," for there was a complete absence of any other symptoms, I gave the patient natrum mur. 2 cm. A few doses only were required to effect a complete cure; and now, after three years there has never been a return of the trouble. As the patient was entirely ignorant of the circumstances governing the choice of the remedy, the cure cannot be attributed to the effect of the mind. About two years after, her sister became affected in the same manner, and natrum mur., in the same potency, cured her, one prescription only being required.

Hospital Notes.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

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

POSSIBLE REMOTE EFFECTS OF TUBO-OVARIOTOMY.—*Case 20,957.* Mrs. —— æt. 44, mother of six children, the youngest five years old, complains of uterine bearing down and desire to urinate when standing. She had both ovaries and tubes removed in another hospital, two years ago, and one year later for the relief of this same dragging sensation, the cervix and perineum were sewed up. She has been worse since the last operation. There has been no menstruation since the ovaries and tubes were taken. The womb measures four and one-half inches.

Observe that this abdominal cicatrix is a good one, and that the vulvar outlet is almost entirely closed. You have heard this poor woman's story, and whatever may have been her condition prior to the first operation, she seems not to have been benefited by all that has been done for her. Which opens up the clinical question as to the remote effects of the removal of the ovaries and tubes in a certain share of cases. That, when the broad ligaments are crippled by a tubo-ovariotomy, the operation may conduce to uterine prolapse is evident; and that such a descent of the womb, especially if it be enlarged, would not be cured by stitching up the cervix and the perineum afterward, is shown in this case. And remembering that confirmed disease of both ovaries and tubes in a multipara means that the uterus has not escaped, but in all probability, was the primary source of mischief; that it was left behind in a diseased condition deprived of its proper nutritive and functional relations and at a critical period of her life, how

*Continued from page 181.

much better and more sensible to have performed uterine as well as ovarian castration, and thus to have relieved her of the whole difficulty. As it is, here is a diseased uterus which, like a decaying tooth, is left to become worse instead of better; and what is more, the vulvar outlet is so closed that we couldn't get it away if we wanted to without first making a perineotomy.

VAGINAL HYSTERECTOMY FOR CAULIFLOWER OF THE CERVIX. *Case 20,960.* This patient is 48 years old, mother of an eight year old child. She was delicate but not ill until about one year ago when she lost strength, became exceedingly nervous and began having severe pain in the rectum. This pain has lately extended to the uterus and is at times unbearable. The eyelids are sometimes puffy in the morning, and the urine is scant oftentimes. The flow has decreased, and for the past few weeks only has she had an offensive vaginal discharge. She was not aware of a growth on the cervix until she was examined by the physician who sent her here.

Operation. Prof. L. made a vaginal hsyterectomy, and afterward remarked upon the specimen as follows: It may seem strange to you that such a growth as this could have developed while the patient was unconscious of its existence. But the suffering was not characteristic, and there was an entire absence of the hæmorrhage which usually sounds the alarm and sends the patient to the doctor for a diagnosis. Even the leucorrhœa did not begin and was not offensive until within a very short time. The absence of the copious watery discharge, which usually accompanies a cauliflower growth, is explained by the fact that these proliferations are more firm and less exuberant and vascular than usual.

Observe that the margin of the cervix is everted all around, and the enclosed growth is like a solid head of cauliflower. In this case, as in several other hysterectomies for cancer of the cervix, I observed a more decided development of the disease on the left side of the organ; and I am led to believe that this is not a mere coincidence; for it is a clinical fact that the left ureter and the corre-

sponding kidney are often the first to be involved in very advanced cases, and so also is the sciatica of advanced cases most likely to begin in the left side. In both conditions there is probably infiltration of the tissue about the ureter on that side, and possibly also the proximity of the rectum may have something to do with it. The occasional scantiness of the urine, the puffiness of the eyelids, and the rectal pain and distress complained of by our patient were symptoms that led me to insist upon the immediate removal of the uterus. This patient made an excellent recovery from the operation and has gone home.

VAGINAL OVARIOTOMY FOR A DERMOID CYST.—*Case 20,968.* Mrs. ——, æt. 35, married twelve years but has never conceived. Health always poor and menses so very painful that she has taken morphine, especially for relief during the first day. The flow is regular but very profuse, lasting from seven to twelve days. She is worn out with suffering and extremely nervous; has had all sorts of treatment but to no effect. Local examination detected a retro-uterine tumor lying very low in the Douglas pouch, slightly movable, firm but not painful to the touch. Diagnosis, probably a fibroid, but possibly an ovarian growth.

Operation. May 9. Because of the accessibility of the tumor from the vaginal side the posterior cul-de-sac was opened and the growth removed in that way. It proved to be a dermoid of the ovary, the sac being filled with hair and sebaceous matter.

AMPUTATION OF THE CERVIX FOR HYPERTROPHY OF THE CERVIX AND PROCIDENTIA.—*Case 20,970.*—Mrs. ——, æt. 42, sent to the hospital by Dr. Rains, of Kansas, is the mother of two children, 17 and 11 respectively; has never been well since the birth of the first one. She has suffered with extreme prolapsus, the lower segment of the uterus lying outside the vulva much of the time. The symptoms, including a severe gastric disorder, were increased by the second labor; and of late there has been a general feeling of numbness and prickling, with inability at times to use the lower limbs. The spine is painful in the lumbar region. Since she was operated upon a year ago for hæmorrhoids, the bowels have been regular. The

menses have always been normal. Local examination finds the depth of the whole uterus to be five inches, but the vaginal cervix itself is nearly three inches long. The cervix is cylindrical, smooth, non-ulcerated except between the lips of the os-uteri, has the normal consistence, and is easily reposited. The perineum is torn to the margin of the anus.

Operation.—May 13. The double operation of amputating the cervix and of closing the perineal rent was made at one sitting. You will not forget that a longitudinal hypertrophy of the cervix may cause and perpetuate a procidentia of the uterus, especially when it is conjoined with a wide open perineum, as most cases of procidentia are. And whether the hypertrophy is congenital, or if it is acquired through post-partum inflammation, or other morbid deposit, it constitutes a condition for surgical treatment. To have closed this perineum without disposing of the elongated cervix; or to have cut off the cervix without also making a perineorrhaphy, would have left our work only half done, and would have failed to bring the desired relief to our patient.

EXFOLIATIVE EMDOMETRITIS WITH UTERINE SUBINVOLUTION. —*Case 20,971.*—What might be styled the "clotted" form of menorrhagia is usually dependent upon an endometritis that is either exfoliative or hæmorrhagic. When it occurs in those who have not conceived it is a cause of obstructive dysmenorrhœa; and after delivery as a post-puerperal condition it is a frequent source of relapsing inflammation, subinvolution, prolapsus and uterine leucorrhœa.

Having been subject to a menstrual form of the disease this woman doubtless suffered from puerperal endometritis with mammitis of a pyæmic type after the birth of her child or children. And this was the cause of the arrested involution of the uterus. I pass the sound and you see that the depth of the organ now, three years from her last labor, is plus five inches.

Naturally enough the symptoms of prolapsus are very pronounced, and the incidental suffering from frequent and

painful micturition, expulsive pains at the month, and soreness over the lower abdomen and in the back are easily explained. We will give her sabina 3 to-day, but the curette will have to be carefully and thoroughly used before she can get well again.

TUBERCULOUS PERITONITIS WITH ENCYSTED PERITONEAL DROPSY.—*Case 20,973.*—Mrs. —, aet. twenty-eight, mother of one child two and a half years old, was sent to the clinic by Dr. C. A. Brown, of Plymouth, Ind. Her health has been failing for two years; menstruation normal until two months ago, when it became scant, and last month it was entirely suppressed. Two months ago the abdomen became distended and she had a sense of suffocation upon lying down. The distension diminishes at times, but does not disappear. The appetite and strength are very poor, with attacks of pain in the abdomen that are followed by diarrhœa. She has become very much emaciated. Local examination discloses a collection of fluid in the centre, with resonance at the sides of the abdomen but although the parietes are very thin, nothing like a cyst-wall can be detected. The uterus is normal but prolapsed, and there is fluctuation at the roof of the vagina. Diagnosis, encysted peritoneal dropsy from peritoneal tuberculosis.

Operation, May 18.—An exploratory incision was made to verify the diagnosis and to determine whether an operation was expedient. The peritoneum was found to be very much thickened (the boot-leg peritoneum), and to form a compartment along the mesian line which was so broadened below as to include the whole pelvic cavity. From this inflammatory sac twelve pints of ascitic fluid were removed. The inner surface of the peritoneum was then found to be covered with miliary tubercles (the *grains de riz* tubercles) which were especially thick and numerous on the tubes and the ovaries. The left tube, which was as large as a sausage, was detached and removed and the adhesions about the fundus were also broken up. The wound was closed with the Mikulicz drain.

Wednesday, May 24. I am glad to say that our patient is doing extremely well. Although the night before the operation her temperature was 103° and her pulse 120, a con-

dition that had been going on for a fortnight when she came to us, neither the temperature nor the pulse have exceeded 100 since the operation. She has had no pain, diarrhœa, or vomiting; the drainage is free and the wound is sweet and clean. The sutures will be taken to-morrow.

Concerning the nature of this case there can be no further question, for we have a double confirmation of the diagnosis made in my last clinic: First, the direct evidence of what you saw when the peritoneum was exposed, and when you examined the specimen that was removed; and second, the result of the bacteriological investigation that was most carefully made by my friend, Dr. C. F. Fisher, who is one of Koch's pupils, and who found and demonstrated the presence of tubercle bacilli in the specimen.

Wednesday, May 31. The patient is gaining in every way. The sutures, were taken the eighth day, the drain has been replaced; she eats and sleeps well and there is no evidence of returning ascites.

If this case continues to improve the probabilities are that the miliary tubercles will either be removed by absorption or became fibrous. When the latter, which is the more frequent, occurs there may be a troublesome development of gas instead of a reaccumulation of ascitic fluid within the abdomen. These are the cases in which the temperature instead of being hyperthermal, as in the acute miliary form, sometimes becomes subnormal and remains so until the end.

The New College & Hospital.

THE ALUMNI REUNION AND THE NEW COLLEGE AND HOSPITAL.

A special meeting of the Alumni Association of the Hahnemann Medical College and Hospital, of Chicago, was held in the new Art Institute building, Chicago, May 30th, 1893, during the World's Homœopathic Congress, when a large number of the alumni from all parts of the country were present, and took an active part in the discussions that came before the Association.

After the meeting was called to order by the President, Dr. E. J. Abell, the following new members were enrolled:

Dr. Julia M. Orr, Dr. W. J. Cole, Dr. J. W. Dickinson, Dr. W. B. Carolus, Dr. G. T. Applegate, Dr. J. Hallett, Dr. Harriet A. Miner, Dr. Minerva A. Kline, Dr. Helen M. Parker, Dr. N. H. Laury, Dr. Ada A. Fowler, Dr. R. M. Genius, Dr. A. E. Genius, Dr. Chas. E. Colwell, Dr. J. W. Barrett, Dr. Alex. Donnell, Dr. K. B. Clapp, Dr. J. G. Seidell, Dr. G. H. Gates, Dr. J. T. Webster, Dr. G. S. Culver, Dr. S. E. Winget, Dr. F. B. Wilkins, Dr. Emily F. Swett, Dr. S. J. Milsop, Dr. L. S. James and Dr. W. J. Clement.

Then followed the discussions of subjects as follows: The relation of the Graduate to his Alma Mater, opened by Dr. A. K. Crawford, of Chicago, who in very appropriate remarks pointed out how the alumni association, by concerted action, could not only shape the course, but even dictate the policy of its alma mater; its power is in proportion to its numerical proportion between graduates and faculty, and if this strength were put forth no doubt it would all redound to the glory and growth of the institution.

Dr. O. W. Carlson, of Milwaukee, followed Dr. Crawford, speaking of the alumni, What they Could do and What they Should do for their Alma Mater. The subject was further discussed by Drs. C. G. Higbee, of St. Paul,

Stearns, of New York, E. S. Baily, G. F. Shears and Dr. Roberts.

The Dean, Prof. H. B. Fellows, then took up the Policy of the College, showing how it had always been progressive, and how the faculty is putting forth every effort to increase the teaching facilities which the New College and Hospital when equipped with all modern conveniences will afford; the clinical instruction will as in the past be kept in advance of other schools.

The President, Dr. E. J. Abell, then appealed to the alumni to support the institution, not only by subscribing themselves, but to work and get others to subscribe to the alumni fund; requesting that we all follow his example and make subscriptions in yearly payments, and those who have subscribed continue the subscription each year for three or four years.

Dr. H. P. Skiles emphasized the President's remarks, and added that we should also solicit our wealthy patients and friends to contribute to the fund. Dr. Fisher, of Sydney, Australia, Dr. M. J. Moth and Dr. Barrett, also encouraged the work by appropriate remarks, as well as by their subscriptions.

F. H. HONBERGER, *Sec'y.*

THE TREASURER'S REPORT.

AMOUNT ALREADY REPORTED FROM THE ALUMNI, $1,876.60.

NEW SUBSCRIPTIONS.—Mrs. H. R. Gould, '94, Chicago, $10; W. J. Clements, '87, Berlin, Wis., $10; A. E. Genius, '92, Chicago, $10; R. M. Genius, '92, Chicago, $10; S. B. Parsons, '63, St. Louis, Mo., $100; G. E. Richards, '79, Chicago, $100; T. F. H. Spreng, '79, Sioux City, Ia., $100; J. W. Barrett, '79, Osage, Ia., $100; G. T. Applegate, '83, New Brunswick, N. J., $100; C. H. Vilas, '73, Chicago, $50.

ADDITIONAL SUBSCRIPTIONS AS FOLLOWS:

A. K. Crawford, '81, Chicago, $75; H. V. Halbert, '87, Chicago, $75; E. S. Bailey, '78, Chicago, $75; Jos. P. Cobb, '83 Chicago, $75; M. J. Moth, '90, Chicago, $75; W. P. MacCracken, '87, Chicago, $75; F. H. Honberger, '90, Chicago, $45; C. Gurnee Fellows, '85, Chicago, $75; W. A. Dunn, '81, Chicago, $75. Total to June 10th, $3,111.60. Total amount paid in, $1,396.60.

Special subscriptions as follows: S. B. Parsons, sufficient to furnish one room in the new hospital; Alex. Donald, St. Paul, Minn., $200 toward a fund to endow a bed in the new hospital to be known as the G. A. Hall Memorial Bed, and to be free for the use of any student who may be ill while attending the Hahnemann College.

To endow a bed requires the sum of $5,000 and all who desire are invited to subscribe to this special fund.

The Executive Committee have decided to undertake the task of furnishing the new college building from top to basement, including the lecture rooms, laboratories, library, reading rooms, museum, and dispensary. This will be an enduring memorial to our departed brethren and one which our successors will gladly maintain. Much of this work must be done this summer, and it is hoped that the Alumni will be liberal in their subscriptions and prompt in their payments.

JOS. P. COBB, M. D., Treasurer.

THE PROGRESS OF THE NEW BUILDINGS.—The new College building is finished and most of the rooms are furnished and ready for occupancy. The walls have been tinted and the floors either oiled or painted; the opera chairs placed in both amphitheaters, and the shelves, closets, etc., for the physiological, chemical, microscopical and bacteriological laboratories thoroughly fitted up. There will be no need of going outside for lecture-room facilities next winter.

The Hospital building only awaits the finishing touch of the plasterers and the inside painters, and, now that they can return to us from the World's Fair work, this will soon be done. The furnishing of the wards and the private rooms will then be rapidly completed, so that there is no doubt of the hospital also being ready in season for the opening of the winter session.

Miscellaneous Items.

During the World's Homœopathic Congress in this city, which closed June 3d, 863 physicians were in attendance; and during the Congress 300 Alumni of the "Old Hahnemann" visited and heartily approved of the new college and hospital buildings.——Bœricke & Tafel will soon issue a new and valuable edition of Hahnemann's *Chronic Diseases*.——Dr. O. Hottelman, an excellent alumnus, died of diabetes, at Lyons, Ia., April 22, aet. 33.——The Daily *Century*, issued by Gross & Delbridge, during the Congress, was an enterprise worthy of Chicago.——The summer course on Microscopy is a grand success.——Forty new members have just been added to the Alumni Association of the Old Hahnemann.——The *Homœopathic News* is responsible for the following: "As we read history tobacco was not known in biblical times, else the ancient children of Israel, who took all the habits they could lay their hands on, would doubtless have incorporated this one too."——The College Announcement can be obtained by writing Prof. E. S. Bailey, 3034 Michigan Avenue, Chicago.——The next meeting of the American Institute will be held in Denver, Colo., with our old friend McClellan, as President.——In conformity with the judgment of those who should know what is best to do with it, the address on "Homœopathy and the Public health," appears in this issue of the CLINIQUE.——The Clinical Society meets at the Great Northern Hotel, on Saturday evening, June 24. ——Dr. J. P. Dake, of Nashville, Tenn., paid an eloquent tribute to the late Prof. Hall at the opening of the Homœopathic Hospital in the World's Fair grounds, May 29.—— A fitting and more extended notice of the life-work and decease of our most worthy friend and colleague on the Pacific coast, Dr. Isaac Fellows, of Los Angeles, will appear in our next issue.

THE CLINIQUE.

VOL. XIV.] CHICAGO, JULY 15, 1893. [No. 7.

Original Lectures.

THE ÆRO-THERMAL BATH.

A LECTURE DELIVERED IN THE HAHNEMANN HOSPITAL, OF CHICAGO, DURING THE SESSION OF 1892-1893.

BY PROF. B. S. ARNULPHY, M. D.*

It is mainly in the broad field of the arthritic and infectious diseases that the æro-thermal bath displays its intrinsic worth.

Almost every conceivable form of rheumatic or gouty ailment calls for this mode of treatment, and not only is relief constantly afforded, but often you will have the satisfaction of effecting a cure.

Such will happen, for instance, in recent cases of arthritic neuralgia, no matter what region is affected. I can recommend it in sciatica, an affection, as you may learn in the course of your practice, that is not easily to be overcome.

The bath is not to be thought of during an attack of acute inflammatory rheumatism; but cases are on record showing that an early application of the method can break an attack; also that at the period of defervescence it will promote a rapid convalescence, and shorten the duration of the disease to a degree.

*Concluded from page 285.

Still less should you think of resorting to this bath in the course of an acute attack of gout. I have told you before what we must think of the pathological significance of an attack of gout; that it is a salutary effort of nature, and that the fever especially, which is its most striking feature, ought not to be tampered with.

But it is different with the incomplete, abnormal, insidiuous forms of rheumatism and gout; here is the triumph of the æro-thermal bath; used in conjunction with sulphur, it will help the system to throw off the burden that oppresses it.

As to muscular rheumatism, it *always* comes within the scope of the bath; no matter how acute it will do good, and very promptly. I have seen severe forms of lumbago and torticollis entirely relieved by one single bath.

You will also find that some rebellious forms of monoarticular arthritis, among which gonorrhœic arthritis is conspicuous, yield readily to this treatment.

Whenever you can satisfy yourselves that you have to deal with some form of *slackening of nutrition*, let it be lithæmia, an acid dyscrasia, oxaluria, obesity, biliary or renal colic, or even diabetes, do not hesitate to resort to it.

Obesity it will control, if persistently used, not, as is the mistaken belief, through the immediate loss of weight which the bath superinduces, but through the improved nutrition and greater activity of all the functions.

I believe that for non-diabetic glycosuria no better remedy than this can be found. As to diabetes proper, some discrimination must be used. Be sure to examine the urine carefully before you order the bath, as the presence of a large excess of urea in the urine (azoturia) would be a positive contra-indication. There is danger in those cases of producing uræmic accidents. This is readily explained. If you subtract water from the system by dint of perspiration, the urinary secretion will fall off, and as you may remember that the kindneys throw off a much greater amount of urea than the skin, a retention of poisonous material is liable to occur.

This naturally leads me to speak of the indications of the treatment in nephritis. Now, while I have reason to consider the bath devoid of danger and highly beneficial in all forms of acute, infectious and toxic nephritis, I should refrain from using it in the later stages of Bright's disease. No doubt it would alleviate the dropsical condition of the tissues at large, but there is also danger of precipitating an uræmic crisis. In the early stages, however, the bath, by relieving the renal congestion and the arterial tension, would appear to be decidedly indicated.

In fact, whenever you are confronted by symptoms that point to a state of visceral congestion, especially of the abdominal organs, be it the liver, the kidney, the intestine, the bladder, or the uterus, remember that the æro-thermal bath affords you a safe and prompt means of relief, such as no other method possesses in the same degree.

As a corollary to this indication you will do well to remember that most of the nervous and circulatory disturbances of woman's health at the climacteric easily yield to the regulating influence of the bath. It stands to reason that this is the time when the increased activity of the peripheral circulation, that the anti-spasmodic influence of sudation, and the increased elimination thus created must be particularly grateful to the feminine organism. And it is not unreasonable to suppose that by so relieving the uterine congestion we may possibly avert or retard the development of some lurking growth.

Now we come to the important class of infectious diseases; and first in line we find the eruptive fevers. Let me tell you that in order to speedily bring out a tardy eruption, this bath is unsurpassed. Only you must abstain from ministering it to children below the age of five or six.

By giving the bath during the period of eruption you hasten the whole process and considerably shorten the duration of the disease. But it is especially in combating and preventing the dreaded post-scarlatinal nephritis that this bath is invaluable.

In order to illustrate its heroic action in an equally

redoubtable form of nephritis, the puerperal variety, I shall cite the following case reported by Dr. Lairac (Thèse, Paris, 1885).

Hotel Dieu. Service of Prof. Vulpian.—Case. — Mme. T., age 36, gives birth to twins on January 8, 1885. Ten days later, on leaving the ward, she takes a chill, and develops puerperal nephritis, promptly followed by a very severe attack of eclampsia. The convulsions succeeded each other every hour.

Under the influence of the æro-thermal bath the paroxysms rapidly disappeared, and in spite of the abundant perspiration, the flow of urine which had been very scanty, became very free. The woman was up and about shortly afterward.

Good results have been obtained in the treatment of typhoid fever, and also in typhus. In the former I would use the bath promptly from the start, at all events during the first week, and then during convalescence.

Mr. Noël has had considerable experience with yellow fever at Panama, and has been fortunate enough in rescuing scores of sufferers, himself included, by the free use of this bath.

All the practitioners who have given a trial to that mode of treatment in cholera are loud in its praise. The first symptoms of algidity imperatively call for it.

Last but not least I would say a few words of the good work of this bath in the treatment of "*La Grippe.*" Here I can speak from personal experience. I had the "grippe" twice these last years, and was promptly relieved both times by Mr. Noël's apparatus. I positively know of no better treatment for "La Grippe." This is also true of the sequelæ of that insidious disease, especially of those rebellious muscular pains, sometimes attended by atrophy, which will persist for months and years after the acute attack. I have seen a great many of these cases, and whenever I could have my way, a course of baths and sulphur cured them.

I recall the case of a young girl, who came under my care three years ago. She had a severe attack of the

grippe, which developed into generalized pseudo-rheumatism. Most of the joints were painful, though not swollen, and the muscles of the limbs and trunk were the seat of much pain. There was a great prostration of force; no appetite, no sleep; the fever was moderate. Bryonia and gelseminum were utterly powerless to relieve. There seemed to be a total lack of response on the part of the nervous system. In spite of all I could do after two weeks of treatment, the patient suffered more and was growing weaker. I then had Mr. Noël give her a course of sweat-baths and she promptly recovered.

I would strongly impress upon your minds one principle, viz: that the cutaneous surface is the easiest and safest way of exit for any virulent, or venomous, or septic matter, whether introduced into or developed within the organism. Therefore in case of bites from venomous animals, or of wounds from which septic poisoning may be feared, the sweat-bath ought to be immediately resorted to, and persisted in until all danger is passed.

Does this statement apply to hydrophobia? you might be asked. Undoubtedly it does. You know that Pasteur's method is only available during the first few days following the infection; it is utterly powerless against the attack of hydrophobia itself. But here it is that the sweat-bath seems to display its power. So asserts Dr. Binkin, the inventor of the apparatus, who has cured himself and many others of the dreaded scourge by that simple means. It is my belief that a course of baths given immediately after a suspicious bite might eliminate the poison and arrest the whole trouble.

Nor is this all. We have it on the best authority that the bath does remarkable work in the treatment of venereal diseases. The experiments made in the Paris hospitals on syphilitic subjects leave very little doubt as to its efficacy. The rapidity with which the bath heals a chancroid is almost incredible. Drs. Martineau and Legroux cite cases in which a course of three baths was all that was necessary to effect a cure.

After all this you will find nothing wonderful in the statement that the best results have been obtained in the treatment of almost all forms of cutaneous affections, including rebellious varieties of eczema and even of lichen.

By way of conclusion I would say that a therapeutic agency for which so much can be claimed deserves some recognition. For therapeutics does not consist entirely in the art of drug prescribing. Aside from drugs there are many helpful things, of which a well-informed and unbiased physician is always eager to avail himself.

This apparatus will enable you to successfully treat an amazing variety of diseased conditions, acute and chronic, from a simple chilling of the body to the most confirmed forms of rheumatism and gout; from a simple boil to the worst forms of blood-poisoning.

The apparatus is handy, safely carried about, and inexpensive. It is the only apparatus that will enable you to give a hot-air bath to your patient in his own bed, at a moment's notice, without hesitation and loss of precious time; an apparatus that will develop a high temperature, which, however, you can regulate at will; an apparatus from which you can derive powerful effects with perfect safety.

It can truly be said that the principles governing the manifold indications of this device embrace the whole field of hygiene, of prophylaxis and of therapeutics.

As to the contra-indications, they are few. I have already cautioned you with regard to diabetes and Bright's disease. In a general way the only source of danger lies in the direction of the heart. Satisfy yourselves that there is no aneurism present, as it would be very imprudent to excite the arterial circulation. Valvular disease of the heart is no contra-indication, as long as the compensation is satisfactory.

Do not give the bath when the pulse is intermittent and the subject presents evidence of organic cardiac trouble, more especially if the case is one of aortic insufficiency. And look out for fatty hearts in old obese people, or in subjects afflicted with profound anæmia, melancholia, or alcoholism.

THE SURGICAL DISEASES OF WOMEN.

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

REPORTED BY CORNELIA S. STETTLER, M. D.

HYSTERORRHAPHY AND TUBO-OVARIOTOMY AFTER FAILURE OF ALEXANDER'S OPERATION.—*Case 20,982.*—Mrs.—— aet. twenty-four, has one child now six years old. Three years ago had an accidental miscarriage at the sixth week. The menses were always regular and normal, but very painful. To overcome the dysmenorrhœa and a very bad retro-displacement, Alexander's operation was made at her home in February last. She says the operation failed because of suppuration in the wound on both sides, and that her monthly pain, backache, dragging in the pelvis, and general aching are worse now than before. Examination shows two long, red, savage looking scars in the inguinal region, and also confirms the existence of a bad posterior displacement of the body and fundus of the womb.

Operation. June 13. This clinic has furnished four examples within as many months of the failure of Alexander's operation, after having been made by other operators, to cure a retro-displacement of the uterus. These failures are becoming so frequent that we should enquire into their cause and learn whether a surgical expedient that fascinates young surgeons especially, and does more harm than good in their hands, should not be abandoned. Before opening this abdomen I am satisfied that a lesion of the left ovary and tube are largely responsible for a persistent retro-displacement with fixation. Whether that condition existed when the former operation was made I cannot say; but if it did, the shortening of the round ligaments could have done no possible good. I have seen a number of cases of this kind, and have cured them too, by such an operation as we propose to make this morning. Sometimes I prefer to make a radical cure by vaginal hysterec-

*Continued from page 310.

tomy, but each of these two expedients has its especial indication in selected cases. * * * * * *

Here is the left ovary and tube, which were very adherent and which dragged the fundus-uteri and anchored it in an abnormal position. This being ablated we expose its fellow and find the tube so diseased that it also must come out. Now, the fundus is free, and I place the sutures into its substance, so as to hold it up and forward, out of its old bed and against the peritoneal surface of the abdomen. The wound is carefully closed and I am certain that the prospect of a cure is what it should be. For not only is the uterus free from its tether backward, and placed as it should be in its own axis, but with the diseased ovaries and tubes out of the way, the recurring menstrual congestion, and the risk of pregnancy and abortion disposed of, the womb will atrophy and the pelvic suffering will soon be ended.

Wednesday, June 14. The patient is going on well. A careful examination of the specimen shows, as you can see, that the left tube was very much enlarged, tortuous, and completely closed at its outer extremity, while the right one also was badly damaged. The uterus is maintained in position by a packing of iodoform gauze in the posterior cul-de-sac. To make this form of ventro-fixation successful, by taking off the strain from the sutures, and to keep the womb from falling into its old sacral pocket, the patient lies most of her time upon the side and not upon the back.

Wednesday, June 28. This being the fifteenth day the patient was brought before the sub-class, and after the abdominal wound had been shown to have healed by first intention, without a drop of pus, a careful examination disclosed the fact that the body and fundus of the uterus had remained forward, and that the result of the ventral fixation was all that could be desired.

VAGINAL HYSTERECTOMY FOR MULTIPLE FIBROMATA WITH ANCHORAGE OF A RETROVERTED UTERUS. DEATH FROM PERITONITIS. — *Case 20,984.* —— aet. forty-three, married, mother of

one child fifteen years old, has always been regular without especial monthly pain, but with a profuse flow. At the period the abdomen bloats enormously, and she has much bearing down, backache, constipation and hæmorrhoids. She has had two attacks of cystitis in each of which her life was despaired of. The cervix uteri is pressed firmly against the pubic arch, and the whole lower pelvis is filled with a tumor nearly or quite as large as the fœtal head. This tumor is immobile. The sound indicates a decided retrodisplacement.

The location, form and density of the tumor, the history of its slow and insidious growth, as well as the menorrhagia, make it almost certain that we have to do with one or more fibroids, which are intimately attached to the uterus. Hence the patient and her husband have been informed that, in all probability, the womb will need to be extirpated. But this tumor, uterus and all, lies below the superior strait, which is a bar to its removal by way of the abdomen. So we must make a vaginal instead of a ventral hysterectomy, and we must make it very carefully, for there are certain contingencies in such a case as this which, while they are not always fatal, should not be disregarded. That this patient has been subject to localized and relapsing peritonitis and pericystitis is evident from the achorage of the tumor, the bearing down, the backache, and the urinary retention, as well as the recurrent menstrual tympanitis.

Now there are a few considerations of a clinical kind that may mean very much in this case. When fibroids, whether large or small, lie within the abdominal cavity they rarely form any very serious attachment to other organs. The exception to this rule is in case they are sarcomatous, or have degenerated in some way. But when they are confined below the pelvic brim, or almost wholly so, they are pretty sure to be anchored by mischievous adhesions.

Another point is that, while by its slow growth and freedom of motion an abdominal fibroid will create a degree of tolerance of pressure and of manipulation on the part of the peritoneum; the pelvic fibroid which lies in a bed of

adhesions often, not always, predisposes to relapsing peritonitis with the menstrual return, and as a consequence of surgical operations for their removal. Therefore, while we can take away this tumor per vaginam, secure the vessels, and meet all the surgical indications that may present themselves, there will yet be a serious risk of inflammation as an unavoidable sequel of our interference. I never make a vaginal hysterectomy in such a case as this without first having given a very guarded prognosis. It would not be a good case for you to begin with.

Operation.—June 26. A careful, aseptic, vaginal hysterectomy was made. The utero-rectal adhesions were very firm and vascular, but neither the rectum nor the bladder was injured. The patient was put to bed in excellent condition.

The surface of the uterus was found to be the seat of numerous small fibromata; its walls contained several more of various sizes, and its interior was completely filled by a large, hard, encapsuled fibroid. The specimen was very carefully examined and its relation to the clinical history of the case explained. The uterine wall was friable and of varying thickness.

Wednesday, July 5. As we feared, this case has ended unfortunately, but in so doing has furnished another lesson of the fallibility of our resources when the conditions are unfavorable. She did exceedingly well for the first few days, when a rapidly fatal peritonitis was developed, so that she died on the night of the third day. That this lesion was a consequence of the acquired and abnormal susceptibility of the pelvic peritoneum to surgical injury I have no doubt. That the operation was the only alternative in her case, no one who saw the specimen will question; and it is equally evident, I believe, that the contingency of post-operative peritonitis was entirely unavoidable.

VAGINAL HYSTERECTOMY FOR CHRONIC PROCIDENTIA. RECOVERY.—*Case 20,985*, sent to the hospital by Dr. Thomas

Gillespie, of Kenosha, Wis. Mrs. ——, æt. 66, passed the climacteric twelve years ago. Soon after the change the womb became very badly prolapsed until finally it was completely extruded. When standing or walking she is almost crucified by the irritation of the parts and desires very much to be completely rid of the cause of her suffering.

Operation.—Saturday, June 17. The uterus was removed by a vaginal hysterectomy, the greatest care being taken to protect the prolapsed bladder from injury. So long a time had intervened since the menopause that being atrophied the ovaries were left behind. A strong argument in favor of total extirpation of the uterus was found in its being considerably enlarged and in the chronic abrasion and ulceration of its exposed portion, conditions that would not warrant a plastic operation for its retention within the vulvo-vaginal passage. And, the childbearing period being passed, the organ could be of no further use.

Wednesday, June 28. She is convalescing as if she had had a normal labor.

Wednesday, July 5. The eighteenth day; she is sitting up and will go home in a day or two.

OVARIOTOMY FOR A LARGE MULTILOCULAR CYST. RECOVERY.—*Case 20,988.*—Mrs. ——, æt. 58, came to the hospital from North Dakota. She has been married twenty-five years but has never conceived; passed the change two years ago with no unusual symptoms except a distention of the abdomen that afterward subsided. A year later, or about a year ago, the abdomen again began to enlarge, and it has steadily continued to do so. The swelling began in the right and extended to the left side; meanwhile she has suffered intense pain through the back and the abdomen, being often confined to the bed for a month or more at a time. The girth of the body is thirty-nine inches. During her whole menstrual life the flow was very free, but the climacteric passed without any unusual hæmorrhage. She is very emaciated, and extremely weak and feeble.

Since Dr. Bantock published his excellent "Plea for Early Ovariotomy" in 1881, the good counsel therein given has been so generally followed that large ovarian tumors

like this one are becoming comparatively rare. In certain quarters much has been said of the general exemption of women with fibroids from pregnancy, but my experience has taught me that quite a proportion of the women with ovarian tumors are also sterile. And when they are barren, I think you will find that they constitute the exceptions to the rule that ovarian cysts are not accompanied by menorrhagia. At any rate you will note that our patient has always flowed quite freely at the month.

Operation, June 24. A cœliotomy was made and three large cysts, weighing in all 35 pounds, were removed. These contained each a different kind and quality of fluid; the steps of the operation were fully explained to the class; the wound was closed aseptically, and the patient sent to her room in a better condition than could have been expected.

Wednesday, July 5. She was so very feeble that she reacted slowly from the operation, but now at the twelfth day she has made an uninterrupted convalescence. The sutures were taken five days ago and the wound had closed by the first intention.

UTERINE DRAINAGE IN HÆMATO-SALPINX.—*Case 20,989*, æt. 26, married seven years ago, has had one child and no miscarriages. Prior to the birth of the child her health was perfect, but since that she has had many complaints. She is now a great sufferer from dysmenorrhœa and menorrhagia. The periods are too frequent, sometimes recurring in two weeks, and they are also too free. Between times she has a profuse leucorrhœa. In consequence she is becoming very weak and generally run down. Two years ago she had the lacerated os-uteri stitched up, and four months ago the uterus was curretted, but neither operation did her any good.

Local examination showed that the uterus was not enlarged, but the os was very patulous. The left ovary was two or three times its natural size, and the corresponding broad ligament very much thickened. Diagnosis hæmato-salpinx. A strip of iodoform gauze was inserted into the uterus for drainage and trillin 3 ordered to be taken every three hours.

Wednesday, June 28. The leucorrhoea is greatly improved, as are many of the other symptoms. The gauze was reapplied and the same treatment continued.

One of the objects of this clinic is to illustrate the importance of a careful analysis of the various cases that come before us. This woman had good health until her child was born, but has been ill ever since. Her trouble therefore, is of puerperal origin; and since she sustained a lacerated cervix at her labor, we have a key to the initial cause of her chronic and persistent ill health. For that lesion involves the extreme probability of endometritis from direct puerperal infection, and the possibility of indirect sepsis through the cervical lymphatics. In the one case we would have an ascending salpingitis and ovaritis, and in the other a primary affection of the appendages which may have continued until the present time. It is not improbable that these two methods of extension from the injured cervix may have been combined to produce this result.

But, however that may have been, the disease for which she should have had treatment lies outside of the uterus altogether. And the lesson of this fact is that you should be very careful not to confound an extra-uterine with an intra-uterine, or with a cervical lesion. Because he discovered that it had been torn, one doctor sewed up the neck of the womb in this case; while, because she flowed too freely and too often, another one curetted the uterus. Each made an operation that is extremely useful in suitable cases, and so far as I know did it skillfully; but both were wrong in not adapting their surgical resources to the case in point. And this is the kind of work that is fast bringing gynecology into disrepute. The mania for operating tempts one to stitch up every torn cervix that he can find, regardless of conditions and complications that may perhaps contra-indicate it altogether. Another believes in an indiscriminate divulsion of the uterine orifice and canal, and he tears them all open; while a third hoes out its cavity

in every case as if it were sure to be choked with pathological weeds!

It is very certain that no amount of careless surgery can compensate or can atone for a habit of faulty diagnosfs. There is no excuse for such blundering, and no explanation for it except the ruinous propensity to consider one operation or one class of operations as suited to all cases alike.

The gauze drain, as you have seen me apply it, is sometimes very useful in clearing up the diagnosis in chronic affections of the generative intestine. In conjunction with appropriate internal remedies, it may also be sufficient to cure them; but when the case has run along for years without relief, you will usually find that a radical cure can hardly be expected without a final resort to extirpation of the diseased appendages, and possibly of the uterus itself.

To The Old Hahnemann Alumni.—The Alumni Association has decided to undertake the entire furnishing of the New College building. This will necessitate the raising of $5,000 for immediate use, as the building must be furnished complete for the opening of the winter session early in October. The officers of the Association are earnestly at work, and feel confident that this amount can be raised. They have prepared a circular letter, appealing to every alumnus to obtain contributions to swell the alumni fund, and to use their influence with their classmates, urging them to help in the good work. This letter will be in the hands of the class secretaries in a few days, who will mail them to each member of their class, and it is hoped that each one thus received will be promptly answered.

F. H. Honberger,
Secretary.

July 15, 1893.

Clinical Society Transactions.

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

JUNE MEETING, 1893.

The regular monthly meeting was held in the Great Northern Hotel, Saturday evening, June 24. This being the first meeting since the election of officers, the President, Dr. Ludlam, read the following as his Inaugural Address, premising that he had taken the same topic and the same title as his predecessor of a year ago, Dr. W. A. Dunn.*

XVIII. "IS A SPECIALTY POSSIBLE?" I think it is; but not for everybody, nor yet for any one unless the proper requisites are furnished, and the conditions are favorable. Several reasons might be given for the failure of some of those who have hoped and expected to succeed in particular lines of practice. In considering these causes of failure, as well as the conditions of success, I wish to make a plain statement of views that are based upon personal experience and observation, and to disclaim any intention of unkind or unfriendly criticism of those whose opinions differ from my own.

With many, and possibly with most medical specialists, the choice of a single branch of study and practice is either premature, accidental, or arbitrary. These unfortunate conditions take no note of personal fitness or adaptation; the selection is made in disregard of the requisites of success, and upon the theory that the party in interest is gifted with such a universal genius that failure at any point is out of the question. It is quite a common occurrence for the medical student of only a few months to decide that he will be a surgeon, an oculist, or, worse than all, a gynæcologist. Before he knows anything more of

*See the CLINIQUE, Vol. xiii., 1892, page 259.

mechanics, or of physics, or of the hysterical diathesis than the veally theologue does of human nature, it is settled that one or the other of these specialities shall occupy his attention and constitute his life-work. With no conception of the idea that specialists, like poets, are born and not made, he does not wait until his natural gifts and tastes have declared themselves, but determines the choice by a whim or caprice that is more likely to put him in the wrong groove than the right one.

That the outcome of this unseasonable and unreasonable haste should be disastrous is not surprising; for without a special fitness for a single line of work, and without a good foundation in the general knowledge with which all the branches of the art and the science of medicine are inseparably associated, there can be no real thrift and healthy professional development.

The accidental circumstances that often determine the choice of a specialty by the older pupils and physicians are familiar to the members of this society. Whether consciously or not, most of these recruits are imitators who are ambitious to do what some one else has done, or has seemed to accomplish. Weary of the toil and drudgery of general practice, and discouraged by the small reward in hand for a large amount of honest, hard work, they turn to what promises to lessen their labor and anxiety and to swell their income. In exceptional cases, indeed, experience may have taught them wherein their strength lies, and in a very pronounced way may have indicated the path to be taken. But it does not always follow that, because one has been a successful obstetrician out of town, therefore he will be a good teacher of midwifery; nor because he has been fortunate in curing the croup or diphtheria, therefore he would soon be the best man to make a tracheotomy or to practice intubation. Our city horses know more of geometrical lines and curves than most of their drivers, but they never learn only just enough to avoid colliding with their fellows in the street. With all their practical everyday knowledge of curves and angles, which is most useful and really

astonishing, they would not succeed as teachers of mathematics. And so it is that a narrow round of simple duties which are ever so well done does not necessarily imply the possession of a gift or genius for special work of a high order.

The suggestion that the doctor who is doing well as a general practitioner might do a great deal better in a narrower field of labor, has tended to demoralize the profession, and to drive physicians into special lines of practice when they were neither adapted to them nor fitted for them. And so the specialist net brings all kinds of fish; but to claim that specialism in general is a failure because these circumstances are unfavorable to its practice, and this class of persons are unsuited for it, would be very unjust and absurd.

It is preposterous to suppose that the most thorough study of one organ, or of one set of bodily organs, as if they were separate and distinct from others, no matter how remote and dissimilar, could result in practical benefit either to the patient or to his physician. First the general and then the special, is the natural direction of a training that fits one for practice in any single branch of the healing art. Sound specialism has its root in an all-around general medical education; and is of real value only as it is the outgrowth of applied science in all directions. It perfects the knowledge of particular branches when these have first been tested by experience and developed to a certain extent in a general way. And not only would the doctor who had narrowed his horizon to the exclusive study and consideration of a single organ, or apparatus, become a mere fractional doctor in so far as his scientific attainments were concerned, but his curative scope would soon reach a vanishing point, and his judgment would become extremely fallacious. For unless one knows and remembers how the different parts of the body act and react upon each other in health and disease, it is impossible that he should succeed in the best sense as a specialist.

Another check to the healthy growth of specialism in

medicine consists in the lack of means and of time on the part of many aspirants to qualify themselves, especially in a clinical way. Multitudes have failed and are still failing because their hurried, hot-house training has been scanty and inadequate. They blunder into special lines of work, and blunder when they get there, and all because they could not, or would not spend the time and the money that are requisite for a careful, conscientious and thorough preparation.

A defective power and habit of concentration will cause one to trip and fall much more quickly and surely in special than in general practice. For in this case the glittering generalities will not answer, nor will routine prescriptions suffice or satisfy. The gradual evolution of the specialist out of the general practitioner is conditioned upon increased devotion and concentration. The focus that will melt away the difficulties of an intricate and puzzling diagnosis, and that will lighten and brighten the field of special research must be constant and intense. We shorten our weapons to define our boundaries, and to do more efficient service. The specialist who will not read and study, and who cannot concentrate his time and thoughts is the worst kind of a subterfuge.

A lack of the perseverence that persistently waits for a healthy growth is a frequent cause of failure in the direction indicated. The American specialist is not always content with the natural course of things, and often puts his case and cause in peril by his impatience. If he cannot accomplish as much in a few months as others have wrought and realized in as many years, he may be tempted into the byways of quackery, and into the vulgar and unpardonable practice of promising a cure for everything by something of his own invention, or by medicines or operations that are peculiar to himself. Such fellows do a lot of mischief, have many imitators and might be classed as belonging to the hasty-pudding series. All honor, therefore, to those who are willing to bide their time, and to labor persistently and faithfully to the end of representing

the best resources of the healing art in the best possible way.

It has been said that "all specialistic bodies, or societies, must work continually in a circle." In the name of common sense, how could it be otherwise in this little round world! Considering the importance of precise knowledge, and the impossibility of obtaining it without a careful adjustment of means to ends; and remembering that the more perfect the special branches, the greater and more refreshing the reaction upon the general practice, and upon the best interests of the whole profession, I submit that we ought not to antagonize, but to aid in their development and their proper employment.

But, for the successful and honorable practice of a specialty, something more than personal fitness, professional qualification and experience, studious habits, pluck and perseverance are requisite. Very much depends upon the choice of a location, for how shall one take root and grow unless the soil is adapted and the surroundings are favorable? If the community is small and unappreciative, or prejudiced against any and all innovations that might reflect upon or unseat those who were established in the general confidence, there would be no reasonable ground of hope for success. The field would be unsuited to the kind of crop that our friend would like to raise upon it; and so he must go to a larger one, where there is more scope and less opposition *per capita;* and where the people have already been schooled into an appreciation of professional labor of a skilled kind at the hands of the various specialists. Only the larger communities are accustomed to draw the line between those who do and those who do not devote themselves to special departments of practice in medicine and surgery; and, while they do not always discriminate properly, and are therefore likely to be duped, we find that their support is the best warrant for the undertaking. It is, therefore, natural for people who live in towns and villages to go to the city when they need the services of an

oculist, an aurist, a neurologist, or of one who is especially familiar with the obscure diseases of the heart, the lungs, or the kidneys, because these doctors are almost always located there, and have had their training and experience in the larger centres of population.

It is vital to the interest of the specialist that, so far as possible, he should have the endorsement and the support of his professional neighbors. To this end he should keep within his own orbit and not fail to respect the rights of the general practitioner or those of other specialists. Disregard of this condition of success has been a stumbling-block in the way of many well-meaning and capable workers, and has finally brought them to grief. For whoever recommends one into a family as a specialist wants to feel, and should feel, that he can trust him to do the fair thing all around, honestly, squarely and with due respect to the rights of all concerned. This high type of professional reciprocity is perfectly practicable, and I commend it most heartily to those who are anxious and ambitious to become successful as specialists of whatever kind.

Finally, it requires more character than most men possess not to be foolishly overcome by prosperity and popularity, if the specialist happens to be successful. He is apt to forget what he owes to the whole body of medicine upon which his own work is engrafted; and to fancy that his position exempts him from the duty of contributing to the fund of knowledge which is the common property of all physicians alike. But more than all, his judgment may become so warped that his sober and sensible brethren can no longer trust his extreme views and extravagant pretensions.

In the light of these considerations the following propositions appear tenable.

Among the causes of failure in the pursuit of a speciality are:

1. A premature, accidental or arbitrary selection of the branch in question.

2. The lack of a general and thorough medical training as a foundation for this kind of practice.

3. The lack of means and of time in which to qualify for it, especially in a clinical way.

4. Defective power and habit of concentration.

5. The lack of perseverance and of patience to wait for a healthy growth in the direction indicated.

The favoring conditions include:

1. The choice of a location in which medical and surgical specialties are likely to be appreciated, and in which the population is sufficiently large to warrant the undertaking.

2. The endorsement and confidence of the local and the general profession.

3. The keeping within one's own sphere of labor, with due regard for the rights of the general practitioner and of other specialists also.

4. The ability to withstand the pressure that is likely to turn the successful specialist into a medical monomaniac or a roaring charlatan.

DISCUSSION—DR. LEAVITT: I do not suppose that I shall be able to say anything which will prove either interesting or profitable concerning the subject of the evening, but I will not refrain from utteirng a word of commendation of the thoroughly practical address to which we have just listened.

Of course it is impossible for one to engage extensively in special practice outside large cities, but I have been the witness of grotesque efforts in that direction. Cards are frequently sent me by recent graduates, and others, bearing the announcement that the practitioner represented gives special attention to some particular branch of medical or surgical practice, it may be the eye and ear, or chronic diseases, or what is much more common, as Dr. Ludlam frequently says, diseases of women. The penchant for special practice is quite sure to strike the recent graduate, but in my judgment, outside of populous communities it proves but a deceit and a snare.

I am quite in accord with what our President says in

his address concerning the adoption of a specialty without previous, and prolonged, general practice. The young man or woman who starts out in a specialty without having had any experience in general work is quite likely to make a failure of the undertaking. I do not deny that such a one may draw to himself or herself a coterie of patrons and coin many fat fees, but we are to recollect that success is not to be measured alone, or even chiefly, by that standard. Well may we ask, what percentage of cures does he or she make, and how much misery does he or she leave unaided or even aggravated? We must learn the phases of disease in general, by close observation at the bedside before we are properly prepared to take up a special line of practice in either medicine or surgery.

Concerning advances in medicine and surgery, let us recollect that they are made mainly along special lines. Those who devote themselves to close observation of special forms and phases of disease are the ones above all others who best learn the action of remedies therein and who by the same token, best understand the effects of operative procedures. Their only point of weakness is found in their occasional neglect, or want of discernment, of the real causes of disease which may lie in distant parts of the body from those to which their attention is specially drawn. Upon reflection we will discover that the truly valuable discoveries in medicine and surgery which have been made during the past ten or fifteen years, have proceeded from those whose time and talents are devoted to special study and practice. I do not intend to depreciate the good work of the general practitioner in elaborating applying and working up the material which is turned into his lap, nor to deny that he is steadily pushing medicine toward the high mark of excellence which homœpathy has set for it.

Certain checks to the adoption and satisfactory practice of specialties have been mentioned by our President, but to them allow me to add a few. On the side of the specialist himself, I believe that the fact that many specialists

are altogether too prone to make exhorbitant charges should be mentioned. In the city, those who are under the care of this class of practitioners expect to pay a good price; but the aid of such, by reason of their numbers and proximity, is easily obtainable. On the contrary, when we go outside large cities, many patients are found who sorely need the skillful care of the specialist, but who, at the same time, are unable to bear the heavy financial burden inseparable from its command.

I recall reference to this in a discussion at our recent congress. Now, while I do not advocate the donation of professional service to dead-beats in the community, I do maintain that our devotion should be to the cause of suffering humanity rather than to mammon. We should set a lofty ideal before ourselves whether we ever obtain to all its proportions or not, and be willing to account ourselves servants of those whom it is within our power to aid. I have in mind a case wherein it became advisable to perform laparotomy. The husband of the unfortunate woman was in very moderate circumstances, but the avaricious surgeon who was called to perform the operation ruthlessly demanded a fee of $1,000.00 payable in advance. Since this sum could not be raised, the hard-hearted specialist with great reluctance reduced his demands to $500.-00, and took that sum from a poor man as blood-money. Operative procedures involve a responsibility which should receive just recognition; but "blessed are the merciful, for they shall obtain mercy."

Another obstacle is avarice on the part of the general practitioner. To be sure many a practitioner finds his efforts a struggle for existence, and he holds to what he has with the tenacity of a drowning man; but among homœopathic physicians this is rarely true. Even well-to-do general practitioners are loth to surrender their patients to the tender mercies of the specialist, and if by hook or crook they can retain them, even at great risk to the interests most heavily involved, they will many times do so. There is no denying that this would not be so often true

were the general practitioner always sure that what should be a temporary surrender is quite liable many times to become a permanent one.

Moreover, there is a feeling on the part of the people that the family physician ought to be able to do everything which is required. In the cities the people are becoming educated to a more scientific view of medical and surgical matters, but even here there are many who claim —perhaps after some unfortunate experience with a specialist—that their interests are best subserved by the exclusion of all treatment which cannot be administered by the family physician, and the persuasion of the latter himself is sometimes unavailing. If an operation is thought advisable, the patient, clinging to the regular attendant, insists that he shall do it, although he may not be capable of doing it in a skillful manner.

In conclusion, I believe that specialists should guard themselves carefully against becoming dominated by one idea. They ought to be men of liberal minds. They ought to have a measure of precise knowledge of other specialties, and when in their own line they run across a case which does not yield with wonted readiness to their peculiar modes of treatment, they surely ought to consult those who are proficient in other specialties, or even those in general practice, to ascertain, if possible, whether there are not, in other parts of the physical economy to which their attention is not so readily directed, some explanations of the failure which they have suffered. If the specialist will do this, and if he will otherwise conduct his business in a way which shall give due consideration to all interests involved, there is no reason why he should not pursue his specialty with true success.

Dr. G. F. SHEARS said: After the able address from Dr. Ludlam and the exhaustive review of the same by Dr. Leavitt there is very little to say. I have always believed it possible to confine one's self to a specialty in medicine and to limit one's practice to the department selected. In saying this I do not mean to say that the specialist may not

need to consider other parts and organs than the one in the treatment of which he is supposed to have more than ordinary skill. Indeed, I believe the failure to do this is one of the most frequent causes of non-success on his part. Unless he continually holds himself in check each specialist is so liable to believe that all the little troubles which he may find are due entirely to some disturbance of the particular organ with which he is the most familiar that he forgets the relation which it bears to the general system. Our ears, our eyes, our noses have not a life of their own separate and distinct from the general economy, they are dependent upon other organs for their nutrition at least and are often more disturbed from some failure in these organs than from any inherent disease. Unless the specialist has this in mind he is liable to make a mistake. How many eye troubles there are for which some oculist wants to clap on a pair of glasses and all the patient wants is to be built up generally. How many uterine troubles there are, or supposed rectal difficulties, when the patient needs rest, not local treatment, and so it is with other specialties. A specialty is not possible, therefore, if one thinks that in the practice of it he need not be familiar with with general medicine and an adept in its practice. He must first be a good general practitioner; if to this he adds special skill in some direction he may be a successful specialist. At this point the question arises, must the specialist refuse all general practice? Undoubtedly in the end it will be to his advantage to do so, but not every one who is beginning the practice of a specialty has the means at hand to enable him to follow the best plan. Many are obliged to rely upon the receipts of a general practice until a sufficient income has been reached from special practice to warrant the cutting loose and depending upon special work alone. But whether carrying out a general practice or not he should adhere strictly to one rule, never to treat a patient referred to him by a general practitioner for any other than the condition demanding special skill, and to send the

patient back to his physician as soon as these conditions are removed.

The statement made by Prof. Leavitt that the avarice of the would-be specialists is one of the things that stands in the way of making specialties possible, may be considered from several standpoints.

No doubt there are those who ask and receive for their services much more than the service rendered is worth. No doubt there are those who do not take into consideration the circumstances of their patients, and ask that which is an impossibility or a grevious burden to the patient, and in thus doing injure their own cause. But in considering the higher prices of the specialist, it must be remembered that in many cases it means greater responsibility; it means greater time devoted to the patient; it means greater expense in books and instruments; it means a restricted practice and greater attainments. No man is called upon more frequently for gratuitous service. How many letters he receives, and how much advice free of charge he gives to his professional brethern, who themselves collect the fees. How often the patient pays all his money to the general physician before he is referred to the specialist. How often while attempting to do his part to relieve the suffering poor he is imposed upon not only by patients but by physicians. Not long since a patient was sent to me from a distant State for operation; he was a man possessed of a good farm, and entirely able to pay a moderate fee. Upon his arrival he stayed for a few days with some friends, and during the visit made the acquaintance of their physician, who said to the patient, "There is no use of going to his office and paying a fee, I know of a way of getting him to do the operation, and it won't cost you anything. I'll take you to his clinic."

In this case the man was self-respecting, and replied that he wasn't a pauper, and didn't want to be considered one. Now such a proceeding is demoralizing to any patient, unjust to the specialist, and in the end injurious to the physician, for his patient feels that if special skill

can be obtained for nothing, ordinary skill is not worth much more. Once a dead-head he is always a dead-head.

Only a few days ago a man came to the hospital and wanted to see me, saying he had come a long distance to consult me. I was not at the hospital, and he came to my office. After having received my opinion and advice, he prepared to depart without paying a fee. Upon being reminded, he said he was a poor man and had nothing but what he earned and could not pay a fee—not even a dollar. He had been told that we treated poor people free of charge. He was well dressed, and had been attending the Exposition for two days. Not all of us have the courage of Prof. Gross, who, as he relates in his biography, being imposed upon in a similar way, shut the door and said, "You have a watch and paid for that; you must pay me."

Avarice is not the common property of the specialist or the family physician, it depends more upon the man than the department of medicine in which he is engaged.

Dr. Jos. P. Cobb: I have enjoyed this paper and the discussion it has elicited. I believe that it is a timely addition to our observations. I do not know that I can add anything of particular value to what has already been expressed here to night. I am one of those every-day drudges—the general practitioner, who sometimes looks with longing eyes at the specialist on his pedestal.

I believe that it is possible for a physician to be a specialist and thereby be of great service to the general practitioner with whom he may be associated. It has been my good fortune to be associated with and receive help from specialists who were just the right men in just the right places, and who appreciated the fact that the general practitioner had an interest in his patient even if he had sought the aid of "the man on a pedestal." It seems, however, that there is getting to be a feeling that a physician can proclaim himself a specialist, demand the rights and immunities he believes belongs to his exalted position and still do all kinds of general work even in families to whom he has been introduced for a special purpose. This course

is suicidal to his interest as the general practitioner can be his best friend.

Dr. C. H. EVANS: The choice of intending specialists in these days is principally confined to diseases of the eye and ear, obstetrics, surgery, gynecology, cardiac and pulmonary affections, or disorders of the nose and throat; and within these limits they seem to feel they are necessarily hedged. As a consequence specialism in these departments is becoming crowded with many who have only the attainments of general practitioners who experience only the drawbacks of specialists without their influence and emoluments. To these, and others, who dream of becoming such, it can be said that there are many other diseases which may be the subject of especial study and skill, and this without abandoning their established patronage wherever located. When visiting the smaller cities and towns it is not infrequent to hear it said of Dr. B. that he enjoys a good practice, is highly respected, etc., and is then eulogized. "He is so good in fevers." "Hardly ever loses a case of fever." Or it may be, "Dr. X. Y. Z. secured the large practice he has because "he has such excellent success in treating the diseases of children." Again, "Dr. C. always has such good luck with 'lung fever' every year." These doctors had made greater study or closer application of such studies than their neighbors, and in consequence had become more proficient and better qualified. For this reason they were in greater demand, not only for this special aptitude but for the whole range of general practice. This is as much specialism as the exclusive practice of surgery, gynecology, etc. In his line he is certainly able to do better work; it is creditable to himself, to the community in which he lives, and to medicine in general. So it will be seen that specialism does not need to be confined to a few branches in which operative procedures are chiefly demanded, and requiring residence on the part of the doctor in large centers of population. They may be cultivated in numerous directions, not by arbitrary choice, but by selection before the diploma's

ink is dry, or for that matter, before the diploma has been earned, but from interest in it and a fitness for it acquired by patient and unremitting study and observation.

Dr. Leavitt's remarks to the effect that specialists are extortionate in fee and should render their services for less money and serve more gratuitously seem rather a sweeping assertion. It is undoubtedly true in some instances, but in every large city nearly every specialist holds a clinic, once or twice a week, usually the latter, and during its continuance performs operations gratuitously, worth anywhere from $25 to $200. If these were all recorded it would be seen that he has donated many thousand dollars not only to the poor, but to those in considerably better circumstances. The sum total in fifteen or twenty years would in any one else be considered sufficient for a philanthropist, or a newspaper notice. Specialism in a certain sense is not only possible, but commendable. The performer of tracheotomy who operates once or twice a year cannot be as skillful as the one who does it twenty times in the same period, for the manual dexterity acquired by frequency cannot be obtained by the occasional operator. On the other hand, as has been stated by Dr. Shears, many specialists look upon the particular organs in which they are interested as if they were independent of all the rest, and yet it is well known that there is not an organ or tissue in the body which is not connected to a greater or lesser extent with two, three or more others, or strictly speaking, with all the others. Such a conception of medicine is false that encourages the evolution of a purely fractional medical man, for the really valuable specialist is, after all, one who is the all-around doctor. The reflex origin of disease which, more correctly stated, is direct nerve distribution in distant organs, is becoming prominent and will be recognized still more in the future. There is still a boundless field for the specialist to cultivate, and that is the broad domain of therapeutics. With a natural law for guidance, a light from nature's own hand, investigation in this direction will be rewarded most bountifully.

Dr. O. L. SMITH: I am extremely sorry to have missed hearing the paper of the evening; however, I have been enjoying the interesting discussion of the same very much. I thoroughly believe in, and am thankful for specialists and special work, despite several unfortunate experiences with such piratical specialists as my friend Dr. Cobb roundly scores, who abuse the confidence of the general practitioner by appropriating those patients for general work, when they have been referred for special care. I am quite sure that Prof. Fellows, with whom it is my good fortune to work, could recount from his own clinic many cases that he has ultimately cured which would have remained unbenefited had it not been for the skilled care to special organs by the gynecologist, the surgeon, the oculist, etc.

THE PRESIDENT closed the discussion by thanking the members for their evident interest in the subject chosen. Three parties are concerned in it: The general profession, the specialist, and last, but not least, the patient. If the rights and proper relations of each are justly regarded there need be no conflict or misunderstanding. The first needs the second, the second needs the first, and the third needs both the others. When the general practitioner feels that the case in hand requires a measure of special skill and care in which he is not an expert, he should be free to ask for it at the hands of a brother who is trained for that work and responsibility. But the specialist should so conduct himself as not to place the attending physician in an unfortunate or uncertain light, and should courteously withdraw from the case and the family as soon as his duty is done.

Concerning Dr. Leavitt's suggestion that specialists are sometimes avaricious, the charge will hardly apply to them as a class. Their position is peculiar, *id est* the experienced and reliable specialist must have done a large amount of charity work at his own expense of time and of money before the people will trust him; and he must relinquish a general practice, and all other sources of professional income, before his brethern will send for him.

Under these circumstances, is there any good reason why the "dear people" should not remunerate him whenever they are able to do so? The fee for his skilled labor should never come from the attending physician's pocket, either directly or indirectly; nor should it be wrung from the scanty resources of those who are unable to pay a large, or even an adequate sum. I have always held, and have always practiced the plan of adjusting my charge for special service as nearly as possible to the ability of the patient to pay, without extortion or oppression of any sort. And yet, as Dr. Evans hints, and as hundreds of students and poor women could testify, the experience that is put in requisition when I am sent for has cost me many thousands of dollars in the way of charity work, done in my hospital clinic, as well as in private practice.

An interesting fact about specialties is that sometimes one is the most popular, and sometimes another. This gives them all a chance to grow, and to contribute to the development of medicine and surgery in general; for there is not one of them which is not useful in this way. The hope is that when some of these branches shall have reached the limit of their growth, others may come to the front, and that when surgery shall have been as fully perfected as possible, medicine and clinical therapeutics may claim and receive their merited share of attention.

XIX. FOREIGN BODY AND CALCULUS IN THE BLADDER OF A GIRL OF TWELVE YEARS BY DR. G. F. SHEARS.

Case.— I desire to present to the Society this interesting specimen of vesical calculus formed about a slate pencil. Ten months ago a little girl now twelve years of age while investigating the mechanics of the flow of urine let go of this pencil and it slipped up into the bladder. For some time it gave her little trouble but gradually she began to have pain in the bladder and a constant desire to urinate. Of late these pains have been so intense and her cries so heart-rending that her father would stay away from the house unable to bear the sound. The urethra had been dilated by the physician who discovered the stone and there was resulting incontinence of urine, not only urine

but pus flowed freely from the bladder. An operation was determined upon and the patient brought to the Hahnemann Hospital. An attempt was made to use the lithotrite but it was not a success as the bladder, unable to hold the urine, had so contracted down upon the stone that the lithotrite could not be used. The child was therefore placed in the Sims position and the vesico-vaginal incision made. The lithotrite was now introduced through the opening and the stone broken and removed in three pieces. With the index finger of the right hand in the urethra and that of the left hand in the bladder through the vesico-vaginal opening the pencil was turned about and extracted.

The patient is doing well and already has some control

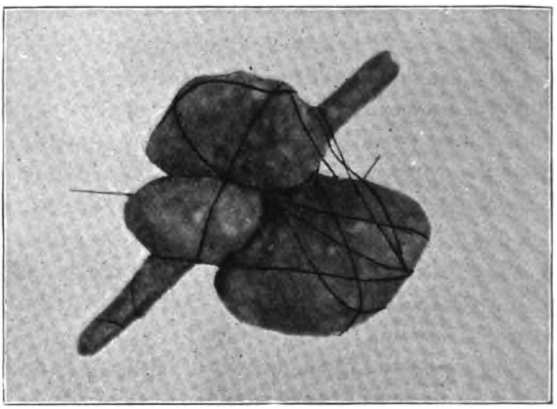

FIGURE 23.

of the urine. The pencil is three inches long and the diameter of the stone at right angles to the pencil was two and one-half inches. The pencil was covered for two inches, half an inch at each end being clear. It was placed almost transversely in the bladder the free uncovered ends resting against the walls of the bladder and almost entering in them.

The variety of foreign bodies which may and have been introduced into the bladder is wonderful to contemplate, penholders, watch chains, bougies, needles, heads of wheat, stems of plants, glass tubes, pieces of bones, earpicks, ivory whistle, bodkins, sticks of sealing wax, handles of

tooth brushes, handles of mustard pots, wax candles, hair-pins, fruit stones, beans and corks are many of the substances which have been introduced. Most of them during attempts at masturbation but occasionaly they are the results of accident as when old catheters break in the bladder or a catheter slips in as the result of urethral contraction during the inattention of the attendant. Occasionally it is introduced, as in this case, in an exploratory way as children slip things into the nostrils and into the aural canal. However introduced, it is not long before they become covered with calcareous incrustations, the successive deposits of which result in the formation of a calculus. Considering the grave consequences that follow the presence of a foreign body in the bladder and considering also the greater difficulties that the formation of concretions present to the extraction of the body, an attempt should be made to remove it at an early date. The bladder may tolerate the foreign body for a time, but not long. Calculi, cystitis, pyelo-nephritis, urinary infilteration, peri-vesical abscesses, gangrene, peritonitis and death may follow. Hectic fever and marasmus are common general conditions.

XX. CLINICAL HINTS ON NEW REMEDIES. BY CARL F. FISCHER, M. D., of Sydney, New South Wales. [The following paper is possessed of a peculiar interest as being the last one written by our lamented friend.—EDITOR.

Karaka.—I fortunately came across the report of a very extraordinary pathogenic record of the karaka berry, the kernel of this fruit of a tree in New Zealand, many years ago while practicing in Aukland. I have introduced this poison as a remedy in my practice prepared in an alcoholic tincture among several others and made a proving of it; however, I never produced the extraordinary effects of distortion and stiffening of the limbs—cases of which I have seen among the Maories, the natives of New Zealand. I used it in the third potency in convulsions and fits in children with satisfactory results. Here is the interesting extract, taken from Vol. IV, of the *Proceedings of the New Zealand Institute:*

The symptoms attending cases of poisoning through eating the raw kernel were violent spasms and convulsions of the whole body, in which paroxysms the arms and legs were stretched violently and rigidly out, accompanied by great flushings of heat, protrusion of the eyes and tongue, and gnashing of the jaws, but unattended by vomiting.

Unless speedily attended to the poisoning by karaka quickly proves fatal, and even in those few cases in which I have known natives to recover, very likely it was more owing to the small quantity received into the system than to the means used as internal remedies.

As the sufferers were invariably little children they were more easily dealt with, and to prevent the limbs becoming distorted, or stretched and rigid, a pit was quickly dug into which the child was placed in a standing posture, with its arms and legs bound in their natural position, and the mouth gagged with a bit of wood to prevent the sufferer biting its own tongue, and then the child was left buried up to its chin until the crisis had passed by.

The writer well recollects having seen at Bream Bay, in the years 1836 and 1839, a fine healthy youth of about twelve years of age, who had been recovered from poisoning by karaka kernels. He, however, had not been properly attended to as to the tying of his limbs in their right position while under the influence of the poison, and he was, therefore, now a curious spectacle, reminding one of the instrument called a caltrops, more than anything else. One leg was curved up behind to his loins, and the other bent up in front with the foot outward; one arm inclined behind his shoulder, and the other slightly bent and extended forward and all as to muscles inflexilby rigid. He could do nothing, not even turn himself as he lay, nor drive off the sand flies (which were there in legion,) from feasting on his naked body, nor scratch himself when itching, nor put food to his mouth.

He was the only child of his parents, who, fortunately for him, were both alive and took great care of him, turning and shifting his position very often by day and night; as from his body not evenly resting he could not possibly remain long in one position. When not asleep he was laughing (if not eating), and greatly enjoyed his being so placed that he could see the children at play, in which he always encouraged them by his voice, often seeming the merriest of the village. I frequently sat by his side during my visits, to talk with him and to drive away the tormenting sand flies which he would beg me to do. His skin was remarkably fine and ruddy. I might call it pretty—being wholly without eruption, blemish or scar; his teeth pearly white, and voice and laugh regularly strong, hearty and ringing. His eyes were very brilliant, and of an intelligent cast, but in conversing with him I always thought his intellect was not so sharp (or developed) as ordinarily that of Maori boys of his age.

Tupaki or *Tusa*, an herb of New Zealand bearing grape-like scarlet berries of which the natives partake, but carefully avoiding the kernels, for these are also very poisonous and as asserted producing lockjaw, also very similar in effect to the karaka. The alkaloid of this fruit or of the kernel has been introduced into the medical pharmacopœia of Great Britian I have used it frequently also in the third potency for epilepsy for which it is given in the old school.

Brachyglosin rependa.—The leaves and flowers of this tree are a remedy which I recommend warmly for Bright's disease, and albuminuria. It has been for more than twenty years a servicable remedy in my hands, and of great assistance with other remedies in ameliorating if not curing these patients. The proving of this remedy is recorded in Allen's cyclopædia and also with others in an early number of the *North American Journal.*

The *Veronica speciosa.* The smallest leaved of this genus, although a native of New Zeland, will be found plentifully cultivated in gardens and plantations in America and Europe. The natives were in the habit of curing diarrhœa and dysentery by eating the young unexposed leaves. By dividing the last leaves on a branch two or several leaflets will be found which have not been exposed to sunlight. These they eat with remarkable good effect. I have been taught this by the Maories, and now even I am in the habit if I find the plant to cure myself in this manner. With a third dilution of these leaves I made a medicine and used it with gratifying results, but what was remarkable, however, was that it had no effect with children. Other symptoms of bronchitis, or better, catarrh of the stomach, are among its pathogenetic effects.

Diornis gloriosa, the gigantic lily of Australia, I have used very effectively in supra-orbital neuralgia, and neuralgia of the eyes. I poisoned myself once with the pollen of this flower and such were the immediate effects that I was led to its application with good results. I think they are also recorded in our literature.

Zamia.—The conic fruit of this palm produces violent gastralgia, and gastritis and is much dreaded by the natives of Australia although it is harmless to eat when boiled. In my hands it rarely failed me in relieving and even curing the vomiting of pregnancy, and colic and gastritis with chronic affections of the stomach, It also was used in the third or sixth potency. *Eucalyptus globulosa* and other varities of this genus of tree, is well known, but besides its prophylactic effects in malaria I have used it with excellent results in chronic dysentery when many of our old remedies have failed.

I have been induced to bring these few hints before you knowing how much interest you take, and you may find them of sufficient value to publish them with the view of inducing your enthusiatic homœopaths to subject them to further proving, and so bring some morsels of antipodean

remedies into the ranks of materia medica where America stands so brilliantly with her treasures.

XXI. SEPTIC INFECTION AND DEATH FROM A BUNION. BY Dr. G. F. SHEARS.—At the suggestion of the President, at whose request I saw the late Dr. Carl F. Fischer, I desire to make the following statement concerning his last illness:

I saw Dr. Fischer, as a patient, the first time on Monday evening June 19, and elicited the following history. His age was seventy-two years. He was of a full habit and very active temperament and for some time has been upon his feet more than usual For a week past he had suffered greatly from pain in a bunion on the great toe of the left foot and the day preceding my visit, June 18, had given up and sent for Dr. R. Ludlam, Jr. He found the foot very much inflamed and applied a poultice and ordered appropriate internal treatment. Twenty-four hours later, he was seen by Prof. Ludlam in consultation and the symptoms being of a grave nature, I was also summoned to meet him.

I found a temperature 102⅘° pulse 123, the face flushed and the breathing labored.

The left foot was swoolen, tense and of a bright red color, the swelling extending above the ankle. Around about the metatarso-phalangeal articulation of the great toe—at which point the bunion was located—the swelling was most marked. On the dorsum of the foot, over the fourth metatarsal bone, their was considerable ecchymosis, and on the inside of the leg a bluish red line extended along the course of the internal saphenous vein as far as the groin.

Feeling the case a critical one a nurse was procured at once and every effort made to place our friend in as comfortable a position as possible. The bunion was opened and cleansed and the more tense portions of the foot incised. Pus was found about the joint, but only dark venous blood came from the other incisions.

The next morning he felt much improved, but by evening the temperature had mounted to 105° and he was delirious.

The ecchymosed condition of the dorsum of the foot was more marked and the infiltration extended up to the middle of the leg. Thirty-six hours after my first visit the parts were devitalized and cold, and gangrene had super-

vened. He died Wednesday morning, a little less than sixty hours from the date of my first visit. The pathological phenomena present were, inflammation of the bunion with septic infection, as witnessed by the red streak to the groin. Septic thrombi in the veins, gangrene and death. The cause of the primary inflammation of the bunion I do not know, whether to an abrasion and infection from the stocking—a prolific cause of septic troubles—to excessive walking and fatigue with high living—for our good friend and the guest of our homœpathic physicians, as a representative of his government and as a genial, pleasant gentleman, was the recipient of much social attention and an attendent upon many banquets, I could not decide.

The treatment consisted locally in the evacuation of the pus, the antiseptic cleansing of the cavity, the application of calendula to the inflamed tissue, and later, when gangrene supervened, the application of tar antiseptic plaster. Internally the patient was given belladonna, bryonia, arsenicum and cantharis.

The question of amputation was considered, but his age and the fact that infection as high as the groin existed when first seen by me, led to the prompt decision that interferences of this character would not avail.

In answer to several questions Dr. Shears said: Gangrene is one of the terminations of inflammation and may follow many diseases as well as traumatism. Whatever has the tendency to obstruct the flow of blood may cause gangrene. In old age the arteries become obstructed by the narrowing of their lumen due to roughness of their coats, blood coagulates, the thrombus occludes the vesicles, the distal parts are not nourished and gangrene results.

Rheumatism may be followed by gangrene, an embolus being detached from the valves of the heart, is swept into the circulation, is arrested in an artery and occlusion occurs. In diabetes the same cause is operative, although I believe on this point there is some doubt, certain authorities holding it to be due to thermal changes in the blood. Certain nervous disturbances which produce spasm of the vesicles resulting in what has been called local apoplexia or local syncope, are other causes of gangrene.

Heart failure from shock may produce thrombus, which

being swept into some smaller vesicles obstructing them may cause gangrene. The more common causes are traumatism and infection, complicated fractures in which injury to vesicles or nerves are pronounced, chemical agents, or pronounced heat or cold resulting in depression of the circulation and lack of nutrition, are the more frequent examples of the former, while the introduction into a wound of the microörganisms generated in suppurating wounds is the most common cause of the latter. In this instance septic thrombus formed and gangrene followed.

I did not call this senile gangrene because that is usually of a dry character and is a much slower process, due mostly to a narrowing of the lumen of the arteries.

RESOLUTIONS OF RESPECT FOR DR. FISCHER.

After the reading of Dr. Shears' report, the following resolutions were adopted by the Clinical Society:

WHEREAS, We have all been pained and shocked by the sudden death of our good friend, Carl F. Fischer, M. D., M. R. C. S. and L. R. C. P., who participated in the last monthly meeting of this Society, and also in the World's Medical Congress recently held in this city, and who has spent some weeks with us as Commissioner from New South Wales to the World's Exposition now in progress; it is therefore,

Resolved, That this event has deprived the profession of a highly skilled and successful physician and surgeon, whose dignity was commanding, whose enthusiasm was contagious, and whose friendship was something that we shall always hold dear.

Resolved, That our warmest sympathies are hereby extended to his daughter and her family, and also to his niece and her family, in their sad and sorrowful bereavement, and to all those who had known and loved the good old doctor so long and so well.

Hospital Notes.

THE CLINIC FOR THE DISEASES OF CHILDREN.

SERVICE OF PROF. JOS. P. COBB.

CONGENITAL SYPHILIS WITH EPILEPTOID SEIZURES. — *Case 240.* Lena J. —— æt. 4 years. When six months old she had brain fever, followed by measles, and was very ill. Since that time she has been very well until the last three months, when she has been having dizzy spells; these spells come on suddenly, the floor seems to be going round and she feels as if she were falling. These attacks occur two or three times per week; following the attack she is nervous and irritable and cries a great deal. Her appetite is good and her bowels are regular. The urine at times excoriates very severely. As a baby she had sore, inflamed nates most of the time, which nothing would seem to heal; she also had water blisters on the soles of her feet.

Prof. Cobb called attention to the significance of this persistently red, inflamed skin, and the occurence of the blebs on the feet. Questioning of the mother failed to elicit any definite information concerning the father's health. The mother complained of frequent, dizzy headaches, and informed us that just previous to the birth of this child she had several miscarriages. She has six other children ranging from twenty to two years of age, but there is an interval of five years between this child and the next older. This family history, together with the child's personal history, warrants the conclusion that a syphilitic dyscrasia is at the bottom of the child's illness. It also indicates very accurately the time when syphilis entered the family. Under the use of tarantula 6 there was continued improvement for two months. She slept better, cried less, and had very few dizzy spells. She has not been as irritable and is more inclined to play. The urine continues to burn and has a very strong urinous odor, is dark colored and fre-

quently turbid. The dizzy spells, when they return, come soon after breakfast. The medicine was changed to nitric acid 30. At the end of two weeks she reported herself as entirely cured.

TUBERCULOUS MENINGITIS.—*Case 241.*—Fred. G., æt. 10 years. Is of a tuberculous diathesis. The mother's health is good but the father died of consumption at the age of 39. This boy had measles at four and whooping cough at two years of age. During infancy he was raised on the bottle. For the last few months he has not been well. He sleeps but a few minutes at a time, is cross and irritable. About once in two weeks he will sit for a day or two, dull and stupid, hanging his head down all the time; he does not want to be talked to, and will not pay any attention to what is said to him nor to what is going on around him. During these spells he will sometimes scream out for no apparent reason. His bowels are regular, but the movements are very hard, dry and light colored. he cries with pain when he has a movement. Between these attacks he brightens up but does not act as he used to, does not want to play and never has any good sleep. Until six months ago he seemed very well.

PROF. C. said: "These cases of tubercular meningitis often develop very slowly, are frequently overlooked and neglected, as this case has been until all hope of help was well nigh gone. They are much more frequent in younger children, and often follow one of the exanthemata or whooping cough. In this case we cannot find any exciting cause, probably because the inception of the disease was some time ago; an exciting cause, however, probably existed, though it may not have been anything more than an ordinary cold. We learned that this boy was fed during infancy by the bottle; it is a significant fact that bottle-fed children, even when ten years old or over, do not make as good a fight against any kind of constitutional disease as those who were nursed during infancy. This fact makes our prognosis more grave. We shall give him calcarea carb. 6, but cannot hold out the hope to the mother that it will materially check the progress of the disease.

(The case came from a distance, and nothing more was heard from it.)

TUBERCULOUS CACHEXIA.—*Case 561*, Adelaide W. æt. 8 years. The family history shows two cases of consumption, viz., the father, who died at the age of 37, and a brother of the father who died still younger in life. The mother's health has always been fairly good. The child had measles at three years of age, and whooping-cough and bronchitis one year afterward. She has been ailing for a year or so; she takes cold very easily, and the mother thinks the present illness began by taking cold. At present she coughs, more at night than in the daytime; the character of the cough varies. She has a "cold in the head," watery discharge from the nose, some catarrhal swelling of the mucous membrane of the pharnyx and the nose. She is restless at night, has cold sweats all over while asleep, but especially about the head and face; her feet are cold most of the time. Her appetite is fairly good, the tongue but slightly coated, and the bowels regular.

Prof. C. remarked that this was one of a type of cases which we frequently meet with in dispensary practice; an inherited tuberculous tendency, evidences of poor care, in all probability imperfect food at improper times and intervals, and neglected ailments like whooping cough, combine to induce a depraved condition which in this case is manifested by a lowering of the tone of the vaso-motor system. The tendency to take cold easily, the catarrhal inflammations, and the night sweats are all evidences of an imperfect circulation. It is a commonly accepted opinion among this class of people that whooping cough is a disease which requires no medical attention; that the child must cough three months or more, and that it is of no use to see the doctor; and yet we know that it is one of the diseases which very frequently leaves trouble in its wake. Directions were given concerning the proper food for the child, its clothing and care, and calcarea carb. 30 prescribed.

Marked improvement was reported in one week when sac. lac. was administered, and continued satisfactory improvement was reported for several weeks, and like many

of our patients, when feeling well she failed to report any further.

ENURESIS.—*Case 576.*—Emma S., aet. thirteen years. She has never had any of the ordinary children's diseases except chicken-pox which occurred in infancy. She has always complained, however, of headache over the eyes and through the temples, and backache through the lumbar region. She has always been troubled with enuresis; she is aware of the desire to urinate, but cannot retain the urine long enough to reach the closet. Coughing will always cause urination, and this is especially the case at night. She sleeps well, but lately, her mother says, that during sleep her muscles twitch. Her appetite is good and her bowels are regular. There was no unusual peculiarity of the urine either in odor or color. No family history was obtained.

Prof. C. called attention to the fact that the etiology of enuresis presents several distinct features. The bladder is controlled by two distinct muscles and two different nerve supplies; the sphincter muscle is in a state of tonic contraction all the time, while the detrusa muscles contract normally only in response to a stimulation supplied by the presence of urine on the mucous wall of the bladder, ordinarily the nerves of the mucous membrane which come from the center in the lumbar part of the cord, do not carry back the impulse until the bladder is fairly well filled; if the urine is irritating in character, however, the impulse will be generated by a very small amount, even a few drops; this will produce frequent urination and usually pain and tenesmus; the unusual character of the urine will also attract attention; when this process continues inflammation of the mucous membrane will be produced and the consequent mucous fermentation of the urine which spits up the urea and liberates carbonate of ammonia will be induced. In this case we have neither the frequent urination nor the evidence of an irritative urine. If the impulse were interrupted on its passage from the lumbar center to the sensorium, we should have unconscious urination, which is not the condition in our little patient; we must conclude there-

fore that the fault is not in the sensorium. Two possible explanations remain, viz: that the detrusa muscles when they receive their impulse back from the lumbar center refuse to be controlled by the center in the sensorium and act immediately or that the tone of the sphincter muscle may be lowered so that it is unable to restrain the bladder urging. The latter condition is the one which causes the trouble in this case as is shown by the fact that the act of coughing produces involuntary urination. She was given causticum 6. For four weeks she was kept on this remedy and gave weekly reports of satisfactory improvement. Headaches were rare, cough was entirely relieved, but the twitching of the muscles during sleep was not entirely relieved. She sleeps very heavily, wakes up in the early part of the night to urinate, but wets the bed in the early morning. She no longer has any trouble in holding the urine in the daytime. She was given gelsemium 6x and at the end of two weeks reported herself as entirely cured.

ALUMNI ASSOCIATION REPORT:

Subscriptions already reported	$3,111.60
Carl Gruber, '86, Clinton, Ia	10.00
Marie H. Warren, '91, Chicago	40.00
A. C. Halphide, '93, Chicago	40.00
Additional from former subscribers as follows:	
R. Ludlam, Jr., '86, Chicago	75.00
A. A. Whipple, '80, Quincy, Ill	30.00
C. E. Colwell, '85, Aurora, Ill	30.00
G. W. A. Collard, '80, Bridgeport, Conn	10.00
Total subscribed	$3,346.60

July 15, '93.

JOS. P. COBB, Treasurer.

Miscellaneous Items.

At the next meeting of the Clinical Society, July 29th, Dr. Arnulphy will present a paper on the *Various Heart Affections during Pregnancy*.—Dr. G. Hardy Clark, of Humboldt, Iowa, was sent by Gov. Boies as delegate to the National Congress of Charties, etc., held in this city last month.—Prof. C. Gurnee Fellows, who is in London for fresh study in his specialty, the nose and throat, will return in season for the opening of the college session; meanwhile his clinic is in charge of Dr. C. J. Swan.—Dr. H. K. Macomber, of Pasadena, Cal., and his excellent wife, have been delighting their friends in this Exposition city with a visit.—The death of our dear old Senior, Dr. Henry D. Paine, of New York, æt. 75, occurred June 11th, and that of our good friend Dr. Carl Fischer (see page 352), June 21st. We sincerely regret that a lack of space prevents a more extended notice of their life-work, as well as of that of the late Dr. Isaac Fellows, of Los Angeles, Cal.—Prof. Crawford is recuperating on salt air and sea food off the Coast of Maine; and several other members of the faculty will soon "fish or cut bait" in order to be ready for their winter's work in the new college and hospital.—The summer clinics have never before been so full and interesting as they are now.—The winter term in the "Old Hahnemann" will open October 3d, and students who want reserved seats at the clinics should write to Prof. E. S. Bailey, 3034 Michigan avenue, Chicago, at once.—The special attention of the Alumni is called to the half-page communications at pages 328 and 357.—The London Homœopathic Hospital, now almost half a century old, laid the corner stone of an elegant new building June 23.—The CLINIQUE will appear as usual during the dog days.

THE CLINIQUE.

VOL. XIV.] CHICAGO, AUGUST 15, 1893. [No. 8.

Original Lectures.

*THE BACTERIOLOGY OF UTERINE DISCHARGES.**

A LECTURE TO A SUB-CLINIC CLASS DURING THE SUMMER VACATION, 1893, BY PROF. E. STILLMAN BAILEY, M. D.

[CONCLUDED.]

At the December meeting of the Clinical Society, I had the honor to present a report of some investigations I had been making in the field of bacteriological research, confining my experiments to the study of uterine discharges. In that paper I explained why the report was incomplete, and I wish now to finish what I then began. My studies, both in growing the microörganisms and in determining the variety, or the families to which they belong, do not essentially differ from that of other investigators. In fact, as time goes on, and as these discharges are studied, the field as found by investigators is narrowing rather than widening, is becoming simplified rather than growing more and more complex. It is becoming better understood, and it is my experience that the cases having a clinical history of discharges, unhealthy and unnatural, are being treated with greater success than in former years. In a word; the causes being known the successful form of treatment is

*See January CLINIQUE, 1893, pp. 22 to 30.

easily or more easily applied. I wish you would review with me a little of the literature on this subject before we proceed much further. It will clear the way for a better understanding of the subject.

Bacteriologists say to the gynecologists at the present time that there are really only three of the many kinds of microörganisms that enter as factors in producing special forms of diseases of the generative tract. The three kinds of germs known as exciting causes of disease are: 1. The streptococcus pyogenes. 2. The staphyloccus pyogenes aurens. 3. The gonoccocus. To the mind unwilling to investigate, or too opinionated to believe what others may have discovered, these bodies and the traits or habits they may possess seem but as myths. To some members of the profession they will always remain so.

A new idea is upsetting, and for fear of its effects upon them, they decline to be upset. I heard arguments by certain members of a national medical organization not long ago, which I am morally certain that you as students yet on the benches, could have brought proofs to bear against that would have been convincing to any receptive mind. I am not fault-finding, but am sorry that truths seem to travel so slowly, and that facts are such elements of discomfort. To begin with you would readily agree with me that many of the forms of the microörganisms that I have shown you from time to time, have presented simply the forms of vegetable mould or fungi. Your teachers have told you of their harmless character. It is by no means true that those culture tubes presenting the appearance of rankest growths would produce most violent or pathogenic symptoms. It is not the moproscopical, but the microscopical history that shows to us the wonders of this world of the infinitely little. The class of germs that act as disease producers in the female genital tract are the pyogenic bacteria. The kinds are as above singled out, each having a microscopical point of divergence to present and a clinical history that is interesting to know.

The *streptococcus pyogenes* is a well-known microör-

ganism. Its peculiar interest to obstetricians and gynecologists is the fact, according to Fraenkle, that it is the exclusive germ and cause of the so-called puerperal fever. This peculiar coccus is sure to be found in the discharges or post-mortem examinations of those dying of the fever. Some authorities say that the nearer pure the culture, the more violent the disease, or in other words, if the germs present a mixed variety, the virulence of the disease is less than when the colonies are almost identically of one kind. This coccus is not difficult to recognize, and to the trained eye it is easily distinguished. The forms are minutely round or globular cells, possessing a pronounced tendency to grow into long chains. In these bead like chains, six to ten of the germs may be found united, but frequently there may be hundreds. These chains are also described as being long enough to present long coils, and are so interlaced as to form long bundles. The one difficulty in the way of recognizing this coccus, is that the streptococcus of erysipelas, known as Fehleisen's, presents the same characteristics in appearance and produces very similar clinical phenomena.

At a medical meeting held here in the city not long ago, the subject being the germ theory of disease in the lying-in chamber, an hour's time in the discussion was wasted to hundreds occupying the seats, from this fact, that in the discussion those taking part undertook to describe the cases they were called upon to take care of, and the filthy surroundings they met, and the untidy condition of the patient, etc., drawing the conclusion that if filth was the cause of the fever in the lying-in cases that their patients would certainly suffer most, and they did not suffer at all. The arguments would have been valid if they could have demonstrated that this one variety of coccus was present in the filth, and that it entered the bodies of their patients. One student of medicine, and he has a degree to back it, presented the line of argument that at the present time no practitioner would willingly visit the lying-in chamber after visiting a patient sick with erysipelas. Why not? For

fear of inoculation, and that his patient would be sick with erysipelas. Think of it sometime when in a reflective mood and see if the symptoms of the so-called puerperal fever where internal organs are affected, have not a very great clinical resemblance to the erysipelas showing upon the external surfaces of the body, and why should there be such a resemblance? Is there such a thing as the cause being somewhat similar?

The difficulty in assigning this coccus clinically to the place it exactly belongs is this, that the inoculation of this same microörganism at one time causes a typical well defined disease (fever), and at another, or in another person, it causes a purely purulent discharge.

This is explained by the fact that it has different degrees of virulence. As a pure germ it very rapidly excites and produces the phenomenon of fever, but as a "secondary bacterium," when mixed with other microörganisms it may serve only as one factor in symptom producing. As the germ found in purulent changes it is known to exist within tissues and to slowly produce changes, but does not act in the way to produce a rapid breaking down of structures. I believe this microörganism to be criminally liable for a large number of the post-puerperal cases of endometritis, and metritis. While it occupies a relatively important place in obstetrics and gynecology, it is the least of the three evils referred to.

The credentials coming from the lying-in room no longer read, that by the presence of certain elements or factors one-half of our patients are very ill, or that from ten to forty per cent of the cases die of "fever;" but the report now is, *by the exclusion* of certain elements or factors (we believe these identical cocci) very few patients having proper care have post-puerperal disease of any kind, and that in one thousand consecutive cases of labor, only one mother died* of so-called fever (sepsis).

The *staphylococcus pyogenes aureus* is the most common of the pus bacteria. The cells are roundish, minute

*See N. Y. Hospital Report, 1892.

bodies, somewhat smaller than the cocci just described. The characteristic of these germs is to form into groups. They are never found in chains. This is an easy way to remember them. They sometimes, by reason of the aggregation of groups appear in dense irregular heaps, looking especially when found in the tissues not unlike the close clusters of grapes. This fact, as to their appearance, has had a great influence in determining the relation of the microörganism to the diseased condition. Pathologists agree that bacteria act as specific exciters of suppuration, with possibly few exceptions, and that suppuration is a specific reaction of the tissues to the presence and activity of these bacteria, the rapidity of the changes being due to the bacterial excretions, toxines and toxalbumins. The diffusion of this special coccus is extraordinarily large; it is found almost universal. Large numbers are found on the epithelial surfaces of the human body and not a few on the mucous surfaces. The portal of and signal for entrance, to steal health and destroy tissues is through the small lesions or fissures on any surface. Once inoculated the human body may easily succumb to the invading foe and a series of destructive changes may take place. The profuse discharges —muco-purulent or the distinctly purulent, non-contagious in character, are more or less dependent upon the activity, directly and indirectly, of this germ. It has anarchistic tendencies; it has its explosions and its strangling methods of warfare. The distinct uterine and vaginal discharge is very apt to be modified by the presence of other factors, but when this germ predominates profuse purulent discharges result. This germ penetrates tissues at every opportunity, but the only good thing that may follow its description is that it is easily destroyed. Mild antiseptics will do more than hot water or aseptic solutions. I should like to say more of this robber, but I have to tell of another of far greater clinical importance.

The *gonococcus*. In the diseases under discussion it is a matter that daily observation confirms that the pus of gonorrhœa (always a mixed pus) differs very clearly from the

products of the other processes of inflammation by its peculiar contagious properties. There are as a matter of fact but few diseases so strongly marked as being of infectious origin as gonorhœa.

For this reason vigorous efforts have long been made to discover the secret. A great array of facts can now be produced to show that the discovery of Neisser in 1879, of a coccus as the peculiar something heretofore unknown is responsible for the contagious properties of the discharge.

In appearance under the lens the globular cells are larger than in the other two varieties described. They never appear in groups, and rarely in chains. They appear in pairs, gently resting against each other, somewhat flattened and so joined that they have the appearance of a breakfast roll. They therefore need not remain at all mixed up in their microscopical appearance with any other microörganisms. This fact is of great importance, but another means of identification is that in their general appearance these murderous germs have swarmed into the ordinary pus cells and occupy the entire protoplasm thereof, excepting the nucleus, a characteristic almost entirely peculiar to the gynococcus and very found in the other genuine pyogenic bacteria. If not already established beyond any doubt there certainly is very little of doubt as to the existence and office of this germ. Its clinical dignity is almost princely. I shall not at this place branch off and discuss the possible frequency of its appearance in the discharges or its effects by the natural or unnatural inoculation into the human body. That is quite another subject, but it is known positively that through contagion and infection that this germ works immediate and remote, sudden and violent changes in the generative tract in the male and female and that its virulence varies and its chronicity is somewhat on the perpetual order.

The *Vaginal bacillus.* According to Doderlein, of Leipsic, in over fifty-five per cent of cases examined, the normal vaginal secretion contains a bacillus. What is a normal vaginal secretion? It is that discharge having the

consistency of coagulated milk, without the admixture of mucus. It rests upon the vaginal surfaces, in the vaults and rugi. Its source is from the superficial layer of the vaginal mucous membrane, the cells of which, when cast off and mixed with the lymphatic fluid, forms a white mass like thin porridge. This is so often seen and very infrequently recognized as the normal discharge.

The reaction of the normal vaginal discharge is acid. The acid is lactic, and is said by the same observer to be derived from the tissue changes produced by a definite species of bacillus which is always present in the normal secretion, and is called the vaginal bacillus. This germ can be obtained in pure cultures, and the experiment of developing lactic acid can be made at pleasure. In addition to the vaginal bacillus, yeast germs and certain saprophytic and pathogenic microörganisms other than those described may be found.

The normal reaction of the secretion being acid, it is not favorable for the mixed germs. It is claimed, and with good reasons, that the pathogenic germs perish, or nearly so, in the acid solution and secretions, and that this fact alone is sufficient explanation why the streptococcus and staphylococcus have different degrees of virulence.

The pathological secretions and discharges from the vagina differ from the normal very materially. The latter are very fluid, yellow or yellowish white, and contain many pus corpuscles. The reaction is faintly acid, neutral or sometimes alkaline.

To close, in my microscopic examinations of culture tubes I was at first very much disappointed and discouraged. None of these beautiful types leaped at once into my vision. I thought that my clinical cases had a distinct clinical history, and the causes would be revealed. The disappointment was, after all, a victory for the cause.

In over two hundred culture tubes only one remained sterile, when I had reason to believe it should have shown life. All of the others examined, either by the general appearance of the growth on the surface of the media used,

or with the high power lense, revealed the presence of the mixed bacteria. There were those where pathogenic germs appeared in greater numbers than in others. I am able also to add that in the more acute cases and when the uterine discharges were most profuse, that the strict antiseptic treatment sufficed and rapidly cured these cases.

The lesson of culture test-tubes in uterine discharges in my experience is the lesson twice learned of the strictest attention to the technique of the gospel of cleanliness and of antisepis. I am firmly convinced, by proofs to me positive in their nature, that were we able to exclude the mixed and pathogenic microörganisms from the genital tract at all times, that the true cause of unnatural discharges would be removed.

SOME POINTS ON TRACHEOTOMY.

By WESLEY A. DUNN, M. D., PROFESSOR OF LARYNGOLOGY AND RHINOGOLY IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

Many were the dangers attending the early operations of tracheotomy, and the death list resulting from the operation or its after-treatment was so great that for many years it struggled against the contentions and prejudices of the physicians as well as the laity.

As early as the sixteenth century a scattering case was now and then operated upon with but a poor chance of recovery or success. So little was understood at that time of the pathology, physiology and anatomy of the parts involved and the recuperative powers of such tissues, that physicians were then afraid to make incisions through bones or cartillages, believing it impossible to unite them again.

The early operations were all made by transverse incisions of the membranous tissues between the cartilaginous rings. The canula was at first but a catheter or a straight tube inserted into the wound which was removed at the earliest possible minute.

In the latter part of the sixteenth century, and even again in the middle of the eighteenth century, the operation of

laryngocentesis was performed by inserting the trochar into the trachea and allowing the canula to remain in the wound two or three days. It was not until the time of the American revolution that any enthusiastic use of this surgical operation was published, and even then the results were far from satisfactory and met with much opposition. Only an occasional success crowned the then considered ventursome surgery.

Slowly it bettered its record until the time of Bretonneau of Tours, who by his faithful and unceasing efforts did much to establish the success of the operation. He increased the size of the opening and maintained it during the necessary time for relief of the stenosis above. He had eliminated the fear of large incisions and continued irritation of the trachea by the canula. He experimented on animals and observed the trachea not to be injured by foreign bodies. Bretonneau did much to establish the success and remove the fallacies of the operation before the first quarter of the present century; but to Trousseau we owe the permanent popularity of the operation of tracheotomy and the elimination of many of its dangers and the establishment of its success. The publication of his investigation and experience in 1833 placed the operation beyond the uncertain and dangerous methods of the operators of the period and established an era of improvement which has resulted in our present successful methods.

In 1839 one hundred and thirty-eight cases had been performed with twenty-nine recoveries, and in 1844 two hundred and twelve operations with forty recoveries. From 1849 to 1858, after the invention of the double canula, there were four hundred and sixty-six tracheotomies performed under the observation of Trousseau, of which one hundred and twenty-six were successful, or more than one-fourth.

The serious results from this operation did not follow entirely from the operation in itself, but largely from the disease of which the patient was suffering at the time.

The success of intubation during the last few years has limited the indication for tracheotomy and will at the same time lower the record of its future history, because it removes from tracheotomy the most dangerous class of cases for which it was formally performed, viz.; membranous coup and laryngeal diphtheria. However, no operation will succeed to the role of tracheotomy for many forms of laryngeal stenosis and for the removal of foreign bodies in the treachea or bronchii.

Tracheotomy at the present time is not indicated in the usual forms of croup, either diphtheritic or simple, unless intubation has already failed to relieve the stenosis, and even then the success is far from happy and the danger of bronchial stenosis is extremely great. Yet I would not fail to perform tracheotomy in any case in which the intubation did not relieve the stenosis. In stenosis resulting from laryngeal tumors, perichondritis, ulceration of the larynx or vocal cords and from foreign bodies within the trachea, tracheotomy is clearly indicated, while intubation would but add irritation to the already seriously changed laryngeal tissues. The operation, except in children, is not in itself extremely dangerous, neither is it devoid of accidents which may prove in themselves serious. In children, the small size of the trachea, its activity during difficult respiration, the short space from the sternum to to the larynx with the close relations of the vessels of the neck add very seriously to the dangers and difficulties of the operation in those so young.

Patients suffering from pneumonia, bronchitis or other diseases of the lungs are liable to aggravation of such maladies by the sudden ingress of air abnormally admitted to the lungs. In the usual method of inspiration the air is warm and moist before it comes in contact with the lungs, but owing to the free ingress of air by a large permanent opening so directly connected with the bronchi and lungs the delicate tissue is prone to irritation and inflammation; therefore, it is well to cover the opening of the tube by a layer of gauze covered by a fold of flannel which retains the heat of the expired air, and if slightly moistened will also transmit its moisture to the inspired air. This difficulty may also be overcome by keeping the patient in a well warmed room in which a steam atomizer is kept in operation until the air is surcharged with moisture.

In regard to the anæsthetic much depends upon the condition of the patient. In extreme asphyxia anæsthesia is not necessary as the carbonization produces sufficient anæsthesia to enable the operation to be performed without pain. In the early stage of stenosis, before carbonization begins, anæsthesia is always indicated, the selection of which must rest with the preference of the operator. It is possible to perform the operation by the anæsthetic effect of cocaine by injecting a few drops of the 5 per cent solution along the line of the incision. It must ever be borne in mind that the most dangerous collapse will follow the

sudden ingress of air produced by opening the trachea in those who are deeply anæsthetized; therefore, it is always advisable to discontinue the anæsthetic before the incision is made into the trachea and allow the patient to partially return to consciousness before the trachea is open. It is well to bear in mind the necessity of having a perfect canula that accidents may not happen from its introduction or breakage. The end of the tube must be smooth and regular; the attachment of the external mechanism with the canula proper must be perfect and substantial. This is of the utmost importance as it not infrequently happens, especially in tubes made from rubber, that the canula becomes separated from the external portion and falls into the trachea, causing an unfortunate and often serious complication. The rubber tubes are very satisfactory because they do not become oxydized and are as antiseptic as silver or plated wares.

The size of the tube should vary, depending upon the size of the patient; care should be taken, however, that the tube be not too small and of the right curve. If the curve be too great, irritation of the anterior wall will follow. It is always best to use the double canula, especially in children, but it is not always advisable to have an opening in the external canula on the posterior surface as it frequently happens that granulation at this point will close up the opening of the tube or cause serious irritation during he removal of the inner canula. In young children, however, where the tube completely fills the trachea collapse of the larynx may follow its inactivity and removal of the tube becomes difficult.

Case.—Such a case came under my observation at the Hahnemann Hospital. A child two years old had suffered from acute laryngitis following the inspiration of a nut shell. Œdema was extreme and tracheotomy had to be performed. A single canula without an opening in its wall was used. It was of silver and large for the size of the child. After several weeks an attempt was made to remove the canula when the child immediately became asphyxiated and it was found necessary to restore the tube. A similar attempt a week later was attended by the same result. The child was then brought to the city believing the foreign body was still in the larynx. I was able to make a laryngoscopic examination of the larynx and found it to be perfectly normal and diagnosed the case as one of

collapse of the larynx from muscular inactivity and the extremely soft condition of the cartilaginous walls of the larynx. I changed the tube for a double canula with an opening in its wall allowing the child to breathe through the larynx when the inner canula was removed. In this manner the patient gradually regained the use of its larynx. After a few days the external opening of the tube was closed and the child breathed wholly through the larynx. In two weeks the patient returned without its tube and has since remained perfectly well.

The care with which the operation is performed depends much upon the condition of the patient. Frequently it is necessary to hasten, or even to produce immediate incision in the trachea. This may be accomplish by grasping the larynx and portion of the trachea between the thumb and finger of the left hand; while with the right hand the bistoury or knife of any type is quickly inserted into the trachea and an upward incision made in the median line. This is frequently indicated in Œdema of the larynx and spasmodic closure of the larynx which frequently produces asphyxia and death without warning. It is sometimes difficult in such cases to control the hemorrhage, which may be produced by severing the thyroid artery or the isthmus of the thyroid gland. A bent wire hairpin or curved tenaculum is sufficient to retract the sides of the wound and allow ingress of air. In the absence of the tube, of a thread through the tissues on each side of the wound, including the cartilage, will aid in holding the wound apart. It is in such desparate cases that the skill and judgment of the physician are in the best light and many are the lives allowed to slip away because of a moment's hesitation on the part of the attending physician.

The selection of the location is of much value as pertains to the results to be obtained. At the present time the majority of operations are performed for the benefit of the larynx. It is of advantage therefore, to keep the incision as far from the larynx as possible; in consequence, low tracheotomy is the operation usually selected. This locality, however, is not as free from danger as the higher operation, because of its intimate relation with the surrounding vessels, but with due care serious complications do not often arise from the hemorrhage.

It sometimes happens that the vessels are abnormal in their course and incision of the large vessel may hap-

pen. It is said that the left internal jugular has been wounded on several occasions, also the left primitive carotid. The innominate may also be in reach. In little children the tube is extremely small and soft and retreats before the finger and the muscle may be punctured of it. Sometimes the trachea deviates from the median line and the incision may be made in the side instead of the median line. The isthmus of the thyroid gland should be carefully avoided and if necessary be elevated and retained by a blunt hook. Care should be exercised not to puncture the posterior wall of the trachea and penetrate the œsophegus during the incision of its anterior wall. If the trachea be elevated by a sharp hook during the incision, the danger of penetrating the posterior wall is not so great, and the trachea is under better command of the operator during the incision.

The introduction of the canula is one of the important features of the operation. It is usually recommended that the wound be opened by a dilator until the introduction of the canula. I find it is successful, however, to separate the wound by retractors until the tube is inserted. Care is necessary that the tube properly enter the wound which may be known by the exit of air through the tube, which can be felt on the face of the operator. If the tube be not properly inserted, the mucous membrane may be separated from the trachea because of its loose attachment to the surrounding wall. The tube may be inserted beside the trachea or in front of it, thereby predisposing to abscess of the neck or the mediastinum.

Should asphyxia continue, the canula must be removed and if not closed by foreign substance in its caliber can be returned with more care and circumspection. The tapes are then tied to keep it in place.

Hemorrhage following the operation is not usually severe, but may persist in sufficient quantity to cause serious complications. Usually, if the operation has been slowly performed and the hemorrhage controlled before the incision of the trachea, future trouble is not anticipated. In rapid operations the introduction of the canula usually closes the wound sufficiently to expel the blood from the external opening. It sometimes happens, however, that hemorrhage into the trachea occurs in sufficient degree to produce asphyxia or collapse. It might be necessary in serious cases to remove the tube and ligate the vessels. The hemorrhage is usually venous unless some of the larger

arteries have been wounded which would give immediate serious result.

Traumatic emphysema sometimes follows tracheotomy from improper introduction or poorly fitting tubes. If the tube be expelled or slip from its place in the trachea, especially in low tracheotomy, emphysema is very liable to happen unless the tube is properly restored. Perforation of the posterior tracheal wall may produce emphysema which is extremely serious, resulting in rapid asphyxiation. The emphysema may produce enormous distension of the neck, walls of the chest, face and eyelids and may even extend to the lungs. Proper introduction of the tube will immediately relieve the progress of the emphysema and the air will finally be absorbed from the celular tissue.

It sometimes happens, however, that the neck becomes so enormously distended that the tube will no longer reach the trachea, and a special tube must be used which is of sufficient length to properly enter the tracheal wound.

Super-granulations of the wound may cause irritation from the tube and excessive discharge of pus producing an unpleasant odor and copious discharge. Granulations in the trachea may also prevent the introduction of the inner canula and also interfere with the final removal of the tube. Copious expectoration is frequent from the irritation of the canula during the first days which sometimes produces serious results because of its dessication on the inner surface of the tube producing mechanical stenosis of the canula. This is extremely difficult to remove and much care is necessary to avoid breaking the canula, or allowing the patient to become asphyxiated.

Frequent removal of the inner tube and cleansing are the only remedies for this condition.

It has been my intention in this lecture to mention certain complications and accidents that are unusual, and not the prescribed surgical manipulation which has already been described in former lectures. These suggestions may stand you well in practice as it is the unexpected complications that give us the trouble in our everyday work.

Clinical Society Transactions.

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

JULY MEETING, 1893.

The regular monthly meeting was held in the Great Northern Hotel, Saturday evening, July 29, the President in the chair. Dr. Arnulphy, the essayist, having been called out of the city and being unable to present his report, the society heard and discussed the following

VOLUNTEER PAPERS. XXII. CLINICAL EXTRACTS FROM FOREIGN JOURNALS, BY CORNELIA S. STETTLER, M. D.

1. *Renal Neurasthenia.*—Dr. Grocco* has recently published a very interesting memoir upon this subject in which he advances some ideas that are decidedly new concerning the analogy existing between neurasthenia and renal disease. Calculi and displacements of the kidney are, according to him, causes of neurasthenia, which should be recognized as a source of chronic uræmia.

But, besides this etiological question, the author believes it important to describe the spinal symptoms of renal neurasthenia under the title of nephrasthenia. He reports the case of a patient who with a series of symptoms classified as neurasthenia, had considerable oliguria with a decrease in the quantity of urea. No morbid concondition of the kidneys, at least of those that have anatomical lesions, could explain this scanty secretion, neither could we ascribe it to hysteria. The treatment of general neurasthenia did not give good results; on the contrary the cure was effected by vigorous treatment designed to stimulate the renal secretion (dry friction over the loins, lumbar douches, diuretics, etc). In addition to gastric, intestinal and cardiac neurasthenia we should, therefore, recognize a renal variety.

The author deplores the fact that renal insufficiency is still so imperfectly understood. It is worth noting, however, that certain individuals are predisposed to renal inadequacy as others are to nephritis, and to albuminuria. In general, alcoholism, a too stimulating diet, volatile oils

*Revista Clin. e terap. 1893, p. 81.

and diuretics have favored this morbid tendency. Among those which he has observed, two have ended with interstitial nephritis, four have been attacked with transient nephritis in the course of other affections, and have finished with a chronic nephritis, parenchymatous or mixed.

The intermittent type of renal obstruction is most frequently found among the aged. As those who possess a heart that is easily fatigued ought to be careful not to overtax the cardiac function; even so should over-stimulation of the kidneys be avoided by those who are very susceptible. In its onset and development renal inadequacy varies greatly. He recalls a case in which at the uræmic period there was what the author styles a renal ataxia. In one day, for example, there were found twenty-five grammes of urea, and in another 1.28 grammes, but it increased to 12.60 grammes on the third day. Such great variations should make one suspect uræmia.

Among the factors susceptible of producing uræmia the author believes that the causes which depress the general nervous system ought to be carefully considered. During the course of other diseases the renal insufficincy is usually in relation with a nervous, adynamic state, and especially with cardiac and gastro-enteric symptoms.

Just as auto-intoxication is productive of dyspnœa, so certain cases of vertigo, and confirmed insomnia are associated with renal inadequacy and with intermittent obstruction of the kidneys, even when there has been no nephritis, nor anything that would lead one to suspect the kidney.

Grocco also speaks of a clinical form of albuminuria which is called Pavy's disease, and which may simulate nephritis in its onset or in its termination, the same as renal lithiasis. He has seen seven cases of it and it always attacks the young, especially those who are delicate and lymphatic. In some of these patients there was at the same time cutaneous symptoms (urticaria, copious perspiration). One of these ended in nephritis. In all of them the expulsive ligation of the limbs caused the albuminuria to disappear promptly during its application, which proves that albuminuria in Pavy's disease arises from a deficient blood supply to the kidneys. This ligature tried in sixteen cases has caused a diminution of albuminuria, principally where the renal lesion was less profound and less inveterate. In very serious cases the results have been almost *nil*. We must, therefore, conclude that the albumi-

nuria of nephritis, which is a part of it, and sometimes a very serious part of it, is in proportion with the insufficiency, the rapidity and the pressure of the renal circulation.

Concerning the therapeutics of renal affections he attaches no especial importance to the gallic acid, to fuchsin, or to bromide of strontium, while calomel and scilla appear to him to be harmful in nephritis. He believes that iron has been greatly abused. Hydrotherapie seems like a two-edged instrument, but very useful, however, in certain cases. He puts foremost among the diuretics the acetates of soda and potassa, and praises very highly large doses of caffeine, in preference to theo-bromoine; regulates the digestive function when it is necessary, and gives milk, iodine, acetate of soda, caffeine, with dry rubbing over the loins. These are most suitable for renal insufficiency in the aged. For that which supervenes the other grave disorders, especially the acute diseases, he recommends caffeine in large doses, or caffeine and digitalis, acetate of soda, honey of squills in diuretic decoction, warm baths, cutaneous stimulation, saline cathartics, dry friction over the kidneys and milk.

The author remarks that what may happen to nephritics may also happen to subjects of heart disease. In case of physical or intellectual fatigue or, if from any other cause, the renal function is required to be more active in the elimination of an excess of urea, of ptomaines, etc.; or if there are special local signs that signify a serious disorder of the kidneys, we can readily see that renal insufficiency would follow, as in analogous conditions there would be cardiac insufficiency. In one case there results a stasis in the circulation of the blood, in the other an accumulation of its noxious elements; consequently the functional debility, whether of the heart or the kidney, is aggravating, the effects multiply, and one organ, like the other, becomes paralyzed, providing life is not terminated before the grave and acute symptoms of paresis have been developed in them.—*La Mèdicine Moderne*, July 8.

2. *The Multiple Neuritis of Old People.*—In continuation of his studies upon this subject, Oppenheim (*Berlin Klin. Woch.*, No. 25) has just given some additional facts that are worthy of mention. He holds that the symptomatology, development and course of this affection present certain peculiarities that distinguish it from other forms of neuritis, and warrant its being classed as a special affection. He has had eight cases, of which six

were perfectly developed, and which he could study carefully for a long time. Of these six, five were men and one was a woman; the ages varied from 70 to 82; they had decided arterio-sclerosis, and were more or less emaciated, but not marasmic. There was a slow and gradual development, with impairment of the motility of the upper and lower extremities. The hands and the feet were especially attacked, but it was the fingers and the toes that were most often diseased. The affection was insidious, and pains were either lacking entirely or were very slight; but, on the contrary and almost always, the patients complained of paræsthesia, and especially of a very severe pruritus, but without any rise of temperature.

Physical examination showed that beside a general weakness, there was degenerative change, paralysis in the region of certain nerves of the upper and lower extremities, the small muscles of the hand were attacked, and with the lower ones it was especially those which were supplied by the peroneal and posterior tibial nerves. Usually the paralysis was not complete, but was sometimes more pronounced in the upper and again in the lower extremities. In one case the legs were exclusively attacked, while the sensibility of the muscles and of the nerves to pressure persisted, it was not very marked; the knee reflex was absent in all cases but one. The tactile sensibility, which was always lowered, was not so in the extremity of the limbs; hyperæsthesia was frequent, but there was not complete anæsthesia. There was no alteration in the cranial nerves, neither of the vesical or rectal function, and no ataxia; slight trembling that might be attributed to senile weakness. The gait was slow, and there was a tendency to remission of the symptoms. In two cases there was an improvement amounting almost to a cure. In the third it was very notable; in the fourth there was an aggravation of the symptoms, while the other symptoms remained the same.

The special peculiarities of this form of multiple neuritis in the aged are: (1) the absence of intoxication and infection as special causes; (2) the pronounced chronic nature of its development; (3) the absence or the slight importance of sensitive excitation, there being none or very little pain, and the sensibility of the nerves to pressure not being pronounced; (4) the imperfect development of motor and sensitive phenomena; for the troubles of motility rarely went so far as paralysis, and the anæsthesia

was very seldom complete; (5) the exemption of the cranial nerves from involvement.

Of these five peculiarities, Oppenheim considers the first three as the most important. They are met with in all decided cases, and justify the recognition of this as a separate disease. But this does not imply that the multiple neuritis of younger persons may not run a similar course and present a like array of symptoms. Such a thing is, however, extremely rare. It may also happen that old people shall have an acute multiple neuritis, with a violent excitation and all the symptoms that are developed from poisons or from infection.

We should not forget that with the comparative mildness of this multiple neuritis there is a tendency to relapse, and that the cause of it is arterio-sclerosis. From a therapeutical point of view, moist applications, the galvanic current, rest, and a moderate and substantial diet, with the use of wine, appear to Oppenheim to best fulfil the indications. (*Ibid.*)

3. The Absence of Agraphia in Hysteric Mutism.—This sign upon which M. Charcot formerly insisted as being constant and diagnostic, he now admits is possible, although exceptional, in the mutism of hysteria.

M. M. Ballett and Sollier have just published a remarkable case of the kind occurring in a woman of 33 years, who, at the same time, had another rare manifestation of hysteria, viz.: a facial paralysis that showed itself only when she attempted to speak. They therefore concluded that a well-defined agraphia may possibly occur along with the hysterical mutism. It seems to depend, not as where there is an organic lesion, upon a loss of graphic or visual verbal images, but simply upon a defect of the mental synthesis of these images which the act of writing makes necessary.—*Ibid.*

4. A New Theory of Cardiac and Respiratory Syncope from the Inhalation of Chloroform.—At the last meeting of the Paris Academy of Medicine, M. Laborde, the physiologist, demonstrated the fact that chloroform may occasion a primitive arrest of the heart's action, or of respiration, or of both these functions, through its immediate effect on the peripheric expansion of the trigeminal nerve upon the nasal mucous membrane. Having first placed an instrument (pneumo-cardiograph) so as to measure the heart

beats and the respirations, a tracheotomy was made on a rabbit, and a canula with a large opening was introduced. Through this a tube that carried the vapor of chloroform was passed. The contact of the vapor with the tracheal mucous membrane caused no irritation and had no influence upon the cardiograph; but directly a sponge holding chloroform was applied to the nose, the lever of the cardiograph stopped and the respiration as well as the circulation had ceased.

This and similiar experiments, which gave the same results, were undertaken to explain why, when M. Guérin, the surgeon, took the precaution to pinch the nose so that the patient must inhale the chloroform through the mouth and not through the nose at the beginning of anæsthesia there had been no serious consequences.—*La Semaine Médicale*, July 12.

5. *Laborde's Method in Asphyxia and Apparent Death From Various Causes.*—*La Tribune Médicale* for July 13 contains an unfinished article in which the author of this method cites a variety of cases in illustration of its wonderful efficacy in asphyxia of the newly born, and in that following attempted suicide with bromidia, from strangulation, persistent syncope, tetanus and apparent death from meningo-cephalitis. This new method, which was first presented to the Academy of Medicine by Laborde, July 5, 1892, consisted in seizing the tip of the tongue of the subject with the thumb and the finger and drawing it outward and then letting it recede regularly, fifteen or twenty times per minute. These tractions should be rhythmic and steady, but not too forcible nor too frequent, and may be continued for an hour or two. In extreme cases, hot, moist towels may also be applied over the chest. The author says: "I am convinced that the simple drawing of the tongue outside of the mouth in chloroform asphyxia, as has been practiced by surgeons for a long time with a view of opening and clearing the throat and preventing the tongue from being swallowed, may sometimes start the respiration; but in advanced asphyxia with apparent death, even after the use of chloroform, we must of necessity make repeated regular and persistant traction of the tongue if we would insure the desired result."

6. *A New Expedient in Puerperal Eclampsia.*—Dr. Bernheim's inaugural thesis which has just been published sets forth a method employed by Porak in his clinic at the

Lariboisiére. The treatment consists in the injection of sterilized water containing 7 grammes of the chloride of sodium to the litre. The injection is thrown beneath the skin of the gluteal region, which has first been made aseptic. Its temperature should be from 116 to 118° F. To facilitate the absorption of the liquid a light massage should be practiced about the needle during the twenty minutes or so that are required for the passage of about a quart of salt water into the circulation. These hypodermatic injections were tested upon eight patients in whom the urinary inadequacy indicated a very dangerous condition. Seven of them had convulsions and the eighth was attacked with uræmia in the form of dyspnœa. With all of them the injections of salt water had the manifest effect to increase or to reëstablish the urinary secretion, and after one or two injections to arrest the eclampsia, as well as the dyspnœa in the single case. Six of these patients were cured and two died; but the two deaths did not invalidate the claim of the treatment, because one of them entered the hospital in a desperate condition, while in the other, after the treatment had stopped the convulsions and restored the reason and the flow of urine, the husband, thinking that she was cured, insisted upon taking her home, where she died soon after.—*La Semaine Médicale*, July 2, 1893.

XXIII. SPINA BIFIDA; EXCISION OF THE SAC.—Dr. G. F. SHEARS. This condition as you know is a congenital one and due in all probability to an arrest of development of the symmetrical halves of the spine, they fail to meet and a gap is left which may extend through the bodies of the vestebræ, but which is commonly limited to the spinous processes.

Any portion of the spinal column may be affected but the lumbar vertebræ are more commonly the seat of trouble, fully fifty per cent of the cases of spina bifida occurring in this region; the larger share of the remaining cases being found in the lumbo-sacral or sacral regions.

As a result of the deficiency of the bone the membranes of the cord bulge through the opening, somewhat as a hernia is formed at the inguinal ring, and a tumor results.

The deficiency of bone is usually accompanied by a deficiency of the integument so that in most cases the membranes of the cord form the only covering of the tumor.

Tumors vary in size all the way from a walnut to that of a child's head and are filled with cerebro-spinal fluid.

This fluid may be continuous with the fluid of the cranium through an opening of the pia mater at the fourth ventricle. Sometimes the tumor contains only the membranes of the cord, a fluid and sometimes a portion of the cord protrudes, in the former instance it is designated as a spinal meningocele and in the latter a meningo myelocele.

The case which I have to report is of the latter character. It has the following brief history:

Case.—Child; age nine weeks, well nourished and perfectly formed in every respect except the condition of spina bifida. The tumor located at the lumbo-sacral region was twelve inches in circumference. About three-fourths of the surface of the tumor was covered only by the membranes, the upper fourth only being covered by the integument. For the last few weeks the child had been quite restless and irritable, the tumor had increased rapidly in size and the child had been afflicted with twitchings of the left side of the face and some jerking of the arm and leg of the right side. The increase of the nervous symptoms led the attending physician, Prof. Snow, to recommend prompt surgical interference.

The best method of treatment in these cases is still a subject of controversy; the results obtained by the most approved method of treatment have not been satisfactory and non-interference even less so. If left alone the tendency is to rupture of the sac. The tumor increases in size, the skin or membrane ulcerates, and the fluid is discharged, convulsions follow and death results. In a few instances in which the tumor is small and covered with skin, spontaneous cure may take place. If curative treatment is attempted a large percentage of the cases prove fatal.

The London Clinical Society, after a careful study of the subject and a collection of statistics, arrived at the following conclusions:

1. Notwithstanding many failures, the plan of treatment by injection is the best with which we are acquainted, and the only one which we feel justified in recommending.

2. A more careful selection of cases than has hitherto been made is necessary.

3. Marasmus, hydrocephalus and intercurrent diseases contraindicate the operation.

4. In cases in which the operation may nevertheless be legitimately performed, we should consider the follow-

ing as unfavorable circumstances: *a*. Distinct evidence of the cord being in the sac as shown by umbilication or a longitudinal furrow. *b*. A very thin membrane or ulcerated sac. *c*. Previous rupture of the sac. *d*. The occurrence of a distinct impulse between the tumor and the anterior fontanelle, or a sac, the contents of which are easily returned into the spinal canal. *e*. Very early age of the patient.

5. The best results are to be hoped for in children who reach the age of two months, in whom there is no paralysis or hydrocephalus and where the sac is covered by healthy skin.

The method of treatment as recommended by the Clinical Society is carried out as follows: The sac is cleansed and a few drams of the fluid removed by means of a fine trocar; through the trocar one dram of an iodo-glyce-rine solution is then injected. The puncture should be made at one side, and if possible through healthy skin, and not through the membranous sac-wall. The child should lie partly on its side and be kept as quiet as possible for an hour or so after the injection. According to the Clinical Society's report of seventy-one cases thus treated thirty-five recovered, twenty-seven died, four were relieved and five unrelieved.

Although my own observation and experience includes of course a limited number of cases thus treated, the percentage of cures has been very much less. The cases of meningo-myelocele die of convulsions within twenty-four or forty-eight hours.

The great probability that we had here a case of meningo-myelocele and the nervous disturbances present led me to believe that the plan of treatment by irritative injection could not but prove fatal, and to decide upon excision of the sac as the most favorable plan of treatment.

Accordingly then in the presence and with the assistance of Prof. Snow and Drs. Jessie E. Shears and J. L. Leffingwell, the tumor was excised. The incision was made round about the tumor in such a manner that the integument around the upper portion would form a flap; the membranes were carefully separated from the surrounding tissue until the aperture in the spinal column was reached. A catgut ligature was passed around the pedicle of the tumor and the sac excised. The child at once showed marked evidence of shock and failure of respiration. Artificial respiration was maintained during the completion

of the operation, and for fully half an hour afterward. Prof. Snow, who had charge of the patient, gives the following report:

Twenty-four hours after the operation the child had recovered fully, and for four or five days was bright and active. Upon the removal of the dressing at the fifth day the wound had entirely healed, except at the point of drainage, at which point serous fluid exuded, probably cerebro-spinal. Upon the eighth day this opening had entirely closed and the operation seemed a perfect success. I no-noticed, however, some bulging of the anterior fontanelle. About this time the child began to show an increase of the nervous symptoms noticed previous to the operation, and a slight rise of temperature followed.

The twitching of the arm and leg of the right side increased and on the fifteenth day symptoms of opisthotonos made their appearanne. The child took food readily, however, and its bowels moved naturally up to eighteenth day.

It died upon the nineteenth day, the opisthotonos having become severe and convulsions frequent. During the whole period the twitching of the arm and leg was confined to the right side.

The temperature from the fifth day was slightly above normal and on the morning of the sixteenth day reached 101°, its highest point, falling to 99° in the evening. There were no evidences of septic or pyæmic complications. An examination of the excised portion showed the presence of nerves of considerable size spread over the surface of the tumor.

Discussion. Several important questions were raised. Did the operation lessen the child's chances of life? Were the convulsions and opisthotonos which came on at the eighth day due to the operation, or were they simply the continuation of the symptoms observed previous to the operation?

Why were the twitchings confined to the right side of the body and the left side of the face if due to the pressure of cerebro-spinal fluid? Would the operation have been a success had it been made previous to the appearance of the nervous symptoms? Upon being asked his own opinion in regard to the questions, Dr. Shears replied that he did not believe that the child's chances of life were lessened any by the operation; that there was evident irritation of the brain previous to the operation of a localized

character; that the subsequent symptoms were merely a continuation of these, and indeed, for a time the operation seemed to have a beneficial effect. Why the left side of the face and right side of the body were alone affected he did not know, and a post-mortem examination was unfortunately not permitted. No one could say that the operation would have been successful had it been performed previous to the advent of the nervous symptoms, but the chances were in favor of an affirmative answer. That a number of successful cases of excision had been reported, but in most of the cases no mention was made of the presence or non-presence of the cauda equina in the membranes of the sac—a most unfortunate omission. Should he operate again for this trouble he would try the plan recommended by Bayer of opening the tumor on each side and loosening the cauda equina from the posterior wall of the sac and replacing it in the spinal canal.

Dr. LEAVITT: Was the ligature only temporary?

Dr. SHEARS: No; it was permanent.

Dr. LEAVITT: Could not the symptoms of collapse have been due to tightening of the ligature involving the *cauda equina?*

Dr. SHEARS: I set out to excise the growth, and I could do naught but ligate the stump. However, the child recovered entirely from these symptoms, and again on the fourth day, you will remember, the ligature loosened and there was an escape of fluid.

Dr. KIRKPATRICK: Might not those later symptoms have been caused by the involvement of nerves in the cicatrix?

Dr. SHEARS: We should remember that those symptoms were present prior to the operation. In operating on a similar case I should incise the membranes laterally, leaving the posterior surface on which the membranes rest, etc.

Dr. LEAVITT: In restoring this canal would you lessen the quantity of fluid?

Dr. SHEARS: Yes; a certain amount of the fluid will escape, which will not of itself cause death, as there are several cases on record where the sac has ruptured and the patient lived.

THE PRESIDENT: Do the spinal membranes heal as readily as the peritoneum?

Dr. SHEARS: I have not had so much experience with the spinal membranes as with the brain membranes, especially the dura mater, which heals very readily.

XXIV. AN ODDLY-LOCATED LIPOMA.—Dr. Shears also presented the specimen of a large, fatty tumor which he had recently removed at the hospital, the points of interest in the case being the location of the tumor, deep in the neck and adherent to the sheath of the subclavian artery instead of being subcutaneous, as is commonly the case; and secondly the resemblance of the fat to the layer fat which is found about the kidney instead resembling the ordinary lobulated fat.

XXV. A RARE CASE OF PEMPHIGUS.—Dr Jessie E. Shears presented the following case of pemphigus:

During the early part of the spring I found among the patients at a public institution to which I am the visiting physician, one who presented the following history: A Swedish woman, aged twenty-three years, a cook by occupation, about three days previously had complained of headache, teethache and violent pains in the small of the back and in all of the bones. The symptoms had gradually grown worse and at the time of my visit I found her with a temperature of 105° and a pulse of 120 beats per minute. There was also an eruption on the forehead at the roots of the hair. The spots were decidedly shot-like in appearance. This same eruption also appeared upon the wrists and dorsal surface of the hand, while upon the cheeks were a few large isolated spots about the size of a pea, formed of a hard, red base upon the top of which was a slight watery bleb. The patient could not tell when the eruption first appeared, but as it seemed to be in different stages of development I concluded that it was at least three days old and so far as I was able to determine this was the fourth day of the disease. I prescribed rhus tox. and belladonna and a mask of white cloth covered with vaseline for the face, to relieve the hot and dry feeling. On my second visit the temperature was 104 4-5° and the pulse beat 120. The pain in the head was very intense and the cervical glands were swollen. The older spots on the face were now filled with pus and began to run together. Spots were also appearing on the ankles and legs at irregular intervals and not following the line of any of the nerves. The tibia was very tender upon pressure. The same remedies were continued. On my third visit and probably the seventh day of the disease the eyes were almost entirely closed but there was profuse lachrymation and the whole face was badly swollen. At this point I called in counsel one who assured me that I had a case of *confluent small-pox*.

This startling diagnosis rather disturbed my confidence in myself for a time, and I called in another physician who had had experience in small-pox, and he agreed with me that the case was not small-pox, but rather a form of pemphigus. Inasmuch, however, as there had been a difference of opinion, and the members of the household had become alarmed, I sent for a health officer who gave the case a careful examination, and said that it was not small-pox, but refused to say what it was. It is a significant fact, however, that after he had been gone half an hour he returned, bringing with him some vaccine points with which he offered to vaccinate the inmates of the institution. This precaution I had already taken on my first visit. On the eighth day the symptoms remained about the same, and the eruption took on a crust-like formation on the face which subsequently came off and left a purple surface. On the ninth day the temperature dropped to 102° and the pulse beat was 120. A few isolated spots appeared on the abdomen, but the general condition of the patient showed a gradual improvement until on the fourteenth day the temperature was subnormal, and continued so for two months; after which time the patient passed from under my care, but I was told that there was a renewed outbreak of the disease in a less violent form.

I have called this case pemphigus, but I am aware that it presents many anomalous symptoms, and for this reason have thought that it might be of interest. Among the difficulties encountered in making a diagnosis in such a case is the impossibility of obtaining a satisfactory history of the invasion of the disease in order that the patient may be saved from the pest-house; and at the same time that his fellow patients may be saved from exposure to small-pox if so serious a disease is present.

Hospital Notes.

THE OBSTETRICAL CLINIC.

SERVICE OF PROF. HONBERGER.

The case before us to-day is a primipara 23 years of age. She has been in the hospital for the past ten days. Her labor began about eight hours ago, the contractions at first being rather light and coming at intervals of twenty to thirty minutes. They have gradually increased in strength and duration and for the past three hours have been quite severe, and now they recur every four to five minutes.

By examining the vulvar structures we find them covered with a peculiar secretion, which serves to lubricate the canal. This is the usual condition of the parts during labor and is one of the distinctions between true and false labor pains, as during false labor pains the vulvar and vaginal surfaces are as a rule comparatively dry. The thin structure which you see stretched across the posterior surface of the vaginal orifice is the fourchette which in this case is quite marked. It is usually torn during the first labor at full term and becomes absorbed.

Continuing our examination a little further we find the cervix fully dilated. This marks the end of the first stage of labor and also the beginning of the second stage. Your cases may not all run along so smoothly as this one has; the first stage may terminate more quickly; and again you will be more perplexed with those cases in which the first stage is more prolonged, lasting sometimes from twenty-four to thirty-six hours, and the cervix may then not be fully dilated. You will be tempted to interfere and try to assist mechanically, but unless your subject is extremely weak and exhausted you should patiently wait, and the cervix will usually go on and dilate naturally. In these prolonged cases the contractions are usually not very frequent and not long lasting, coming on perhaps only once in twenty to thirty minutes, so that the patient can bear them for some time without becoming greatly exhausted.

In the case before us the sac containing the waters has

not yet ruptured, and the liquor amnii is still retained, but we will now rupture them with the finger nail. This should always be done during a contraction when the sac will be found bulging through the open os, thus avoiding any injury to the fœtal scalp. The waters will now partially escape and cause the uterus to contract more firmly down upon the fœtus, and more readily force the head into the pelvic cavity.

This case would go on and terminate naturally, without the aid of forceps, but in order to demonstrate their application we will now apply them to the head, which still lies high up at the superior straight, in the first position of vertex presentation, *id est* with the occiput looking forward and to the mother's left. The blades having first been thoroughly cleansed and well lubricated, and the patient put under the influence of an anæsthetic, we always introduce the left blade first so that they will readily lock. With the head lying in this position we can easily apply the blades to the sides of the head, with the point of the blades looking forward, and thus avoid the trouble of removing and reapplying them. Remember and never make an attempt to apply the forceps with the point of the blades directed backward, for you could not properly adjust the blades to the head, and you would be very liable to injure the maternal soft structures. The blades now being introduced and locked, press the handles together just firmly enough to keep them from slipping upon the head and make traction at first in a downward and backward direction, so as to draw the head in the line of the pelvic axis. This is an important point, as many failures to draw the head into the pelvis are due to the fact that traction is made far too anteriorly, directly against the symphysis pubis instead of in the axis of the pelvic brim. When the patient is not anæsthetized traction should always be applied during uterine contraction and thus simply assist nature; but when your patient is under the influence of an anæsthetic, as this one is, make your traction at intervals simulating those of the uterine contractions, and carefully draw the head well down to the vulva. This you should remember must not be hastily done, for if the vagina chances to be narrow, as it is in some cases, you may cause a rupture of its walls.

The vertex now being well down into the vulva, the traction must be made in an anterior direction at almost right angles. You can complete the delivery without

removing the forceps, providing they are squarely upon the sides of the head, so that the edge of the blade does not come upon the perineum; but if they are applied somewhat obliquely, one edge would naturally rest upon the perineum, and there would be danger of its cutting the distended tissues. In the latter case you can deliver the head by removing the forceps, inserting two fingers into the rectum, and hooking them under the child's chin, which you can readily reach. By this means you have perfect control of the head. By drawing on the chin you can readily force the head through the vulva. With the thumb of the same hand upon the vertex you can prevent its too rapid expulsion, and at the same time keep it well up into the pubic arch, thus relieving the perineum. If the head does not readily come through the vulva, pressure upon the fundus uteri will greatly assist you. Now as the head is about to be expelled from the vulva, you should take plenty of time and allow the parts to become thoroughly dilated, gradually working the head through in the intervals between the uterine contractions Just at this stage I prefer to have the patient entirely under the influence of chloroform, for the case is much more easily controlled than when there are forcible contractions.

I wish to impress upon your memory the importance of bringing the head through the vulvar structures very slowly, for that is where the young practitioner, as well as some of the older ones, err. Supposing that they must hasten the completion of the delivery as rapidly as possible, they do not give the soft structures sufficient time for expansion, and the result is a laceration of greater or less degree, depending somewhat upon the size of the fœtal head, but more especially upon the rapidity with which it passes.

After delivery of the head it is well to gently wipe the secretions from about the eyes, and if the mouth is filled with it, a small piece of absorbent cotton on the finger may be used for its removal. Next examine the neck, and if the cord is found wound about it one or more times, slip it over the head, providing the cord is long enough to do so, but if not slip it over the shoulder and allow it to uncoil about the trunk of the fœtus as the body passes.

The shoulders now remain to be delivered. The same care should be exercised here as with the head, not to allow them to pass with too much haste, as they are nearly as liable to tear the perineal tissues as is the head. If the

trunk does not readily come down into the vulva, you can introduce one or two fingers into the posterior axilla and draw upon it while making pressure on the fundus from above. As the shoulders are about to pass keep them well up to the pubic arch by means of firm pressure, until after the elbows have passed, for if the arms are flexed and the elbows slip through with a sudden jerk they may lacerate the perineum even after the head and shoulders have safely passed. The elbows being delivered the balance of the trunk will readily pass without injury.

As soon as respirations are thoroughly established the cord may be cut. It has been my practice to wait a few moments until the pulsations in the cord become somewhat weakened, then, respirations being good and regular, I tie the cord about three-fourths of an inch from the umbilicus. Give the child to the nurse who should be instructed to wrap it up warmly, and leave it until the mother is cared for. The uterus must not be forgotten. Its fundus should be followed down by your hand, or that of the nurse, and carefully watched from time to time to see that the organ does not relax and become filled with blood, thereby endangering the life of your patient from internal hæmorrhage.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

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

DRAINAGE OF THE UTERINE CAVITY AS A CURATIVE RESOURCE.—At the clinic on Wednesday, July 26, the following remarks were made: I have several times directed your attention to the importance of surgical drainage in chronic uterine affections, but there are some points that remain to be considered. The case before us is suggestive in this regard. You may perhaps ask why, with women who stand erect, the natural drainage of the internal generative organs is not sufficient? It would be if they did not spend one-third, or perhaps more, of their time in bed; if they dressed properly and were especially careful to avoid constipation and to enforce the proper menstrual and puer-

*Continued from page 328.

peral quarantine. Their bad habits often predispose them to uterine affections that are characterized and kept up by inadequate uterine and tubal drainage.

The tendency of the uterus to fall forward or backward, and to remain in an acquired and abnormal position, interferes with the escape of post-menstrual and other secretions that become mischievous when they are retained. I am satisfied that most of the benefit derived from replacement of the uterus and keeping it in position by stems and persaries, tampons, the postural treatment, etc., should be ascribed to the fact that the erect organ, whose axis is restored and retained, can discharge itself freely and all the while of its noxious, not to say nasty contents. We shall place an Albert Smith pessary for this patient, not only with the hope and expectation of lifting the womb into position and of relieving the intra-pelvic and sacral pressure, and the embarassment of the local circulation, which are necessary conditions of cure in her case, but also with the intention of draining the whole generative intestine.

Her clinical history is typical of that of thousands of other chronic invalids. After her last labor, four years ago, she had some sort of puerperal inflammation in consequence of which the milk was suppressed as soon almost as it came. She was confined to her bed for weeks, but had none of the modern safeguards against septic infection, no trained nurse, or doctor either, for that matter. As a natural result there was subinvolution of the womb with a crippled condition of its ligaments, little or no drainage while she remained in bed, and dilapidation that was already chronic as soon as she had left it. Being poor she was obliged to be upon her feet, which but for the inveterate displacement would have brought relief; and so matters have grown worse until she has sought a remedy at our hands. We will first try the effect of this pessary, which can be followed by the application of an intra-uterine drain of some kind such as the tube, the gauze, or Chéron's capillary drain of the silkworm gut.

THE MALIGNANT TENDENCY OF CERTAIN UTERINE FIBROIDS. —When a solid uterine tumor that has been of slow growth suddenly increases in size you may reasonably infer that it has commenced to undergo some form of degeneration. And if this comparatively rapid change is accompanied by a decided loss of flesh and by an increased tendency to local suffering with nervous irritability the chances are that the

tumor is becoming, or has already become, malignant. The first signs of a cachexia, especially at or after the climacteric, will sound the alarm. They tell of threatening danger and warn us against any further delay in the resort to radical measures.

It is quite as important to recognize these symptoms early and to act promptly as it is the case of the initial symptoms of cervical cancer. For, whether the growth becomes cystic or sarcomatous, it soon acquires the habit of malignancy. The integrity and firmness of its tissues are transformed; its juices are infectious; its surfaces become adherent to other organs through a vicious form of peritonitis; its veins become large and tortuous and the worst kind of complications are more or less rapidly developed.

The possible sarcomatous transformation of a primitive and benign fibromyoma should always be borne in mind; and you should remember, too, that, instead of giving exemption from such a possibility, the menopause may predetermine this unfortunate result. For, whatever lowers the vitality of the growth and lessens the general resistance against the inroads of disease increases the risk of such a change. This is the reason why the removal of the ovaries for the relief of an incidental menorrhagia, as practiced by Battey, did so little good in most cases and was decidedly mischievous in others. It precipitated the climacteric, but it left the tumor behind to undergo a destructive metamorphosis that was even more to be dreaded than the monthly hæmorrhage.

VAGINAL HYSTERECTOMY *versus* CERVICAL AMPUTATION IN UTERINE CANCER.—In uterine cancer not only does the safety of the patient depend upon an early diagnosis, whenever we are consulted in season, but it often hinges on the choice of an operation. Here is a case in point. Only a short time ago this woman was operated upon for a suspicious disease of the vaginal portion of the cervix. It was amputated by a local surgeon as high as possible in the hope of getting rid of the whole difficulty; but in a month the hæmorrhage and all the old symptoms had returned in a more aggravated form.

While it is probable that those who advocate a partial removal of the cancerous uterus, whether by the galvanocautery, the écraseur or the bistouri, will not be induced to change their views or their practice, it is equally true

that the total extirpation of the diseased organ promises the best results. But this statement should be qualified; for very much depends not only upon experience and dexterity in operating, but also upon a resort to the radical operation at as early a date as possible. Whatever causes delay increases the risk of a final resort to complete extirpation. I am forced to content myself with a thorough curetting of this uterus because, not only has the cervix been excised at a level with the vaginal roof all the way around (except that there is a fragment of the anterior lip), so that I cannot seize it and draw it down; but the peri-cervical tissues are infiltrated and indurated, while within the orifice are encephaloid masses that bleed severely on the slightest touch.

Now that we have removed all the brain-like tissue, washed away the *débris* and arrested the hemorrhage, you can see that there is a cavity into which one might put a large lemon. We proceed to fill this cavity with iodoform gauze. What is left of the uterus is a mere husk that it would be impossible to extirpate, and which, while it remains, is a menace to the health and welfare of our patient. So that, without reflecting unkindly upon those who did what seemed to be best in amputating the cervix, we can not help wishing that they had resorted to the more serious and satisfactory expedient of a complete hysterectomy. Anything less is of the temporizing kind, and cannot be conservative, for while a scrap of the uterine tissue remains the disease will almost certainly recur; and when the cervix only has been ablated and a few months have elapsed, it may be impossible, as it is in this case, to give the patient the benefit of an operation to which she was justly entitled at the beginning.

POST-MENSTRUAL PERITONISM AS A SEQUEL OF TUBO-OVARIOTOMY.—There is a manifest tendency to disregard the possible effects of precipitating the menopanse by a removal of the uterine appendages in young and middle-aged women. For there are fashions in surgery, just as there are in medicine and millinery. This patient, who is only twenty-five, plump, vigorous and married, had the cervix amputated fifteen months ago for a supposed cancerous affection. Ten months later both ovaries and tubes were taken, the body of the uterus being left. The operations were skillfully performed by a friend of mine in a distant city, but, although she looks so well, she is "worse

off than before they were made." The uterus, minus its vaginal portion, is healthy and mobile, and there is no cachexia and no leucorrhœal or menstrual flow; but she complains of a constant pain in the inguinal regions, especially in the left one, and of indigestion, with bloating and distension of the abdomen. Her form has changed, and as you percieve, there is a decided resonance on percussion all about and above the abdominal cicatrix.

This is a condition of *peritonisme*, or of pseudo-peritonitis that has been described by Gubler, Terrillon and others. It is sometimes developed by the presence and pressure of abnormal tumors, especially if they are old and in the way of degeneration; during the after-treatment in ovariotomy, hysterectomy, etc., and particularly in nervous subjects, in consequence of menstrual interruptions and irregularities. In this case it is due to the sudden and complete arrest of the catamenial function by a removal of the ovaries and tubes, during active menstrual life; and this bloating of the abdomen is the counterpart of a menstrual tympanitis, a form of meteorism that is very common in hysterical women. It depends, we are told, upon a peculiar irritation of the solar plexus, which irritation is reflected to the nervous centres; and in such a case as this, becomes serious only through chronic, exhausting, inflammatory or malignant complications. The nervous and mental symptoms are related to the abdominal distention just as they are in the delirium of typhoid fever.

By my advice the galvanic current was carefully applied every alternate day for a fortnight. At first it seemed to relieve the pain somewhat, but afterward it had the effect to bring on an offensive vaginal discharge, such as she has not had before, and to increase her suffering. She is wretched, nervous and very much discouraged. If we knew what lesions were actually found at the two operations we might form a better opinion of the case, prognosticate its outcome, and prescribe for her much more intelligently. However, I have such confidence in terebinth 3 that we will give it to her every four hours. If the oviducts and the uterine cervix were intact, and if she had ever been subject to a leucorrhœal flow, we might resort to drainage, but that is out of the question now.

Clinical Reviews.

A COMPENDIUM OF MATERIA MEDICA, THERAPEUTICS AND REPERTORY OF THE DIGESTIVE SYSTEM. By A. R. McMICHAEL, M. D. Heavy cloth, $6.00.

This is one of the triumphs of the bookmakers' art, and Bœricke & Tafel never placed their imprint upon a finer volume. It is indeed an *edition de luxe*, and the book lover, as he slowly turns the heavy polished leaves, cannot help but let his fingers linger upon them with an almost caressing touch. We note with pleasure that an improvement in the quality of medical books has been taking place in many directions, and it is sincerely to be hoped that this will continue, for there is no reason why a medical library should not be as attractive as any other.

In the preface the writer says: "To make a work of this nature practical it was deemed advisable to exclude all symptoms of a drug which have not been verified by cures, and although some may consider this a fault, the majority will agree that while the material excluded may be found in the pathogenesis of many provers, until symptoms have been verified by cures they not only encumber but confuse." If this logic were rigidly carried out there would not be a single verified symptom in the materia medica to-day. Hahnemann's own provings would be a dead letter, inasmuch as they would still be waiting for verification before they could be used. But credit should be given the compiler in not attempting too much in a work of this kind, for the comparative study of drugs is the aim and end of it, and not encyclopædic instruction. The same matter is arranged in two parts, one of which consists of its tabulation in columns designated as stomach, appetite and thirst, mouth and teeth, nausea and vomiting, flatulence, stool, rectum, abdomen, hypochondria, umbilicus, hypogastrium, concomitants, clinical. The second part consists of a repertory of the first part, by which the reader is referred to the drug in its tabulated form. The amount of "fat" is such that the heart of the compositor must have danced for joy. That this compendium, although it embraces but a single anatomical sys-

tem, will be of help to many, goes without saying. There is no royal road for instruction in materia medica; it is hard, laborious and slow. But some persons are so constituted that they can accomplish more by one method than by another. It is the old story of how castor oil was taken by the last generation; the vehicles in which it was more or less submerged had their strenuous advocates who declared that it couldn't be tasted, while others acting upon these recommendations found the odor and taste not disguised for an instant. Thus it is that the different forms under which the materia medica is presented find many who are enabled to assimilate it in some way better than in others. No matter how multifarious these methods are, if they conduce to a better, a more comprehensive knowledge of it, they have served their purpose in making more thorough prescribers than otherwise would have existed.

The publishers announce that they will send specimen pages to those desiring them. C. H. E.

HYSTERICAL OR FUNCTIONAL PARALYSIS, By H. CHARLTON BASTIAN, M. A., M. D., F. R. S. President London Neurological Society, etc., J. B. Lippincott Co., Philadelphia, 1893, pp. 200.

As the busy physician's scapegoat, hysteria flounders as "deep in the mire as malaria in the mud."

There appeared in the *Lancet* last year, four lectures on the various forms of hysterical or functional paralysis creating much interest and exciting much favorable comment, with the result that we have on our table, those original lectures somewhat elaborated, more fully developed and enriched by the addition of several very interesting cases.

The paralyses are divided into two great classes, those of the cerebral type and those of the spinal type. Appended to each of the subdivisions of each class are from one to eight cases, illustrative of that functional lesion under discussion. This is succeeded by the treatment employed and the results, thus supplementing the theoretical exposition by the clinical applications which is the scientific and modern method of teaching.

Notwithstanding the number of cases introduced and the minute detail, the methodical arrangement is such that at a glance, one may single out that for which he searches.

As a valuable nucleus for and stimulus to modern research in this difficult branch, this book graces a niche hitherto unadorned. O. L. S.

CORRESPONDENCE.

LONDON, ENGLAND, July 26, '93.

Dear Dr. Ludlam:

According to my promise, made before leaving, I write to let you know something of the situation here. The work at the Golden Square Throat Hospital, made famous by its founder and supporter, Sir Morell Mackenzie, is proving eminently satisfactory. There are few students in attendance, but a large number of patients, who come every afternoon and two evenings in the week.

Each surgeon is a man of note, and whose writings we are accustomed to read in the laryngologcial journals. Among them are Drs. Norris Wolfenden, Greville MacDonald and J. W. Bond. Each one teaches independently of the others, and as is so commonly the case, their opinions differ somewhat concerning the cases.

The greatest courtesy has been shown me, and every opportunity given to treat and operate upon patients.

Methods seem to have changed somewhat since my former visit, and in the direction of being less radical. But they nevertheless fall far short of the speedy cure of diseased conditions as compared with our combined therapeutic and mechanical treatment. I am more than ever convinced that the local and surgical treatment *plus* internal medication, is far better than the former alone. The lack of careful attention to reflex conditions has seemed particularly noticeable in comparison with our present minute search for the remote causes of obscure disease.

As an illustration I give the following:

Case:—Sarah J——, aged eighteen, comes with total aphonia (spasmodic.) Her mother reports that for several years she has had these spasmodic attacks.

When spoken to suddenly or unexpectedly by strangers, or even her own family, her voice leaves her utterly. But many times after the lapse of a moment or two she can speak in monosyllables, provided she first moves her leg. Her health has been unusually good; she has never had chorea or fits of any kind, but does suffer from amenorrhœa.

This case is particularly interesting, as coming so recently upon the discussion in our Clinical Society of the various functional nervous disorders. But I am sorry to say that it was allowed to go without any special question-

ing or search for what I believe to be the underlying cause of the trouble, while the local laryngeal condition was carefully noted and prescribed for.

I believe that I am safe in saying that this case could be entirely cured by referring her to a competent gynecologist; and I have noted several examples of similar reflex troubles.

I shall endeavor to note interesting points as they arise, for possible future discussion.

Very truly yours,

C. GURNEE FELLOWS.

Miscellaneous Items.

The new Hahnemann College building is ready, and in first-class order, for the in-coming Class, while the inside work of the new Hospital, with a capacity for 225 beds, is being pushed to completion as rapidly as possible.——Dr. F. Parke Lewis' excellent essay on the "Hysterical Eye" has arrived in season for the meeting of the Clinical Society, and after its presentation and discussion will appear in the CLINIQUE.——Prof. Bailey has returned from Glenwood Springs, Col., where he has been spending a short vacation in that ideal summer and winter resort in the heart of the Rocky Mountains.——*Apropos* of Colorado, we have three other items: Our late excellent House Physician, Dr. J. L. Alexander, has located in Denver; ditto, our good friend Dr. S. S. Kehr (as an eye, ear, nose and throat specialist), and both have offices in the California Building; and the Denver doctors old and new are already preparing for the Institute meeting in June next.——Students and physicians who visit Chicago, and who care to, are kindly invited to look in upon the clinics at the "Old Hahnemann," of which information can be had at any time by calling up telephone S. 104 ——Prof. Crawford suggests a variety of Agaricus, the *A. phalloides*, as a new homœopathic remedy for Asiatic cholera.——Hurrah for the new and beautiful flags on the new College building, of which ready and royal edifice our hospital friend "Toney," is the *concierge*.——Prof. Cobb is about to remove the dispensary and the out-clinic from the old hospital into the new College, which will be its future home.——Prof. Halbert's lecture on Urethritis, Specific and Non-specific, is crowded out of our present issue, and Prof. Arnulphy's report on the Heart Affections of Pregnancy came too late for insertion in its proper place, but both will keep for another month.

THE CLINIQUE.

VOL. XIV.] CHICAGO, SEPTEMBER 15, 1898. [No. 9

Original Lectures.

URETHRITIS, SPECIFIC AND NON-SPECIFIC.

A LECTURE BY H. V. HALBERT, M. D., CLINICAL PROFESSOR OF VENEREAL AND SKIN DISEASES IN THE HAHNEMANN COLLEGE AND HOSPITAL, OF CHICAGO.

The terms gonorrhœa and urethritis are synonymous. The latter is, however, more comprehensive, including, in the medical nomenclature, all nonspecific inflammatory conditions which invade the urethra.

Gonorrhœa, though etymologically inacurate, is generally employed to designate a specific contagion, and, as this form of attack is most frequent, it has by common usage become incorporated into medical literature as typifying all urethral inflammation with the characteristic urethral discharge. This is hardly correct. Gonorrhœa is really urethritis, but urethritis is not necessarily gonorrhœa. The disparagement of the terms is settled only by the history of the exposure and the microscopic test, though the study of the disease is essentially the same in either case.

In consideration of our subject that form of the disease which has priority of occurrence is first taken up.

Gonorrhœa is a specific urethritis. It is pronounced specific because its origin is due to the particular microbe known as gonococcus. It is therefore virulent and auto-

innoculable. There are exceptions to the microbe theory, yet the most persistent microscopists and specialists are rapidly accepting the same as the most positive and plausible cause of this pernicious disease.

The clinical features of the disease are divided into (1) acute inflammatory stage, (2) subacute or catarrhal stage, (3) the terminal or gleety stage.

It may be well to state at the outset that no genuine case of gonorrhœa is incited except from sexual exposure to the virus of the same kind. After a period of two to five days the acute inflammatory symptoms appear. A prickling smarting irritation is first felt at the orifice of the urethra. The meatus presents a slight, sticky discharge which renders the lips adherent, especially in the morning at first attempt to urinate. Voiding of the urine is soon affected with more or less stinging pain, the patient often describing the flow as a discharge of hot water. The meatus swells rapidly and is surrounded by an inflammatory areola. The apex of the gland becomes puffy and the orifice is nearly occluded by the rapidly increasing tumifaction. Pain extends along the pendulous portion of the urethra and the whole canal is sensitive to the slightest pressure. Sympathetic pains radiate through the groins, testicle, perineum, along the cord and to a certain extent in the sacral and lumbar region. The prostate and seminal vesicles are easily disturbed and painful involuntary emissions are frequent. As the inflammation progresses erections are severe and painful. The prepuce becomes excessively œdematous and phimosis and paraphimosis are common.

The urine now scalds the passage during micturation, giving the symptom known as "ardor urinæ." This is caused by the salts of the urine coming into contact with the inflamed mucous membrane, and also by the distention of the swollen mucous membrane of the urethra.

By continuity the inflammation reaches the trabeculæ of the erectile tissue of the corpus spongiosum; the exuded lympth fills its meshes so that excessive blood for erection

cannot enter the spongy body without severe pain and flexure of the organ. This accounts for the symptom known as chordee. When the inflammation reaches the deep structure of the urethra there is considerable vesical tenesmus and frequent urination which may ultimately lead to pronounced cystitis.

Balanitis is a complication of the first stage due to the inflammation extending over the outer surface of the glans. This is generally due to want of cleanliness.

Balano-posthitis is due to the inflammation involving the inner or mucous lining of the prepuce.

The second stage is recognized when the inflammation has involved the whole urethra and reached its deeper structure. It generally occurs at the end of the first week. The primary symptoms are now pronounced and the discharge is augmented and more pus-like in character. The urethral mucous membrane, being thickened by the inflammatory exudation, gives the stream of urine a forked or dribbling appearance, and often painful detention is due to the spasmodic contraction of the muscular fibres. This is in reality, the most critical stage of the disease and is liable to the most faulty treatment. The anxiety of the patient to be relieved from the increasing discharge and the spasmodic pain often cause the physician to lax in his judgment and resort to extreme stringent measures. It is important to check the flow before it permanently involves the deeper urethral structures and the allied organs. It is also equally important to be conservative enough in the treatment not to aid the formation of a stricture in the prostatic sinus.

Peri-urethral and follicular abscesses are liable to this stage. The suppuration involving the loose connective tissue about the urethra may give the former, and the same occluding the follicles may convert them into pus pockets or follicular abscesses. These may open either internally or externally.

Lymphangitis is frequently found in the lymphatics of the dorsum of the penis and is due no doubt to unclean-

ness about the prepuce. If this is not quickly arrested the induration generally extends to the groin and a gonorrhœal bubo is the result. The termination of this complication is variable. If it involves only the superficial gland and if it is treated promptly, speedy resolution follows. But if the deeper gland and the subcutaneous tissue is affected, and above all if the patient is of a scrofulous tendency, a provoking and unhealthy suppuration ensues. The glandular and periglandular tissue will often remain indurated for a long time, requiring strict surgical and medical attention, which, at best, do not relieve for a long time.

In three or four weeks, as the course of gonorrhœa nears the final stage, there are liable to be other complications which baffle the physician and retard the recovery. These are cowperitis, prostatitis and cystitis. The first two are generally allied, though cowperitis precedes the prostatitis.

In Cowperitis one or both glands may be involved, and it is observed by the painful tension of the perineum, being increased by the sitting posture or by any pressure. Upon palpation a pyriform tumor, about the size of a bean, with its base toward the rectum, is felt. If the swelling includes the surrounding tissue great pain is experienced in the region of the transverse muscle of the perineum which limits it. In this stage it resembles a perineal abscess and will require relief by the knife. If the suppuration tends anteriorly it may break into the urethra, causing, by the urinary infiltration, an ugly fistula.

Prostatitis is a complication more to be feared. It is the frequent result of prolonged gonorrhœa. When the gonorrhœal inflammation reaches the prostatic urethra it invariably extends backward into the follicles of the posterior lobe of the prostate. A decided sensation of weight and perineal pressure are first experienced. The engorged gland pressing upon the neck of the bladder renders urination difficult, frequent and painful. The stream is diminished in size and retention is common. Defecation

causes marked spasmodic pains and a rectal examination reveals a heated, enlarged and throbbing gland. Unless a speedy resolution follows, the inflammation spreads to the surrounding tissue, giving rise to the most excruciating pain during urination or defecation, and even forbids the standing or sitting position. Should the inflamed follicles coalesce, suppuration, attended by pronounced febrile symptoms, will be the result. The pus will discharge into the urethra or rectum, giving thereby immediate relief of acute symptoms. The evacuation into the urethra is the more favorable. The hyperplasia of the cellular tissue leaves the prostate in a condition of chronic inflammation, which by no means yields rapidly to treatment. Attending this there is almost always a mucoid urethral discharge having its origin in the follicular structure of the prostate. This is discharged mostly by deep pressure or the evacuation of the bowels, and thereby differs from the gleety flow.

Cystitis appears when the inflammation reaches the sphincter of the bladder. It may occur in the acute or first stage of gonorrhœa, but it generally accompanies or follows the prostatic involvement. It is often spoken of as prostato-cystitis, inasmuch as there is always some prostatic inflammation so long as the bladder is affected. The symptoms presented are frequent urination with tenesmus but with no retention; severe burning pain not affected by defecation nor relieved by urination; the size of the stream is normal but the last few drops are turbid or mixed with blood. All of these symptoms are generally observed during the middle or terminal stage of gonorrhœa.

In the third or final stage, epididymitis is a frequent occurrence. It is due to the metastatic inflammation or the sympathetic attraction. Preceded by neuralgic pains there is rapid enlargement of the testicle. By immediate care and perfect rest it may escape induration, which is a perplexing condition. Should induration however, continue, the seminal tubes are more or less occluded and stirility, temporary or permanent, attends the atrophy of one or both glands. The left testicle is more frequently affected on account of the pressure of the sigmoid flexure

upon the left spermatic vein and because the vein enters acutely into the renal vein.

Gonorrhœal rheumatism, or better post-gonorrhœal arthritis is incident to the final stage. It is possible to occur in any stage. It is the result of septic absorption though it is often identified with syphilis. There will be a diminution of the discharge, sudden but slight febrile disturbance and pain in and swelling of the knee, ankle, wrist or elbow. The duration is inconstant. It is distinguished from ordinary rheumatism by the lack of febrile and constitutional symptoms.

Gonorrhœal ophthalmia is often a sequela of the septic infection while gonorrhœal conjunctivitis is the result of inoculation. These conditions belong decidedly to a special department.

Gleet characterizes the final stage. It is virtually a chronic gonorrhœa. The discharge is muco-purulent or "milky." It escapes only by pressure, and is observed mostly at the meatus in the morning. It comes from the congested mucous membrane behind a stricture.

Simple urethritis is differentiated from gonorrhœa by the history of the case. It may arise from exposure to leucorrhœal discharge, from acrid secretions of the bladder or the passage of calculi, from the use of the catheter or even from a severe cold, or the protracted use of stimulants. It may also be secondary to proctitis, prostatitis or cystitis. Under the microscope the discharge does not reveal any sign of micrococci. Its course is generally of shorter duration than gonorrhœa and the attendant symptoms are not so violent. It is, nevertheless, in some instances, persistently intermittent, and for that reason a favorable prognosis is many times disappointing.

When it is the sequence of the above mentioned diseases the discharge will never be stopped until the cause is removed. For that reason the consideration of simple urethritis is more naturally relegated to the causative disease and the immediate treatment differs from that of gonorrhœa only in degree.

(*To be continued.*)

Clinical Society Transactions.

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

AUGUST MEETING, 1893.

The regular monthly meeting was held in the Great Northern Hotel, Saturday evening, August 26, the President in the chair. After the transaction of routine business and the election of Dr. O. L. Smith to the post of Recording Secretary, the society heard and discussed the following paper:

XXVI. HEART DISEASE AND PREGNANCY.—BY B. S. ARNULPHY, M. D. It is hardly customary for girls engaged to be married to take the family physician's advice with a view to ascertain the feasibility of such a step. And even if such were the custom, it is greatly to be feared that few young ladies would abide by the advice, if the latter chanced to be adverse to their yearnings. I have no fault to find with the poet who discovered that "matrimony" happily rhymes with "honey," but if clinical evidence and the post-mortem tables are credible witnesses at all, we must admit that however mellifluous the circumstances under which the young woman goes into the venture, she runs a great risk in so doing, if she be not endowed with a stout and whole heart.

The community at large had better know that no young woman ought to marry and bear children whose heart is not sound, however favorable the general appearances may be, as dangerously near to the "honey" lies a deadly sting.

Now, we find here and there in the best works on obstetrics some vague reference to organic heart disease as a complication of pregnancy and parturition.

On the other hand, the special works on "Heart Disease" contain very scant information on the subject, if any.

No wonder then if the general practitioner and the average obstetrician and gynæcologist know little about the mutual bearings of heart disease and pregnancy.

Still there has accumulated within the last few years quite a voluminous literature concerning this most interesting chapter of woman's pathology; in fact the mere

enumeration of the books and pamphlets published in that connection would take up a few pages of the CLINIQUE. I therefore thought that a succinct presentation embodying the practical and valuable points brought to light by so many researches, would be acceptable to this society.

Now let it be well understood that the object of this paper is not to enter into the discussion of the many theoretical views which have been propounded, anent this subject by numerous and able authors.

We live in a busy age. What our practitioners mostly need is a few precise statements, representing the condensed experience of trustworthy observers, passed through the sieve of a careful analysis.

The clinical material which I have examined is extensive, but I took good care only to admit as evidence those cases on the intrinsic worth of which there could be no doubt. And I can assure you that it requires a great deal of discrimination to do that.

Now to the point.

The first query is: *Does pregnancy really exert a special influence over the heart?*

Undoubtedly it does. How could it be otherwise when the constitution of the blood of the pregnant woman is so characteristically altered? We know that while the proportion of the water is augmented that of albumen is diminished, and that while the fibrin seems to be on the increase, the proportion of hemoglobin falls decidedly below normal. So that we have an increase of the mass of the blood, outwardly manifested by a sort of deceptive plethora when the real condition is one of hydræmia, with an impoverishment of all the constituents of the blood, mineral and otherwise.

We conceive that such a defective condition of the blood is capable of creating *alterations of the myocardium.* That such thing is possible has been demonstrated experimentally. Leopold Perl having subjected a few dogs to a systematic loss of blood, found after awhile the heart of the animals affected with fatty degeneration. Likewise that such changes occur in the course of profound anæmia is a well-established fact.

Now the changes which occur in the blood of the pregnant woman are slow and progressive, and are brought to a natural stop by the advent of delivery.

So that while the healthy heart may go through pregnancy without the slightest evidence of discomfort, there is

nevertheless created at the time being, a tendency to enfeeblement of the vital resistance of the myocardium. This would show itself in the way of a slight dilatation of the heart chambers, and if we bear in mind that the total mass of the blood is increased, as well as the sum of the vascular resistances, on account of the uterine and fœtal development, we cannot fail to see that some corresponding changes must occur in the heart chambers in order to accommodate the larger blood-wave which is made to course through them.

True enough the heart might propel a larger quantity of blood in a given time by simply quickening its pace. But it does not choose to quicken its pace.

I have spoken of increased vascular tension. This is more especially evident toward the latter months of pregnancy and has been repeatedly measured by careful sphygmographic tracings. This exalted tension must be felt somewhere in the heart, and met by some additional muscular tissue. That the responsibility for this change is assumed by the left ventricle is made apparent by the hypertrophied condition in which it is generally found at the end of pregnancy.

Ever since Larcher (1857) drew the attention of the medical world to that variety of cardiac hypertrophy a host of workers have been busy in the endeavor to confirm or invalidate the statement.

Time and space forbid my giving even a short synopsis of the controversy. Suffice it to say that it is pretty generally conceded nowadays that some degree of hypertrophy is usually present, though Larcher rather overrated its extent and frequency.

But this hypertrophy is far from being constant. And I am free to say that it would be surprising if it were constant. We must bear in mind that these functional modifications are supposed to take place within the bounds of physiology, that they will vary *ad infinitum* according to the degree of soundness and resistance of the myocardium. In some cases the physiological changes will be hardly noticeable, in other cases they may reach the pathological limit. Anyhow, with regard to many of the phenomena presented by the organism of pregnant women, it is always hard to determine where physiology ends and pathology begins.

Now there is another aspect to the question. We notice during pregnancy some remarkable nutritional modi-

fications. How shall we explain, for instance, the tendency to hypertrophy exhibited by various organs? The thyroid gland, the liver, the kidneys, the adipose tissue, not to speak of the mammæ, increase in size. Osteophytes appear on the cranial bones. Pigmentations show themselves at the skin.

And these phenomena of hyper-nutrition take place *while the blood becomes more and more impoverished.* Would it not be rational to suppose that the development of the uterus creates in the trophic centres a sympathetic incitation, the influence of which is diffused at large, and such being the case, may not the heart also be brought under the influence of the trophic wave which sweeps over the pregnant organism?

It may happen, however, that these nutritional modifications overstep the physiological limit and give rise to decided morbid changes, following the trend of some acquired or hereditary taint.

Thus it is that we encounter *cases of endocarditis, spontaneously developing* in the course of pregnancy with all their possible consequences as we will see later.

It is also probably owing to the same cause that we see old endocarditic lesions, that have been slumbering for years, flare up into activity again, ready for further mischief.

From the foregoing considerations we would conclude that pregnancy does really exert an influence over the heart; influence partly of a trophic character, partly due to exalted function, resulting in slight general dilatation and partial hypertrophy. That these changes should be wrought at a time when the myocardium is ill-nourished by a poorer blood, and when the strain put upon its driving power is steadily added to by the rising vascular tension, appears unfortunate.

No doubt a thoroughly healthy heart will go through the process several times without any appreciable damage. But the question arises: is there not danger that a weak, though not positively diseased heart, might develop some irreparable lesion? Such I believe to be the case, and clinical evidence is not wanting.

The second query is: *If the heart of the pregnant woman be diseased is it exposed in the course of pregnancy, or at the time of labor, or in the lying-in period, to any particular danger?*

Here again the answer comes with no uncertain sound.

That the pregnant woman with a diseased heart is exposed to danger from more than one quarter cannot be doubted. Such is the verdict pronounced by men of the highest authority, abroad and in this country; among them I shall cite Olivier, Germain See, Peter, Charcot, MacDonald, Friedreich, Spiegelberg, Lebert, Virchow, Cohnstein, etc. It is also gives me pleasure to mention the excellent thesis of Dr. Ch. Porak, of Paris, a comprehensive work from which I have derived valuable information.

A most excellent feature of Dr. Porak's work is a collection of eighty-eight cases in point gathered from the most competent writers and best observers, and the inferences to be derived therefrom are of a highly interesting and practical character.

From a careful study of those cases, and a number of others, as well as from similar instances in my own practice, I am enabled to lay down the following conclusions:

The nature of *gravido-cardiac* accidents, by which felicitous expression, Dr. Peter, of Paris, means the accidents to which the pregnant woman is exposed through concomitant heart disease, *ranges from the slightest functional disturbances to the gravest organic alterations.* In the first category we notice palpitation, syncope, cardiac dyspnœa without any pulmonary complication, dizziness, occasional attacks of pseudo-angina pectoris.

A marked tendency to congestion is observable in almost all the organs, but is unquestionably most pronounced in the lungs. These pulmonary congestive spells are frequently mentioned in the collection of cases above referred to; they occur quite suddenly, and when accompanied by œdema of the lung they assume an extremely serious appearance. Hemoptysis and pulmonary apoplexy are noted among the consequences.

In a measure as pregnancies follow each other, or as the heart muscle gradually fails to keep up the struggle, the character of the accidents becomes more threatening. Not a few of those cases die with all the symptoms of asystolia, before the last pregnancy is over. A larger number succumb during the strain of labor or shortly afterward.

I have frequently been consulted for alleged pulmonary difficulties occurring in the course of pregnancy, when in a goodly share of the cases the trouble was grounded in some cardiac lesion *that had been entirely overlooked.*

Those cardio-pulmonary outbreaks characterized mainly

by the abrupt onset of cough and dyspnœa, coupled with rapid, unruly action of the heart, sometimes acquire an extreme gravity.

Even when life is spared, the prognosis remains uncertain and gloomy, as the heart only recovers its balance with difficulty after the storm, and there is great danger that it may not be able to cope with the strain of labor.

I have distinct recollection of a case in point which I shall relate here.

Mrs. A. C., twenty-four years of age, an extremely bright young woman, and the wife of a distinguished Parisian lawyer, had had chorea when a child, and an attack of subacute rheumatism at the age of nineteen. She belonged to an arthritic family and her father had succumbed to diabetes. She married at twenty-one and one year after was delivered of a child, which however, did not live more than a few months. A few troublesome symptoms had attended this first pregnancy, an occasional spell of palpitation, of dry cough, and slight dyspnœa on exertion. That was all. No physician had been called in, and the accoucheur never suspected any heart trouble.

I first saw the patient at the fifth month of her second pregnancy, two years afterward. She had been suddenly seized with terrible cough and dyspnœa, the result of an ordinary cold. There was a scant, rosy expectoration. The fever was slight. On auscultation, the lungs exhibited a shower of fine moist bubbling râles, and on examining the heart, I found in spite of its tumultuous action, a pretty loud systolic murmur, clearly discernible in the axillary region. I rendered the diagnosis of mitral insufficiency and pulmonary congestion, but I was rather young and the symptoms were hourly growing worse, so I called in counsel.

Aconitum and phosphorus, supported by digitalis, gave her immediate relief, and she apparently recovered, but she remained weak; she would become breathless on even very moderate exertion; the lower extremities slowly were invaded by œdema.

One day, presumably toward the end of the eighth month, labor set in. The patient soon fell in a sort of semi-conscious condition, the integument being cold and slightly cyanotic. A venous pulse of the jugular became plainly visible. We directed the accoucheur to effect instrumental delivery as soon as the dilatation of the cervix would permit, which was well and speadily done.

The patient seemed to rally, after delivery, but all the signs of pronounced asystolia set in and the third day she died. The child had only lived two days.

The husband requested a post-mortem and we found the heart considerably enlarged. The mitral valve was puckered up, incompetent; the right ventricle much dilated; the myocardium as a whole was pale and flabby; the lungs exhibited the lesions of chronic congestion and œdema.

In another class of cases, fibrinous clots or vegetations detached from the valves are washed into the blood current, producing characteristic embolic symptoms, such as hemiplegia, with or without aphasia; also various organic infarctions, or splenic, renal and pulmonary embolism.

No doubt many of the cases of sudden death in the course of pregnancy that have been reported, are due to that mechanism.

I shall never forget the case of Mrs. O. B., the young and charming wife of a schoolmate of mine. She was in the sixth month of pregnancy, apparently enjoying the best of health, when one morning while at the breakfast table with her husband, and in the midst of a merry conversation, she suddenly uttered a feeble cry and collapsed. She was dead. It was shown at the autopsy that a good-sized vegetation had plugged the basilar artery, thus bringing life to a sudden stop.

The young woman had had scarlet fever when 17 years of age; the natural inference being that some endocarditic trouble had been set up at the time, which, after a period of latency had received a fresh impetus from pregnancy with the sad result just cited.

Still, from a careful perusal of all available cases bearing on this point, we must conclude that some of the cases of sudden death are really due to rapid degeneration of the myocardium. In fact it is remarkable to see how frequently a more or less advanced condition of *fatty degeneration of the myocardium* has been noticed in the post-mortem reports I have investigated.

Unfortunately while some observers make a careful note of the condition of the myocardium in their reports, the majority of them, through an oversight much to be regretted, totally omit any reference thereto, so that the question remains obscure. But in my estimation the marked gravity of which the gravido-cardiac troubles bear the impress, are closely connected with those degenerative tendencies.

And this view is, after all, in strict keeping with the best teachings of cardiac pathology. It is always on the assumed condition of more or less integrity of the myocardium that we base our prognosis in the appreciation of any given case of valvular difficulty, no matter what the lesion be; as long as the heart-muscle remains unimpaired, and evinces vitality enough to accommodate itself to the mechanical resistances, the outlook is far from gloomy.

Another thing I have observed, which, from a prognostic point of view is worth verifying. It is a well-known fact that on a notable percentage of pregnant women, it is possible to detect a soft, systolic murmur, generally audible over the base of the heart. This murmur can in most cases be followed up in the cervical arteries, and there is but little doubt that it is of a hæmic nature. No particular significance attaches to this sign. But I am satisfied some women exhibit a murmur resembling very much the one just cited, also systolic and soft in character, but not propagated into the cervical vessels, and besides best heard over the ensiform region and slightly propagated to the right and upward.

This murmur, not easily discriminated from the hæmic murmur above, I consider to be due to a relaxation, possibly to an alteration of the right ventricle. There is some *slight tricuspid regurgitation* in these cases, mostly of a functional character, perhaps. Nevertheless, such are the cases, which, when labor sets in, exhibit the venous pulse at the neck, and which are liable to be taken off, either during the latter part of labor or shortly after.

Another element of prognosis, which now seems pretty well understood, is especially related to the seat of the valvular difficulty.

The prognosis varies according, as the lesion is one of the mitral or of the aortic valves. Also as the mitral lesion is one of stenosis, or of incompetence, or of both combined. Therefore, it is not indifferent to know the relative frequency with which the various lesions are observed.

The following figures may help form an idea of the relative frequency of these lesions:

Mitral insufficiency,	22 cases.	
Mitral stenosis,	13 "	57 cases.
Both lesions combined,	22 "	
Aortic insufficiency,	9 "	
Aortic stenosis,	2 "	13 cases.
Both lesions combined,	2 "	
Mitral and aortic lesions,		22.
Combined (complex lesions),		

It plainly appears from these figures that the mitral lesions are much more frequent among pregnant women than aortic lesions.

In this connection it gives me pleasure to refer to an interesting communication which Dr. Ludlam presented to this society in May, 1880 (The CLINIQUE, Vol. 1, No. 6). It was a brief review of a French monograph upon "The Greater Comparative Frequency of Stricture of the Mitral Orifice in Women than in Men," by Dr. Mary A. Marshall, of Scotland, a graduate of the Paris School of Medicine. Out of 508 cases of mitral stenosis, 158 were shown to have occurred in men, and 350 in women, making thirty per cent for the former and seventy per cent for the latter.

One of the conclusions cited runs thus and deserves to be remembered as bearing directly upon our subject:

"In the case of women, the prognosis in endocarditis is much graver than it is with men, on account of this special tendency to stricture of the left auriculo-ventricular opening; and the danger is still greater if the woman is pregnant, a fact of which those who are seized with this affection should be notified."

Commenting upon the subject, Dr. Ludlam stated at the time that he was prepared to refer this lesion, in a large share of cases, to the cardiac changes consequent upon menstrual derangements and upon pregnancy.

But to return to the relative prognosis of the various lesions.

If statistics prove anything, it would appear that the mitral lesions aside from being more frequent, are also more to be dreaded.

Aortic insufficiency is always a serious thing, of course, because it involves a danger of sudden death; but it is comparatively rare among women. Aortic stenosis is more favorable.

As to the mitral lesions, the consensus of opinion is that pure insufficiency, if slight, is pretty well tolerated. It is different, however, if the leakage is pronounced. In such case the pulmonary accidents are sure to develop. The prognosis is worse still in the case of pure stenosis; admixture of stenosis and insufficiency would rather aggravate matters, and the worst happens when complex lesions exist, that is mitral and aortic lesions coupled together. *The more complex the lesion the worse the prognosis.*

The following chart gives, we think, a pretty good idea of the relative influence of the various cardiac lesions on the march of pregnancy:

	No. of cases.	Pulmonary complications.	Asystolic disturbances	Premature expulsion of fœtus.	Aggregation during subsequent pregnancies.	Death.
Aortic lesions	13	5	3	6	6	3
Mitral insufficiency.	22	15	1	13	11	3
Mitral stenosis.	13	6	5	9	8	8
Stenosis and insufficiency. (mitral.)	22	9	3	22	8	10
Complex lesions.	22	3	8	21	12	11

In order to give still more precision to the behavior of the gravido cardiac complications, I invite your attention to the following figures and facts, derived from the 84 authenticated cases as related by Dr. Porak.

Out of 84 cases:

- A stationary condition is noted - - - - - 21 times.
- Aggravation during pregnancy - - - - - 55 "
  - " temporarily - - - - - - - 4 "
  - " permanently - - - - - - - 51 "
- Labor has aggravated condition - - - - 11 "
- Amelioration after delivery - - - - - 22 "
  - " rapid - - - - - - - - - 13 "
  - " slow - - - - - - - - - 9 "
- Death has ensued - - - - - - - - - - 31 "
  - Before labor - - - - - - - - - - 5 "
  - During labor - - - - - - - - - - 2 "
- During lying-in period - - - - - - - 25 "
- After momentary amelioration - - - - 8 "
- Through progressive aggravation - - - 17 "

So that to sum up:

A stationary condition is observed - - - -	in	25%	of the cases
Aggravation during pregnancy - - - - -		65%	
Death - - - - - - - - - - - - -		38%	
Amelioration during lying-in period - - -		26%	

These are striking results indeed, but I am inclined to believe that they rather make the picture darker than it really is, as it would seem that the cases from which these figures are derived are of a somewhat unusual severity.

However that may be, it must be conceded that there is in such an imposing array of facts a weighty lesson for us to learn and to act upon.

The third and last query is: *Is the fœtus affected by the cardiac lesion of the mother?*

Here again we are constrained to answer in the affirmative.

There is plenty of clinical evidence that the various forms of cardiac affections are liable to exert a marked disturbing influence over the development and the fate of the fœtus.

1st By causing a strong tencency to metrorrhagia.

2d. By bringing about abortion or premature confinment, or the death of the fœtus.

3d. By exerting a bad influence on the health of the child.

Remarkable alterations of the placenta have been found in a goodly share of the cases of metrorrhagia, abortion and premature confinement, whenever the observers have been thoughtful and thorough enough to look for such and I need not point out the interest which a comprehensive study of that question, so little known yet, would present. Here is a good clinical hint brought out by that clever observer, Duroziez: A tendency to recurring metrorrhagia during pregnancy, or the *persistance of the period* ought to draw the attention of the attending physician to the condition of the heart. Most of the time it will be found diseased.

I would suggest that it is better still to examine the heart of all pregnant women; let the family physician clearly understand that such an examination ought to be made in every case, as much can be done if heart trouble be present to lighten the bad consequences afferent thereto by proper management.

In closing, I shall now proceed to formulate a few practical conclusions:

1st. No woman affected with chronic heart disease ought to contract marriage.

2d. It is the strict duty of the physician to strenuously dissuade from marriage under such circumstances.

3d. Such patients as are already married ought to be warned of the danger resulting to them from child-bearing, and such as are found pregnant or in childbed ought not to be allowed to suckle their children, as that seems to increase the risks arising from the defective heart.

These conclusions are clearly in the line of prophylaxis and hygiene, the true aim of medicine.

In this instance, as in so many others, a piece of timely advice avails more than the best skill of the therapeutists.

It would be difficult to estimate how many women lose their lives yearly through the causes referred to in this paper, but the number must be large considering that cardiac diseases are admittedly on the increase, and that considerable carelessness, to put it mildly, prevails among the profession with regard to the subject I have endeavored to study before you.

DISCUSSION.— Dr. LEAVITT: I always feel well repaid for attendance on the meetings of this society, but I feel doubly compensated this evening for the effort which I made to be present. The essayist of the occasion has given us an unusual treat. He has considered at length a subject, which, as he truly said, has been greatly neglected by the makers of medical literature. So deeply has he gone into it, and so carefully has each feature been brought out, that I dare not trust myself to enter upon an extended discussion of the paper for fear of mere iteration of what what has been better said. There is one phase of the subject, not considered by him, which I wish the scope and design of his paper had been made to include, viz.: The use of anæsthetics during labor in the case of women suffering from cardiac lesions. I hope he may, at no distant date, give us his ideas concerning the relation of cardiac lesions to parturition and the puerperium.

My observation of women suffering from pronounced ailments of the character mentioned, during pregnancy, has been limited. To be sure I have had a few cases. Among them I recall one, which fell to my care eight or ten years ago, wherein the symptoms were most alarming when the patient first came under my observation, at about the seventh month of gestation. The precise nature of the lesion I am unable now to recall. Suffice it to say that the woman was found in a state of general œdema, scarcely able to rise from her bed, and greatly distressed. It was a case in which death appeared to be inevitable. Labor came on within a day or two, and the woman was delivered of twins, the second one presenting transversely and requiring to be turned. The children were poorly nourished, and survived but a few days. The mother sank and died within forty-eight hours.

I have recently delivered a woman the second time, who has from early childhood suffered from pronounced mitral insufficiency. She is the daughter of well-known residents of this city. The case became mine the first time owing to the convenient absence of the family physician, a prominent practitioner of the old school, and one who has been professor of obstetrics in a Chicago college. I gave the patient close attention, and facilitated the labor in every rational way. When well into the second stage I terminated the parturition by means of the forceps. The family physician had said, in speaking of the approaching confinement, that he would not dare to administer an anæsthetic, and hence I did not urge the use of this commonly welcome agent of relief. The child proved to be well nourished, and the mother made an excellent recovery. The family reverted to the customary medical care at the close of the puerperium, and I knew nothing of the second pregnancy till about the time I was called to the labor, which again fell to me because of a second absence of the family physician from the city. This labor progressed about as did the first, and was terminated in a similar manner, but this time under anæsthetic influence. The family now owns me for a physician, and I occasionally see the lady, who appears to be in comfortable health. According to her statement her condition is much improved over that which antedated the first pregnancy.

The essayist has adverted to the frequency of abortion in such subjects. Out of 220 cases collected by Courréjol and Porak, 128 only were delivered at term. The mortality arising from pregnancy complicated by pronounced cardiac lesions may well be seen from a collection of 92 cases of endocardial lesions made also by Porak, thirty-five of which terminated fatally.

Dr. ORRIN L. SMITH: I am heartily glad to have listened to this interesting and instructive paper. In my reading I remember the statement that the pulse-rate of the pregnant woman was the same, whatever the posture, lying, sitting or standing. I should like to ask the essayist if his observations or research confirms this statement, and if so the explanation of it.

Dr. R. LUDLAM expressed his thorough appreciation of Dr. Arnulphy's very clever essay. The conclusions reached are sound and practical. But it sometimes happens that, as the gynecologist is placed at a disadvantage

in not knowing the puerperal history of his patient; so the obstetrician may fail to estimate the clinical significance of heart disease during pregnancy, because he is not always familiar with the previous medical history of the case. There are many examples of obscure and neglected heart disease that are aggravated by pregnancy, and which are sometimes attributed to it as a first cause; but, if a woman has had some form of heart trouble prior to conception, the accompanying lesion is not properly speaking gravido-cardiac. If she had already been subject to rheumatism, or to renal disease, pregnancy might act as an exciting cause.

And, remembering the close relation between all serious heart and kidney affections, the detection of a cardiac lesion in a pregnant woman suggests the probability of renal mischief as a coexisting complication. For the same altered conditions of the bodily fluids and solids which are consequent upon pregnancy, and which the essayist has so graphically described as predisposing the pregnant women to heart affections, make her liable also to renal embarassment and disability. If the cardiac physiology is peculiarly interesting and worthy of study during gestation and the lying-in, so also is the renal physiology and pathology of that particular period.

The possible coexistence of heart and kidney affections suggests that the use of an anæsthetic during labor may sometimes be very harmful. It absolutely precludes the safe use of ether whenever we are uncertain as to the integrity of the kidneys, and remands us to the cautious employment of chloroform. No doubt many of these cases have died from the remote effects of ether when it had been used regardless of the renal overwork and inadequacy.

The relapsing character of gravido-cardiac affections and their recurrence with subsequent pregnancies is equally pronounced and imminent in gravido-renal disorders. The type of acute Bright's disease that is incident to pregnancy sometimes repeats itself with the birth of every child in the family, and is not any more likely to be associated with dropsy and convulsibility than with some form of heart disease. And the singular feebleness and mortality of infants, as well as the tendency to abortion which has been ascribed to cardiac troubles in the mother may sometimes be due to uræmia, and urinary mischief.

I am aware that these remarks are not strictly within

the scope of the paper, and that the essayist has not spoken of the kidneys in gestation because the heart was his theme, and he has stuck to it, which is a rare merit of his paper; but these two classes of affections are so closely akin as to be almost inseparable, in pregnant women especially. If we can associate them in our minds as intimately, the lesson of this hour, as the good people say, will not be lost upon those who are present, neither upon those who will read the report of the evening in the CLINIQUE.

In reply to Dr. Smith's question, it gives me pleasure to state that, at a meeting of this society eleven years ago, I presented a condensed translation from the *Archives de Tocologie, des Maladies des Femmes*, etc., for June and July 1882, in which a Dr. Jorissenne published twenty-four cases in illustration of this subject.*

Dr. J. gives full credit to Dr. Graves, of Dublin, who first published this sign of pregnancy in Volume I. of his Clinical Lectures in 1848.

DR. ARNULPHY closed the discussion as follows: I desire to add a few words to the remarks that have been made by some of the members. While I feel gratified at the expressions of commendation to which they have given utterance, I readily confess that there are many important points, directly related to the subject under examination, which I left in the shade. I did so knowingly, *first*, because if I had intended to cover the whole ground this paper would have attained uncomfortable proportions; *second*, because the points involved are far from being settled in the minds of the best authorities on such matters.

Take the question of the application of anæsthetics for instance. We find that while MacDonald, whose work on the subject of pregnancy and heart disease deserves to be cited as a standard one, is distinctly of opinion that chloroform can be given if proper precautions are taken; that he gave it in several cases presenting serious cardiac symptoms and with satisfactory results; on the other hand authors equally reliable, take a very different view.

So I said nothing about it, confining myself to laying stress upon such statements as are supported by good clinical evidence.

Likewise having found no satisfactory document with regard to the influence exerted by pregnancy over exoph-

*See the CLINIQUE, Vol. III. pp. 387-90, 1882.

thalmic goitre, I thought it best not to mention the subject. Here again we find authors at variance. Charcot and Iaccoud think that the neurosis is favorably affected by pregnancy, while Robert Lee affirms that it is thereby aggravated. I also neglected to make any reference to the complication arising from the pericardium, as out of many cases reviewed, I was unable to find a single one in which any pericardial involvement was noted.

We would therefore almost be justified in presuming that the pericardium enjoys a quasi total immunity in the course of gestation; still we heard one of the speakers awhile ago relate a case in which the signs of severe pericarditic trouble with effusion and subsequent death were made apparent.

I fully concur in what Dr. Ludlam has said about the role played by the kidneys. No one who has made the heart a study can for a moment afford to disregard the reciprocal bearing of the kidney and the heart. Important as it is at all times, this mutual relation acquires a peculiar significance during pregnancy and, no doubt, still more so, when the heart is diseased.

We can easily conceive how renal trouble, either primary or dependent upon a valvular difficulty, may seriously affect the blood dyscrasia, already much altered, as we have seen, during pregnancy.

But we ought not to lose sight of those placentary alterations, to which I have referred, alterations which while they can plausibly be considered as resulting from the defective action of the heart and the afferent vascular disturbances, are manifestly instrumental in compromising the health and life of the fœtus.

In closing, I would like to impress upon the minds of our students and young practitioners how necessary it is for them to devote more care and attention to the study of the modern methods of physical diagnosis. Without such help the whole field of practical medicine must ever remain for them like the shifting sands of the desert. Take the subject brought under discussion to-night. How can one who has not been thoroughly trained in auscultation and percussion give an intelligent answer to the young woman who would ask: Doctor, is it safe for me to marry?

Remember that there may be a murmur, or more, over the præcordium, palpitations and pains about the heart, without there being any serious cardiac trouble, such as would preclude marriage.

Such murmurs may be of hæmic nature, or even exo-cardiac. How shall an untrained ear discriminate between an organic and an unorganic murmur?

And even where an organic murmur is suspected, how shall the seat, the degree and the complexity of the many valvular lesions be appreciated, the true condition of the cardiac muscle recognized, its measure of resistance and its vital capacity, as it were, correctly gauged?

The conclusion would seem to be that our colleges ought to offer the best possible advantages to the students with a view to foster the study of physical diagnosis, and that the students ought to be wise enough to improve every possible opportunity offered them in that direction.

It has always been the policy of the "old Hahnemann" to give the students a good drill in that important part of their medical education, and as far as I am concerned, I can promise that I shall make a strong effort to render that study as efficient and thorough as possible, a task which the facilities afforded by our new buildings will considerably enhance.

DR. O. L. SMITH,
Recording Secretary.

VOLUNTEER PAPERS. XXVI. CLINICAL CASES BY DR. HOWARD R. CHISLETT.—The following cases I bring before the society because they are both rare and interesting. They are taken almost word for word from my case book and I offer them to you without further comment:

CASE 1. EXCISION OF THE LOWER JAW.—Mr. William B., age 42 years; American. *History:* First noticed a swelling of the lower jaw fifteen weeks before his entrance to the hospital. The swelling enlarged rapidly and soon necessitated the extraction of the molar teeth of the left side, as the soft tissues were forced directly over them, and so rendered eating both painful and difficult. During the last two or three weeks the growth has been even more rapid, but unattended by severe pain.

Examination.—A firm rounded tumor, apparently *in* the bone and extending from the angle of the jaw on the left side to the cuspid teeth on the right side. Diagnosed as sarcoma of the bone, and excision advised.

Operation.—Vertical incision along the posterior border of the ascending ramus from the level of the lower border of the left ear to below the angle of the jaw; a trans-

verse incision beginning at this latter point, running just beneath the bony margin of the jaw and terminating at the right lateral incisors, a second veritical cut passing completely through the thickness of the lip joining the transverse incision at right angles at its point of termination. The flap thus formed was dissected up, laid back upon a towel and covered with sterilized compresses. Separation of the soft structures from the under surface of the jaw by means of scalpel and blunt dissection, the tongue being controlled by means of a strong silk suture passed through its tip and intrusted to the care of an assistant. Preserv-

FIGURE 24.

ing all of the mucous membrane possible, the dissection was continued until the tumor was separated from the surrounding tissues. A chain saw was then applied just beneath the articulation on the left side and at the second bicuspid tooth on the right side. Attachments of temporal and pterygoid muscles separated and the roughened ends of the remaining fragments smoothed by means of bone forceps. Suture of mucous membrane with fine silk completely shutting off the oral cavity from external wound. Suture and drainage of external incisions and a moist antiseptic dressing applied. (Fig. 24.)

Result.—Recovery. The patient now (one month after the operation) is able to talk distinctly and can swallow easily. There is no sign of recurrence thus far.

Remarks.—The tongue was held out of the mouth for twenty-four hours by pinning the ligature to the dressings.

The patient was fed for the first week by means of a tube passed through the nostril.

CASE 2. LAMINECTOMY.—Mr. W., age twenty-seven years; American. *History.* Gunshot wound; particulars not ascertained, but the patient entered the hospital about an hour after the accident.

Examination.—Wound of entrance in right infra-scapular region, the direction apparently being forward and inward. The missile passed through the right lung, as evidenced by pain in that organ, accompanied by cough with bloody expectoration. There was no external evidence of injury to the spinal column, but *complete loss of sensation and of motion below parts supplied by the seventh dorsal nerve.* Retention of urine, and obstinate constipation. I watched the patient closely for several days and being unable to determine from the history whether the paralysis was immediate, or whether it came on after an interval, decided to operate.

Operation. A straight incision extending from the fourth to the eighth dorsal spines. The soft tissues were separated carefully, and the posterior arches of the fifth, sixth and seventh dorsal vertebræ were removed with a chisel and bone forceps. The seventh arch was the first removed, and disclosing nothing, we then removed the sixth one. Increased mobility of the spine at this part made us suspect a fracture of the body; but there was no displacement, and no pressure. The fifth arch was then removed, and the cord and its membranes, exposed thoroughly for a distance of three vertebræ, appeared typically normal. No hæmorrhage, no laceration, no pressure from displaced fragments of bone, none from enlodgment of the bullet. Wound sutured, and drained for twenty-four hours.

Result.—Wound healed by first intention; no amelioration of symptoms. Death four or five weeks later from septicæmia, in consequence of bedsores and pulmonary abscess.

Remarks.—As it was a coroner's case, we were not permitted to make a post-mortem examination, but the verdict was: Fracture of the body of the sixth dorsal vertebra, and "*slight softening*" of cord opposite to that bone. What is spinal concussion?

CASE 3. EXCISION OF THE SACRUM AND COCCYX.—

Mr. M. L., age forty-eight years; Pole. *History.* Has had considerable pain in the sacrum and extending to the hypogastric region and the buttocks for the past eleven months. Soon after the pain began he noticed an enlargement of the parts which has continually increased. There is some difficulty in voiding urine; considerable pain, and occasionally a discharge of blood. There is a marked inactivity of the rectum, and a movement of the bowels, even with an enema, is extremely painful. For some weeks the pain has been sufficiently intense to prevent natural sleep.

Examination.—A pronounced and somewhat angular enlargement of the sacrum externally, reminding one at first sight of the "chicken breast" deformity of rachitis. Almost complete obliteration of the normal sacral curve by examination through the rectum. Extreme sensitiveness of the parts to manipulation. General appearance anæmic. Temperature ranging between 99^2–100^2. Everything considered I believed we had to deal with an osteomyelitis of the sacrum and coccyx, and determined to excise the diseased parts.

Operation.—Incision from posterior superior spinous process curving to median line and terminating just below the tip of the coccyx. The soft tissues were dissected back on both sides of the incision, and exposed a large sarcomatous mass which had practically replaced the sacrum, being covered on its posterior surface with the merest shell of bone. The coccyx was excised, and from below upward the sarcoma with its shell of bone was removed with scalpel and scissors. Only once was it necessary to use the chisel, the bone having so completely disappeared. The dissection was continued until within a short distance of the upper portion of the ileosacral articulation, where we had to stop (short of perfect removal) lest the connection between spine and pelvis be entirely destroyed. The sarcomatous tissue extended through the spinal canal of the upper sacral vertebra, and probably to the lower lumbar ones. The dissection exposed the rectum for four inches. It was perfectly healthy externally. The soft tissues which were manifestly diseased were removed with forceps and scalpel, the cavity packed with iodoformized gauze, and the wound sutured with interrupted sutures of silk.

Result.—Immediate reaction fairly good, but of course, the growth will recur.

Remarks.—The increased temperature was due to a suppurative degeneration of the growth at its centre.

CASE 4. NERVE STRETCHING.—Mr. P., age twenty-four years; American. *History.* Three weeks before entering hospital he fell down some steps, striking upon the shoulder and arm with such force that he feared the arm was fractured. Since the fall the arm has been useless, and has caused considerable pain and much annoyance by the continual burning in the hand.

Examination.—No fracture. The arm markedly swollen and ecchymosed, especially on the inner side of arm near the axilla and on the posterior surface of the forearm near the elbow. Total paralysis of parts supplied by musculo-cutaneous median and ulnar nerves. There was also "wrist drop" but the radial distribution of sensation was good. Slight glazing of skin, and nails a little roughened; no depilation.

Operation.—Exploratory. Free dissection of axillary and brachial regions, through a five inch incision, disclosed perfectly normal nerves. Cut down then upon the median and posterior interosseous nerves in the forearm, finding them also normal. Thorough stretching of all exposed nerves. Wounds sutured without drainage.

Result.—Primary union of all incisions, but the only benefit was in regaining flexion of forearm.

Sept. 14.—Saw the patient to-day, the first time in four weeks, and am pleased to note a partial return of the powers of extension and pronation. The sensation too is markedly improved, the glazed appearance lessening.

Remarks.—The operation was undertaken in the hope of finding some crushed or lacerated nerves which I might help by resection and suturing. There may have been such an injury could we have dissected the arm for the full length of the injured nerves, but as we selected the parts which seemed to have sustained the greatest harm and found such negative results, I am inclined to the belief that the mischief was higher up; possibly at the exit of the brachial plexus from the spinal column.

Hospital Notes.

THE THROAT AND NOSE CLINIC.

SERVICE OF PROF. C. GURNEE FELLOWS.

By C. J. Swan, M. D., Alternate.*

Of thirty new cases received into this clinic during July and August, five were suffering from hypertrophy of the pharyngeal tonsil. Of these four were females, and all but one of the five were under eleven years of age. The exception was a woman of thirty-six, the mother of two girls of ten and twelve years respectively, each of whom had hypertrophy of the faucial tonsils, but the vault of the pharynx was quite free from adenoid enlargement. Two of the five cases suffered from ear complications due, no doubt, to the pharyngeal conditions; and one was too young to properly respond to a test for hearing, being but three years old.

The adult case, Mrs. H., was referred to me by Prof. Watry, she having been under treatment for some time for chronic catarrhal otitis. Rhinoscopic examination revealed a post-nasal catarrh depending upon marked enlargement of the Luschka's tonsil. The space between the soft palate and the posterior pharyngeal wall was broad and the throat not sensitive. The examination was therefore easily made, and discovered a red nodulated mass in the very vault of the pharynx, extending down a little on each side, filling Rosenmüllers fossa and making contact with the well-defined cartilagenous ring which surrounds "the trumpet-shaped orifice of the Eustachian tube.*"

(Growths of this nature are not frequently found in adults as at the age of puberty atrophy usually begins in all three tonsils, until at the age of thirty they are scarcely apparent. Meanwhile, of course, the patient's health suffers from their presence).

The patient being of a non-neurotic temperament and quite courageous, it was decided to begin the operation at once without local or general anæsthesia. It is a difficult matter in any case, to successfully anæsthetize that part of the throat, not because of its sensitiveness, but

*Dr. Swan had charge of this Clinic during Prof. Fellows' absence in Europe.

on account of its location. The gland itself is not well supplied with sensory nerves and if the attention of the instrument is confined to the glandular structure, there is very little pain.

For the operation, the patient sat opposite me in the usual position, with the head-mirror in position a tongue depressor in one hand and a Gottstein curette in the other, the operation was begun. The tongue being held well down by means of a depressor, the curette was passed behind the soft palate and into the vault of the pharynx the blade brought well forward against the posterior septum, then passed slowly and firmly upward, backward, and finally downward, following the lines of the vault. This manipulation usually brings away the whole or nearly the whole growth at once, but in this case on account of the age and especially on account of the toughness of the tissue and in spite of repeated attempts, blood was the only result, with perhaps a few shreds of tissue. I at once resorted to Lowenberg's forceps, an instrument that I do not like and rarely use, but here it was the right thing in the right place and brought away the entire growth in three pieces. In this case we cannot hope for such brilliant results, as we would expect had the subject been younger. However, I have seen the patient once since, and her hearing has improved from $\frac{1}{15}$ to $\frac{1}{3}$ which is a very fair improvement and due I am sure to the removal of the irritating adenoid enlargement.

The results of this operation in children are customarily so instantaneous, radical and perfectly satisfactory as to excite the enthusiasm of the surgeon, and the wonder and delight of the patient, and his relatives and friends.

While upon this part of the report it may be well to say that there are two forms of ear disease resulting from adenoid vegetations: Chronic catarrhal otitis and chronic purulent otitis. Their method of development I believe to be essentially the same. Many authorities make the statement that the ear disease is due to pressure on the orifice and closure of the Eustachian tube; others, that the renewal of air in the middle cavity is interfered with by the presence of the growth; the theory being that anything that causes a nasal stenosis interfering with a to-and-fro current of air through the nasal passages causes a stagnation of air in the pharyngeal vault, and necessarily a certain amount of rarefaction of air in that region. Also, the action of the levator palate muscle is interfered with,

which muscle has to do with the mechanism of opening and closing the Eustachian tube. The air in the tympanic cavity is exhausted by the constant impact of sound waves upon the drum membrane, and not being renewed, the membrane sinks in, adhesions form, and impaired hearing results. But the simplest, and I take it, the best theory is that of the extension of the catarrhal inflammation from the naso-pharynx where it is engendered by the presence of the irritating and largely secreting growth into the tympanic cavity, which is, after all, but an accessory cavity to the nose. Be it remembered that the tympanic cavity has the same mucous lining as the nose, and this lining is continuous with the membrane lining the nose, and its other accessory cavities. That it is more often the seat of inflammation is due to its more exposed location, as it may be attacked both from without and within; its only protection from the outside being the thin and delicate tympanic membrane. In regard to the per cent of cases of adenoid enlargement that present ear complications it is difficult to judge. Woakes, of Philadelphia, states that not more than five per cent of his cases escape ear complications.

Urbanschitsct, of Vienna, found the hearing affected in one hundred and thirty cases out of a total of one hundred and seventy-five cases of adenoid vegetations of which he had kept a record.

Swinburne, from the reverse point of view, finds that out of one hundred and seventy-nine cases of middle ear disease, twenty-seven had adenoid vegetations. In my own private practice about one-third of all cases of adenoid vegetations have presented ear complications.

Case. A case in my private practice operated upon the latter part of last month is interesting because of the severity of the general and local symptoms produced by the obstructed breathway.

The patient, a girl of twelve, had all the characteristic symptoms of adenoid vegetation, such as the mouth-breathing and consequent vacant expression of countenance, snoring, groaning and restlessness at night, the lack of resonance in the voice, etc. In addition she suffered from the most severe type of chronic purulent otitis, the discharge being constant and very profuse, and an eczematous eruption covered one-quarter of her face and neck. The patient was thin and ænemic, and altogether it was a bad looking case. Examination of the throat showed ton-

sils hypertropied to such an extent that they extended almost to the median line on each side. Needless to say, rhinoscopy was here out of the question, but I confirmed my diagnosis of hypertrophy of the pharyngeal tonsil by passing the index finger of my right hand behind the soft palate and into the pharyngeal vault when it came into contact with the growth. The parents were present and consented to an immediate operation, which was performed, under chloroform, with the aid of one assistant. When the patient was sufficiently under the influence of the anæsthetic to allow the introduction of O'Dwyer's gag without too much resistance (only a partial narcosis is necessary), Gottstein's curette was introduced and the adenoid hypertrophy was removed at one stroke. The tongue depresser was then taken by my assistant, while I with a tonsilotome in each hand removed both tonsils at once. The operation did not occupy time to exceed a minute and a half.

In bringing the subject into position for operation, care should be taken that the head is so arranged that the blood will drain away from and not into the trachea. Otherwise there is danger of blood clot in the trachea or bronchi and asphyxiation. The patient should be supine, the shoulders drawn to the edge of the table and the head hanging directly down. In this way the blood all escapes through the nose. Before returning to the discussion of case, I will say that I think the danger from hæmorrhage is hardly to be considered, and most authors agree with me, although Mr. McBride, of Edinburgh, in his recent work on the nose and throat, places the danger from hæmorrhage as the most important of all. I think that if the blood is kept out of the trachea, it will cause no trouble and will soon cease to flow.

There is not much more to be said about the above case. I have seen it but once since the operation, when many of the worst symptoms had disappeared and those that had not quite left were greatly modified. Two weeks had elapsed. The suppurative discharge from the ear stopped four days after the operation. The eczema was reduced to a few insignificant blotches, the voice had gained resonance. She had been sleeping quietly and with closed mouth during the nights subsequent to the operation, and had the appearance of one well on the road to robust health and to a plumpness of figure to which she had never before attained.

Before closing it may be well to make a few remarks upon the treatment of the three year old girl mentioned earlier in my report. In this case as in the last one spoken of and many others in my experience, rhinoscopy was impossible and I was obliged to resort to what the gynæcologists term a "digital examination." This is not a difficult manipulation. The operator holds the patient's head against his side by passing his arm over the head and holding the chin in a firm grasp, at the same time pressing the head firmly between the arm and the side. The index finger of the right hand is passed into the mouth and with a quick movement backward, following the lines of the root of the mouth, at once engages the constrictor muscles of the pharynx; a pressure is exerted upward and the finger passes into the naso pharynx, and with a little practice will recognize instantly a pathological condition in that region.

In young children the adenoid vegetation is usually a soft mass and feels as much like a bunch of angle worms as anything else. It bleeds easily and the finger upon being withdrawn will be found to have blood adhering to it, no matter how gentle the manipulation.

In the case of this child, as is the case with most children under four years of age, the growth was sufficiently friable to be capable of being removed with the finger nail, and this was done at the same time the examination was made, thus making the diagnosis and accomplishing the operation simultaneously.

For this operation, or examination, various styles of finger protectors have been devised. I remember Mr. Hovel, who succeeds Sir Morrell McKenzie as chief of the Golden Square Throat and Nose Hospital, London, showing me with evident pride a simple conceit of his own for the protection of his finger from the teeth of the subject. It consisted of a piece of rubber hose which fitted the finger after having been trimmed in order to allow free flection. Sometimes a jointed steel finger protector is worn, and some operators use a cloth wound about the finger.

In my own work I have never found any of these devices necessary. The mouth of the subject once open, the examining finger is passed quickly to the soft palate and the gagging sensation produced by the contact renders it impossible for the mouth to close.

Of the remaining three cases of the five mentioned at the beginning of this report two were operated upon with

the curette, under chloroform, and one with the same instrument without any anæsthetic. The results were uniformly good in all cases. The methods of operating for this disease are as numerous as are the names of nose and throat specialists. Various escharotics have been used, such as nitrate of silver, chromic acid and the galvanic cautery. Cutting forceps, crushing forceps, snares through the pharynx and snares via the nasal canal—the heated wire and the cold wire, and sundry forms of curettes have been used successfully and each method has its devoted champions. At present the favorite method in Vienna in Schnitzler's and Chiari's clinics is the cold snare through the nose. This is a safe method, but very slow and tedious, and the demands upon the patience of both subject and operator are excessive.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

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

AN EMERGENT OVARIOTOMY IN THE SUMMER MONTHS. RECOVERY.—*Case 21,020* was sent to the clinic by Dr. W. C. Duncan, of Fond du Lac, Wis. She has been married five years and had two children; the first one being still-born, four years ago, and the other one is living, æt. two years. One year ago she noticed an enlargement in the right inguinal region; but suffered no inconvenience from the same until last May, when it suddenly became very painful, and has continued so at irregular intervals ever since. The tumor has grown more rapidly of late, and the menses have been of too frequent occurrence. She has some gastric irritability at times, while the bowels are usually constipated. There are no vesical symptoms.

August 2. The following remarks were made before the operation: Sometimes it is well to postpone an ovariotomy, and again it is best to make no delay. There is a tradition that such patients as this one do better in almost any other month than in August, and yet in the beautiful summer climate of this city, with its bracing lake breezes

*Continued from page 303.

and cool refreshing nights, and with the improved methods of after-treatment, there is no such dread of the hot weather as we use to have, and as surgeons of heated localities must continue to have. However, I wrote to Dr. Duncan ten days ago concerning this woman, not to bring her here until the first of October, unless in his judgment such a step was imperative. He decided that she must have the operation without delay, and doubtless his opinion is correct.

The rapidity in the growth of this tumor from a certain date; the development of a corresponding cachexia, with emaciation of the neck and the extremities; the dirty, earthy hue of the countenance; a periodical fever; inability to lie down; insomnia; failure of the general health, and more perhaps than all, the occurrence of occasional attacks of severe pain over certain zones of the tumor, are very pronounced. These urgent symptoms make it an emergency case, and really furnish the most pressing indications for immediate operation. The conservative course is to go forward at once.

Operation.—The abdominal incision showed that the parietal peritoneum was intimately and generally adherent to the parent sac. The peritoneum itself was very thick, of a dark port wine hue, and venous blood oozed freely from its torn surface. The walls of the larger cysts had the complexion of an egg-plant, and the fluid contained in them was thick and grumous, and of a chocolate color. One cyst, which was as large as an Osage orange, and located in the left iliac region, had a thin wall and burst while being delivered, its contents being thrown over the person of the assistant and not into the abdomen. Neither flushing nor drainage were deemed necessary, but the peritoneum was stitched separately and the wound most carefully closed and dressed. The weight of the tumor was twenty-five pounds.

September 4. It is a great satisfaction to have saved this patient's life by prompt action in her behalf; for, considering the conditions under which she entered the hos-

pital, and in which we found the tumor and the adjacent tissues, she most likely would not otherwise have survived until the present moment. But now as you see, the wound has healed perfectly by first intention, without a drop of pus, all of her threatening symptoms have disappeared, and she is well enough to go home this afternoon.

OMENTAL TUBERCULOSIS. THE EXPLORATORY INCISION. RECOVERY. *Case 21,021.*—Mrs. S——, a patient of Dr. R. L. Snow's was brought to the clinic by him. She is thirty-five years of age, and has had three children, the youngest being four years old. Since the birth of this child her health has been gradually failing, but the digestive organs have been mostly affected, for she has been subject to severe attacks of nausea and vomiting. Milk has been the chief means of sustenance, as she has not been able to retain any solid food. She has suffered with pain in the left hypochondriac region and across the abdomen, which is very sensitive to pressure. The menses have always been quite normal, the bowels regular, and there have been no vesical symptoms. There is a movable and suspicious tumor lying mostly in the left abdomen.

Operation.—August 14, an explorative laparotomy having been advised and arranged for, the median incision discharged several pints of clear ascitic fluid. A diseased mass being distinctly felt, it was drawn to the wound, exposed and carefully examined. It proved to consist of the larger omentum, which was very much thickened and studded on both surfaces and along its edge with granular deposits of various sizes from that of a large pea, or bean, to a millet seed. In most cases these granulations were single, but in others they were agglomerated, while in all they were firm, white and rounded. The free edge of the omentum was thick, ragged, and serrated. Neither the mesenteric folds, the free or the visceral peritoneum, nor any portion of the generative intestine were involved in the deposit; nor was there any evidence of inflammatory action, old or new, within the abdominal or the pelvic cavities. After having made a diagnosis of omental tuberculosis the wound was closed in the usual way.

In commenting upon this remarkable case, Prof. L.

said: This form of localized abdominal tuberculosis is rare. It is more frequent in children than in adults; in men than in women. In the former it is sometimes curable by medicinal and dietetic measures, but in the latter operative interference will be of the most service, and then only when there are no signs of the disease already existing in other parts of the body.

By means of the exploratory incision, I have shown our classes quite a lot of cases of peritoneal tuberculosis, but none of you have ever before seen one exactly like this. The ascitic fluid was free and not sacculated because there had been no adhesive peritonitis, and because the tuberculous mischief did not begin within or about the Fallopian tubes. The floating tumor consisted of the greatly thickened omentum, but, since there was no breaking down of its tissue and no cysts within its structures; since the nutrition of the intestines and the function of digestion could not be properly maintained if it were wholly removed; and more especially since these abdominal neoplasms are often disposed of by a simple laparotomy, there was no warrant for taking it away.

One of the most recent facts gained from surgical experience in the treatment of local tuberculosis is that it is not, as in cancer, necessary to remove all of the diseased tissue very carefully. To leave some, or even all of it behind in certain cases, and especially within the abdomen, does not seriously interfere with the cure of the disease.

September 4. This patient's wound has closed firmly, and by first intention, with only the dry dressing and rigorous asepsis. Her temperature has not reached 100° since the operation, and she has absolutely had no symptoms whatever. She eats, enjoys and digests her food better than for many months before. She also leaves the hospital to-day, and Dr. Snow will keep us informed of her progress.

TENTATIVE CURRETTING IN UTERINE CANCER.—*Case*

21,023, sent to the hospital by Dr. J. D. Craig, was æt. 47, and had had almost a continuous uterine hæmorrhage for four months. In the brief intervals there was a copious but not offensive leucorrhœal flow. She had been under treatment but a very short time and only internal remedies had been used. There was no pain or pelvic discomfort, but she had lost flesh rapidly and become decidedly anæmic. Local examination showed a fungous growth that filled the uterine cervix, and destructive ulceration of the margin of the os uteri extending nearly or quite to the vaginal junction.

Operation.—August 23. There are three indications for the use of the currette in this case: (1) to remove the friable, vascular growth and thus to arrest the hæmorrhage and the exhausting leucorrhœal flow; (2) to enable us to decide intelligently if the more serious operation of removing the uterus is necessary and possible, by a microscopical examination of the *débris*, by carefully determining the extent of the lesion, and whether there is enough sound tissue remaining to warrant it; and (3) to open the way for antisepsis and drainage, which are always called for, whether we make the secondary operation or not.

The remaining portion of the cervix was thoroughly cleansed of the brain-like tissue, which came away in large bits and chips; the parts were flushed and the uterus packed with a strip of gauze that had been soaked in equal parts of the tincture of the chloride of iron and glycerine.

August 30. You observe that the cervix is entirely free from any sign of the malignant changes that we found here a week ago; it is smooth, healthy looking, does not bleed and has not, since the operation; and by drawing it well down there seems to be sufficient margin to warrant us in undertaking a vaginal hysterectomy. But, since it sometimes happens in these cases that the trouble does not recur right away, and since she wants to arrange her affairs, I think we may safely wait a little, being careful not to lose sight of the case, and to act upon the first note of warning that is given us. So I have consented for her to go home under the pledge that we shall reëxamine her within a fortnight.

VAGINAL HYSTERECTOMY BY *MORCELLEMENT* FOR A RARE FORM OF FIBROID. RECOVERY.—*Case 21,025.* M. A., æt. 49, a patient of Dr. W. A. McDowell, of this city, entered this clinic August 30. The menses were regular until three years ago, when they skipped for two or three months; now there has been an interruption for a whole year save one month in which she had a passive but painless flow lasting seventeen days. Eighteen months ago her health began to fail very decidedly; six months ago she noticed an enlargement in the centre of the pelvis, which sometimes caused frequent urination by pressing upon the bladder. One year ago her eyesight failed and she has not since been able to read or sew. Several oculists, including Prof. Vilas, have told her that this trouble is probably reflex from the uterine irritation. The diagnosis of uterine fibroma, lying chiefly below the superior strait, was made and an operation advised.

Operation.—August 31. A vaginal hysterectomy was made in the presence of Drs. H. K. Macomber, of California, Wild, of Kansas, Replogle, of Illinois, and Joas Petta, of Portugal. The tumor was as large as a cocoanut, partly interstitial and partly intra-uterine, and of so firm a texture as not to be in the least compressible or reducible in size. And as it could not be moulded and delivered otherwise, it was removed piecemeal, a process that required nearly two hours of very hard work. The retro-uterine adhesions were very firm and extensive. The surrounding tissues were not injured; a good quantity of urine that had accumulated in the bladder meanwhile, was taken by the catheter; the usual dressings were applied and the patient put to bed in pretty good condition.

Wednesday, September 6. The patient is doing well in every way; her temperature has not reached 100°; the urine is normal, the appetite good enough; and she says that her eyes feel very much better already.

On examining the tumor you observe the thickness of the lower segment of the uterine wall, and the extreme thinness of its fundal parietes. Here is the stump of the intra-uterine growth, which was sessile, and so mitred into the top of the organ that it could not be separated. We

can explain the passage of the sound for a certain distance between this hard growth and the uterine wall; but how the patient escaped from menorrhagia and severe uterine pains and colic is past our comprehension. I have never before seen just such a growth as this, nor one that was so difficult of removal.

Wednesday, September 13, the fourteenth day. Thus far her recovery has been uninterrupted and uneventful.

A POST-PUERPERAL SUPPURATING CYST OF THE OVARY. —OVARIOTOMY.—RECOVERY. *Case 21,026.*—Mrs. ——, æt. 27, married six years, has one child, five years old. Three months ago she had a miscarriage at the fourth month, at which time she was very ill, and since which time she has been in wretched health, having menstruated but once, and scantily. She has a tumor lying in the centre of the abdomen, which was first noticed three years ago, and which has grown much more rapidly and become quite painful. It began on the left side, and standing or walking causes great discomfort throughout the lower pelvis. The bowels are always constipated, and just before a movement extremely painful in and about the rectum. Until lately she could lie best on the affected side, but now must lie on the back. There is a febrile exacerbation every evening; she is losing strength and courage, and the complexion is dirty and copræmic. On local examination the cervix was swollen and ragged, but mobile; the uterus in its normal position; the tumor, located beneath the mesian line, is immobile, extends an inch above the umbilicus, and gives doubtful signs of a deep fluctuation.

Operation.—September 7, a laparotomy was made before a sub-class. The peritoneum was inseparably adherent to the anterior surface of the tumor, while its fundus and posterior face were covered everywhere by adherent intestines. The sac was a monocyst, and contained four pints of pus. The stripping of the cyst wall from the intestines and the mesentery left a large cavity, the surface of which was bleeding and denuded. This cavity was

flushed, cleansed and filled with iodoform gauze, and the wound dressed in the usual way.

The case offers a few points of clinical interest. Whether or not this tumor caused the abortion we cannot say, for the pregnant uterus is strangely tolerant of ovarian tumors. But two results may safely be ascribed to her lying-in, even at the fourth month. These are (1) the agglutination and the intimate union of the abdominal and the intestinal peritoneum with the tumor, and (2) the change of the sac contents into a nasty, puriform fluid.

Three months ago, our friend, Dr. W. H. Thomas, who brings her here, treated this woman through a very severe attack of puerperal peritonitis, and the plastic exudation which resulted from that attack anchored the tumor on all sides, above and below. I have never before seen so general and so firm and vascular a union between the intestines and the wall of a cyst. At some points, as you observed, I had to separate the coats of that wall and leave its lining membrane attached to the gut, where serious injury would have resulted from tearing it away.

No one who has ever witnessed a post-mortem in case of puerperal peritonitis will question the possibility of serous fluids being converted into pus products during the lying-in period. I have seen, and have removed a number of these suppurating cysts of the ovary in which there was every reason to believe that the purulent degeneration of the cyst contents dated from childbirth.

If these points are well taken, they furnish another argument for ovariotomy during pregnancy, and before delivery. Taken in connection with the remarkable results obtained by that operation, and the exemption of the gravid uterus and its contents from harm thereby, I commend this idea to your careful consideration.

September 14. The drain has once been replaced; there is some suppuration from the wound, but no fever; the appetite is good, and she eats and sleeps well. The flesh tints are returning, and she is cheerful. Neither the pulse nor the temperature have reached 100.

September 16. The sutures were taken. The pus is diminishing in quantity, and there are no symptoms. The edges of the wound are firmly united throughout excepting at the site of the drain which, as it empties the pocket once occupied by the adherent cyst, is just below the umbilicus, and not at the lower angle of the wound. The patient has been removed to the convalescent ward.

CASES FROM PRACTICE.

BY DR. M. HISLOP, OF WASHINGTON, D. C.

1. EXCESSIVE FLATULENCY CURED BY CARBOLIC ACID.—A young girl of nine years, tall, thin, but in good general health, had for three months been affected with excessive flatulency, which was extremely annoying to herself, as well as to those who were associated with her. She was banished from the school room in consequence. The usual remedies had no effect whatever, but a very few doses of carbolic acid 2c. sufficed to overcome the whole difficulty. The cure has been a permanent one.

2. GALLSTONE COLIC IN AN INFANT CURED BY CALCAREA PHOS.—This child first came under my care when about two weeks old. She was pale, blue, looked illy nourished and cried all of the time. I thought at once that I had either a case of mal-nutrition or a severe type of intestinal colic to deal with. I gave the usual remedies, but the child kept growing worse instead of better. One morning the mother of the child called my attention to some pebbly bits, some as large as a hazel nut, that were being passed with the fæces. Not knowing what they were nor how to account for them, and as they continued to be passed each day in an increasing ratio, I took some of them to an expert microscopist for examination. He pronounced them gallstones. Magnesia phos. 3 was thereupon given. This relieved the colic, but the stones continued to pass. The stools then became diarrhœic, and pulsatilla was indicated. Thereafter, instead of the pebbly bits being passed with the stools, there were solt, pulpy particles of considerable size. These were pronounced cholesterine by this same expert. Calcarea phos. 3 was then prescribed, and at once the child began to improve, and now for more than two months no such foreign bodies have been found in the stools, and the child has grown plump and healthy looking.

CORRESPONDENCE.

The Red Cross Nurses at Pomeroy, Iowa.

Perhaps at no time in a doctor's life is the white cap and blue dress of the trained nurse such a feast to the eyes and relief to the anxious mind and overtaxed body, as when having under his care the injured from railway accidents or cyclones.

Such was the relief afforded the physicians who for days and nights of ceaseless toil had been ministering to the victims of the cyclone which occured at Pomeroy, Iowa, July 6th, when Dr. J. B. Hubbell, Gen. Field Agt. of the Red Cross Association, brought to Pomeroy four of Hahnemann Hospital nurses, Misses Anna L. Smith, Ida Battell, Augusta Sager and Emma Bergwall, who had been cheerfully furnished by the superintendent, and their services freely given to assist in caring for the wounded.

I shall never forget the vision of those four with their bright, fresh faces encircled with the halo which is the insignia of their office. From that time their services were unremitting and not one of the thirty physicians but asked for a Red Cross nurse for his worst cases.

On the tenth day forty-four of the wounded were taken on stretchers and placed in Pullman sleepers and carried to Sioux City, being distributed equally between the hospitals. Two Red Cross nurses were assigned to accompany them, the other two being left at Pomeroy with patients too seriously wounded to admit of removal.

Enough cannot be said of their untiring and most satisfactory work, and this in the atmosphere and under the direction of Allopathic surgeons, who have not considered time wasted in acknowledging by letter the good work which they accomplished.

Homœopathy was represented by but two physicians, both Chicago graduates; in my own case no instruction was made as to amount or character of work given to do, nor was credit or appreciation withheld for the same. All were working with one end in view—relief of suffering—and no questions were asked.

I desire to acknowledge the receipt of a large supply of Hall's Tar plaster, donated by Tappen Halsey's pharmacy which was hailed with delight by some who had seen its good work in the past. R.

A CALL FOR MORE CLINICAL CLIPPINGS.

MR. EDITOR:

One thing about the *Clinique* that has always interested me is its originality. For many years I have not found a second-hand article in its pages. And what is more, its clinical items are not gotten together in scrap-book fashion without any regard to their usefulness. I was especially interested in Dr. Stettler's Clinical Extracts from Foreign Journals, contained in your August No. Give us more of them, and oblige,

Yours, etc.

T. R. P.

For instance? *Rules for the prevention of tetanus after wounds.*—In a recent discussion upon this subject before the French Academy of Medicine, Dr. Péan offered the following: 1. In case one is wounded ever so slightly, and whether in the city or in the country, the wound should be bathed with an antiseptic and covered with an impermeable dressing. 2. It should be dressed with still more care if the injury is serious. 3. In all cases the bistoury should be used instead of the thermo-cautery, to liberate the tissues, and when it is necessary to remove foreign bodies. 4. Use the forceps instead of ligatures. 5. Do not leave the wound exposed, but keep it from the air during and after the dressing. 6. Do not dress it too often. 7. Keep the part immobile. 8. Isolate the patient from all infectious diseases, as erysipelas, purulent infection, etc., which, like tetanus, have in our time disappeared from the hospital service.

Relaxation of the broad ligament, and dilatation of the stomach in cases of neurasthenia.—Dr. Chéron, of Paris, reports that in sixty-six cases of women, married and unmarried, with or without children, and in whom there was no decided uterine affection, there was relaxation of the broad ligament with a sense of weight in the pelvis, dragging in the loins, pains around the waist radiating into the lumbar region, and fatigue upon standing or walking. In every one of these cases there were manifest symptoms of dilatation of the stomach, and of a coincident neurasthenia. The treatment, which was very successful, consisted of injections of serum, uterine massage, and the employment of electricity.

Miscellaneous Items.

Prof. Vilas, ill for the first time in fifteen years, has quite recovered.——Prof. C. Gurnee Fellows is safely at home from Europe.——After getting the new college building ready for the students, Prof. Cobb is taking a brief and merited holiday.—Prof. Chislett's article at page 421 of this issue will interest everybody.——Prof. Arnulphy gives the Introductory Lecture at the opening of the Winter Term, Oct. 3, in the "Old Hahnemann," Chicago.——Prof. Bailey is as busy as the man at the World's Fair turnstile, arranging for the incoming Class.——Prof. Shears has had another donation, one that will amply equip the surgical department of the new hospital building.——Prof. Gilman's introductory lecture on Materia Medica and Therapeutics will appear in our next issue.——The Clinical Society will hold its next meeting September 30, at 8:30 P. M. in the new college building, when Dr. F. Park Lewis' essay on *The Ocular Phenomena in Hysteria*, will be read and discussed.——Dr. G. E. Clark, '80, has resigned from the Minnesota Examining Board to accept the professorship of Theory and Practice in the State University.——We are thinking of publishing a roster of the thousand or two jolly good doctors, men and women, who have made it convenient to call upon the editor of the CLINIQUE during the World's Fair season, and only await a few more arrivals.——Dr. Mary Gamble Cummins, '93, has located at Davenport, Iowa.

With three fine, large lecture rooms, and one spacious amphitheatre for the general clinics in the new college building, there will be ample accommodation for the graded classes in the old Hahnemann this winter.——Our thanks are due to a lot of good friends for a large and respectable list of new subscribers, as well as for the payment of dues from the old ones.——The recent death of Charcot is a sad blow to clinical medicine, especially in its relation to diseases of the brain and the nervous system.

THE CLINIQUE.

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Original Lectures.

INTRODUCTORY LECTURE.

A LECTURE INTRODUCTORY TO THE OPENING OF THE XXXIV. ANNUAL WINTER SESSION IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

BY PROF. B. S. ARNULPHY, M. D.

LADIES AND GENTLEMEN:—I feel greatly honored to have been called upon to address you on this occasion of unusual solemnity.

And if after the great and good things that have been said by the speakers that have preceded me, I may succeed in retaining your attention for a few minutes, I shall consider myself singularly fortunate.

In this memorable Columbian year our people have been so surfeited with celebrations of every description, with so many dedications of buildings, with such floods of eloquence in the halls of debate and around the festive board, that one may well wonder that all talkers are not hoarse and all audiences fast asleep.

And even here to-night in the course of these dedicatory exercises a peculiar hallucination stole over me.

This wondrous White City of ours in the fairy atmosphere of which I have spent nearly the whole summer, has thrown such a spell of bewilderment on my brain, that for a moment I lost sight of the reality and allowed myself to fancy we were all transported to one of the shows on Midway Plaisance. My error will appear more pardonable when you remember that President Higginbotham is also

one of the trustees of this college, and take into account other circumstances which added to the illusion. Gazing upon the fair faces before me, and with all due respect to the ladies present, I was reminded of the congress of beauty; and on yonder seat methought I recognized the familiar face of some doughty Columbian guard and the out line of more than one wily gatekeeper, or of a courteous guide; and then came the final touch to my reverie in the guise of those songs we have just heard, as in the improved performance of the artists, some richer depth of tone prevailed which vaguely recalled the troubadours of the South Sea Islands and the vocalists of the Dahomey village. *Sed paulo majora canamus.*

My object in addressing you is to make you acquainted with the higher philosophy which permeates the thoughts of this faculty. To-morrow

"When the gentle day
Dapples the drowsy east with spots of gray"

we shall enter upon our duties for the coming term, you as listeners, we as teachers. And it is not immaterial that you should be rendered familiar with the leading tenets of our medical faith, with the thoughts that are uppermost in our minds.

What we propose to do is to give you the soundest medical education within the reach of our best endeavor, within the scope of the highest scientific attainments of the day, in the light of the polar star which illumes the north of our belief, the law of similars.

To put it in a nutshell we propose to teach you the medical art under the guidance of homœopathy.

It sounds very simple at first. It seems as though there were but one way of doing it. It is not so, however. Men are not all built on the same pattern, neither anatomically, nor physiologically, and least of all, psychologically. Let an object, of given dimensions, be placed at a certain point and a crowd of observers disposed all around at an equal distance from the object, and the individual impressions gathered by the lookers-on will be vastly at variance. Some will see it plainly, some as if through a mist, some will have to strain their eyes and will complain of headache; some, affected with confirmed myopia will hardly perceive its outline; some with a bad squint will see it distorted and some will fail to see it at all.

So is it with homœopathy; most of those who do not see it must be affected with willful blindness and among those

who worship at its shrine most devoutly, the refractory power of the ocular media is sometimes so altered as to make it appear to them very different from what it really is. It is a matter of more or less mental achromatism, letting alone the hysterical eye.

Under cover of preserving in their pristine integrity the tenets of the pure doctrine, some over-zealous adepts have taken to rebuking their less sanguine brethren. We have heard issuing from certain quarters of late, a "low, melodious growl," the public being taken into the confidence, in a prophetic language, not unalloyed with uncharitable innuendoes, that the unadulterated teachings of the homœopathic doctrine are fast disappearing from the recognized medical institutions of that faith in this country, to find refuge in one or two sanctuaries, where vestal hands are piously keeping the sacred flame alive.

One need not dive very deep under this crust of pretense to discover how ill-suited are those self-appointed custodians of the tabernacle for the assumption of such duties.

Are we to blame for refusing to be carried away by the glowing arguments of those misguided apostles, arguments clothed in a style that seems better fitted for the glitter of paradox than the sober guise of truth?

Does not the ever recurring history of all creeds, religious, philosophical or otherwise, show that the greatest danger to their existence, and oftentimes the secret of their decay lies in the loud trappings of conceit and exaggeration wherewith their followers persist in smothering them? *Quos vult perdere Jupiter dementat.*

When the whole position of Homœopathy reduces itself *to that of the identity of the pathogenetic and therapeutic phenomena of a medicinal substance*, a fact of observation which any unprejudiced mind can verify for himself, and of which all schools of medicine do avail themselves, some on the sly as it were, some unbeknown to themselves, as Mr. Jourdain was writing prose, when, I say, the whole thing narrows itself down to one of such simple data, how can the cause be benefited which we all would see understood and accepted by the attitude of a few of its sympathizers?

We see them go about in a sulking mood; then they surround their inflated dogma with a moat and a fence from which they fire away at foe and friend alike. Then apparently satisfied with their work they preserve an inspired attitude, seemingly content to dwell in the misty

heights of conceit, following, perhaps unconsciously, the tactics of good old Homer, who always kept some timely cloud ready at hand wherewith to conceal the pranks of the unruly inmates of Olympus.

Enthusiasm and pugnacity are great qualities indeed. They serve a useful purpose when a new truth has to be planted on the entrenchment of prejudice and dogmatic conservatism. But when that truth has won almost universal recognition, such partisan, passionate and one-sided effervescence *can only foster the growth of parasitic excrescences, which far from adding to its intrinsic worth only disparage its fair face.* Enthusiasm and imagination ought to march in the train of one's understanding, and never lead when they should follow.

It is comparatively easy by dint of flowery rhetoric and passionate appeals to "win the vacant and the vain to noble raptures," but this art is foreign to the stern lines of scientific investigation.

It is comparatively easy to work one's self into a fine frenzy, but eclampsia, even when steeped in metaphysical motives, has never been known to be sound reasoning; and truly does Carlyle say "that we do not call that man strong who takes convulsion fits, though in that state ten men cannot hold him."

We would fight shy of those spongy theoretical views, grounded in self-deception, which when squeezed by the honest hand of analysis, leave nothing but a honeycombed mass through which the zephyrettes of fancy sport themselves at ease.

We would tear away the misty panoply of phantoms which hangs around the wholesome truth bequeathed to us by Hahnemann; we would retain and polish the diamond and reject the dross; we would leave the husk of the letter to his antiquated followers, and infuse its vivifying spirit into the budding flowers of the present and the unfolded possibilities of the future.

We are determined not to allow the alchemy of sentimentalism to corrode the fulcrum of our better judgment. We are determined not to be led astray by the sublimation of Hahnemannian metaphysics, lest the glow of pathos that lurks in it may only be like the shining of rotten wood in the dark.

We claim that the homœopathy of to-day has cast off its leading strings and won its spurs on the field; that its exponents have acquired a right to take a frank and manly

stand upon every question of science coming before them, without being hampered by the dead weight of worn out lucubrations no longer in touch with the requirements of the day.

But if we repudiate the errors of Hahnemannism, it is only to cling all the closer, and with increased veneration, to the tenets of positive Homœopathy.

We humble ourselves in the dust before those truths which like the law of similarity, wear the aspect of eternity and appear to the wondering mind as the fulgurating spark of some stolen secret, the reward of Promethean audacity. *Amicus Plato, sed magis amica Veritas.*

Far from me the suspicion of casting reflections on our beloved master, or in the least minimizing the result of his labors. In the long array of mind toilers and sturdy delvers there never was one more worthy of unstinted praise and undying gratitude, than the thinker who from the Sinai of his titanic work gave mankind the tables of the therapeutic law, and we cherish his name as that of one of the gentlest, the bravest spirits that "wore earth about him."

Do we quarrel with Hahnemann for having spurned the weltering chaos of undigested notions and stultifying methods that passed for the pathology and the diagnosis of his time? Not in the least. But we ask: has nothing been gained since?

We ask: Can any one in his right senses imagine that Hahnemann, if he were alive, would prescribe nowadays exactly in the same way as he did in his lifetime? We give him credit for believing that he would not. Nay, we are convinced that, splendidly equipped for scientific work as he was by nature, he would have towered head and shoulders above the recognized exponents of modern pathology, outwitting Virchow on his own ground as he has heralded Pasteur.

But such is the frailty of man's nature that genius itself in its highest flights seldom catches a glimpse of truth unclouded by some admixture of error. It is for man in the course of time to use his reason in the process of winnowing the chaff from the living seeds.

Does not history show us that the most vaunted achievements of man bear the impress of our shortcomings and of the limitations of our intellect? Scan the most stupendous flights of philosophy. It is when it soars highest into the empyrean regions that it runs the risk of falling flattest.

Remember the symbolic wings of Icarus. Fruitful of empty ideas and wild fancies the philosophy of man has not been unlike those barren women who would have borborygmus to be the certain sign of offspring.

Alas, also for the fruits of human wisdom; it is when finding them clothed in most alluring beauty we press them to our lips, that we are apt to discover that, like the sunny apples of Ishkahar, they are all sweetness on one side and all bitterness on the other.

So great are the difficulties which beset man in his search for truth. The path that leads to the light knows of no variation; honest scientific inquiry suffers no shadow of turning. We must pursue our course, stern and uncompromising, as the straight path of truth is like the bridge from earth to heaven in the Mohammedan creed; if we swerve but a single hair's breadth, we are lost. Lost in a maze where the guiding thread of Ariadne is not easily found again.

Thus do the side paths lead only to half-truths or stale sophisms. But such is the divine virtue of truth that even its dimmest light has power to lead and to satisfy; that the faintest of its glimmerings still sustains the fabric of our hopes; that the simple mirage of its presence still lightens our burdens and warms our hearts.

The gold nugget of truth has been broken into pieces, as it were, then triturated and mixed with the unclean dross of the world, so as to be lost to the sight of the vulgar herd; but let a searcher discover a particle of the precious metal, and an electric thrill pervades his whole being, and we may imagine that he feels around him the fluttering of invisible wings, palpitating in silent applause.

This is what Hahnemann must have experienced, when the immortal law which he restored to science, dawned upon his mind. He must have felt like Sinbad the Sailor when wandering through the cave in which he had been buried alive he caught the first glimpse of the bright day.

We, at least, do not want Homœopathy to become a thing of the past—a fossilized dogma to be found bottled up in some future museum. We would treat it as a young athlete sporting in the sunshine, not as a mummy wrapt up in metaphysical rags.

Convinced as we are of the profound and sublime truth of its principle, we would strive to place it in the lead of the modern scientific movement where it belongs. *A tout seigneur, tout honneur.* But such an enviable position

cannot be attained by sounding phrases alone. It takes unceasing vigilance, sturdy labor, unrelenting abnegation, and vigorous steering in the right direction. It requires a clear view of our resources, a still more distinct perception of our limitations.

Homœopathy must be progressive, or it will not be at all. Should we persist in dragging our weary steps in the desert of symptomatology pure and simple, as some would have us do, whose back seems to be complacently turned against the light, Homœopathy would die of mental phthisis in less than a hundred years.

The forces which push humanity onward are ineluctable. Whoever thinks he can lag behind in the shady oasis of "statu quo" and still not lose his place in the procession, is cruelly mistaken. *He who does not advance, fatally retrogrades.* Such is the edict of natural law.

If the homœopathic fraternity would preserve their position in the scientific movement and win for themselves and their school higher repute and fresh honors, they should lose no time, but by dint of courageous work adapt our materia medica to the mould of advanced modern pathology. I venture to say that there is not a single homœopathic practitioner of good common sense who is not at heart conscious of the emptiness, not to say fallaciousness, of exclusive symptomatic prescribing, who would not hail as a blessing the advent of a deeper insight into the pathological substratum of the outward symptoms.

Some of our school might be compared to the botanist who, engrossed with the study of the leaves and flowers of plants, neglects to look into the structure of the roots and the organization of the seeds.

Full truly said our great and lamented Laning: Is the physician competent to prescribe in accordance with the law of similars, who has no knowledge of the significance of symptoms singly or in combination; who does not know that a given pain or sensation may be due to a variety of causes; who, when he has seen symptoms disappear under treatment, does not know whether they depended upon some grave hepatic lesion or upon some functional or ephemeral renal disturbance, and consequently can have no idea as to the role played by the remedy prescribed in the removal of the symptoms? * * * * * Is it not well, in addition to the oft-repeated question "What cured?" to inquire "*What was cured?*"

Our greatest desideratum is to make the search-light of

our pathogeneses plunge into the most intimate lesions of the tissues.

Is it not those medicinal substances with whose physiological and toxic action we are best acquainted, *that we all prize most highly and all use most confidently at the bedside?*

Only then shall we be truly authorized to speak of the much misunderstood "totality of the symptoms," when the hidden symptoms springing from a recognized organic lesion, and emerging at the surface through the channel of protean reflexes, shall have been freed from the ostracism under which it languishes to-day at the hands of belated prescribers.

This objective side of our arsenal of proven drugs, is as little known to some of our school as that other face of the moon which our dear old satellite never condescends to show to the prying astronomer.

I, for one, feel that the subjective aspect of our materia medica is overdrawn, while its objective phase is kept in the shade; so that the whole complexus of it appears to me in the light of a magnificent structure resting on a narrow and flimsy foundation, ready to topple over under the increasing demands of actual practice, reminding one of the probable fate of those pretentious, top-heavy monsters of the British navy, which, according to expert opinion, are doomed, in actual warfare, to follow the "Victoria" and McGinty to the bottom of the sea.

To remove this source of weakness not only has the toxic effects of the drugs to be more systematically studied, but especially should these ultimate alterations, either temporary or permanent, that are wrought on the anatomical elements, be exhaustively followed to their source.

Then there is the vast field of bacteriology opened up to our speculations and experiments, a field hardly touched yet, holding in reserve a rich mine of new and powerful agents for us to wield in our struggle against disease.

The splendid work of Pasteur, Koch, and the distinguished host of their followers is beginning to tell. And the more delving is done into the subject, the more the principle of similarity is brought into relief and prominence.

In this connection, allow me to refer to an incident which carries with it its own lesson, not unmixed with a sense of humor.

I happened to be present last winter at one of those

genial meetings held by the Sunset Club of Chicago. The essayist of the evening, a clever practitioner of this city, read a paper in which he contended that medicine is a science and offered many serious arguments in support of his theme, winding up his literary effort by a savage attack on homœopathy.

This put me on my mettle and I retorted as sharply as I could, taking at the same time the stand that medicine is not a science, but an art based upon a cluster of sciences.

Then the discussion raged on, homœopathy being in turn attacked and defended by a long array of speakers.

In closing the discussion, however, the essayist gave himself away in the following manner. I cite textually: "There is a point that will teach us a lesson. Take the case of pneumonia. That is a disease which runs its course in a few days, and it is a disease in which the lungs are filled with germs, which are the cause of the disease. Now it is a very strange fact that the germs cease to develop after a certain time, and at a time too when their vitality seems greatest, and when they seem most numerous in the lung. That raises the question, why are the infectious diseases self-limited? The laboratory work has shown us the following: It has shown that these germs excrete certain poisons which are fatal to their own existence. The chemist in his laboratory has isolated these poisons and has examined and analyzed them. The work in this direction is in its incipiency, but the results are so remarkable that we may say that just as we had a stage in medicine of the investigation of germs, so we will have a stage in medicine which occupies itself with the investigation of the poisons which these germs produce in the body. It has been found that these poisons limit the growth of the bacteria that produce them; and it has also been found that if these poisons be isolated and be injected into the bodies of healthy animals, which animals are thus made diseased—that is if the germ of pneumonia is injected into the animal which has thus been inoculated with these poisons, which the pneumonia germs produce—the animal will not take pneumonia, or if the animal already has pneumonia and these poisons are injected before the termination of the disease, the disease will be aborted."

Now I ask: Could a better, a more eloquent vindication of the therapeutic principle for which we claim recognition be imagined?

Neither was the moral of the fable wasted upon the intelligent audience.

A strange thing indeed it must appear to the mind of the essayist, but one which a clear-sighted observer could have foretold from the moment Jenner discovered the properties of the vaccine virus, from the moment Pasteur began the series of his immortal experiments.

A day will come no doubt, and I think is fast approaching, when the treatment of infectious diseases shall rest upon preventive and abortive inoculation of the corresponding ptomaine, according to the law: *Like cures like.*

This is the tempting path opening before the rising generation of physicians. Shall our own school suffer the disgrace to allow our friend the enemy to cull all the laurels in the pursuit of the golden bough? Shall we allow them to outrun us in the race for the Canaan that hovers in sight, and upon which our flag is seen to float in the distance?

This is a land on which we have at least a right of protectorate, if not of annexation, and we ought to assert our right, by such demonstration of strength as shall silence opposition.

Let us work to that end. *Labor improbus omnia vincit.* It shall be our ambition to so instruct and equip our students as to fit them for the coming struggle in the competition for scientific supremacy. But our efforts will remain sterile if the public at large and our friends especially *do not sustain us with more than a platonic interest.*

So intimately are spirit and matter chained together in this sublunary world of ours, that if the material resources of our colleges *are not substantially increased*, the best part of our endeavor may be doomed to failure.

What we need is fully equipped and *amply endowed laboratories* where earnest students can spend their lives in original research without being pressed by the trivial necessity of bread and butter.

If our shores have been free from the inroad of cholera, we owe it to laboratory work. And now come glad tidings from Philadelphia. Owing to the vigorous sanitary measures that have been applied in that city within the last few years, the mortality from tuberculosis is shown to have suffered a notable decrease. This also is the indirect result of laboratory work.

Surely it is of those obscure workers of the laboratory

that it can be said, that they "do good by stealth and blush to find it fame."

But it takes money to accomplish it. Money, conceded to be the sinew of war, is also the trophic ganglion of science. In all sincerity, I ask: is it possible for a man of science, thrown on his own resources, to pursue his favorite investigations and keep the wolf from his door?

I know your answer well. Such a man, were he a genius, could not continue to live in the dreamland of his abstractions, and make a living. He would be called a loafer, and treated first with contempt, and finally with a monument!

The fairest flowers of thought surely need the atmosphere of tranquility and seclusion to unfold themselves and shed their fragrance all around.

Could Goethe and Humboldt have achieved, the former literary, the latter scientific fame, had they not been blessed with ample means of sustenance? Could Claude Bernard and Pasteur have lived their useful lives in the pregnant solitude of their laboratories but for the liberal patronage that the French Government extends to the Collége de France?

Would it have been possible for Charcot, whose death all schools of medicine may well mourn, to accomplish his great work in the field of nervous diseases, and of scientific hypnotism without a comfortable income to start with and to carry hm through?

Out of the humblest of his visions, the wretched dreamer if properly helped, could perhaps evolve unforseen applications worth untold wealth to the community; but he is like the hidden treasure over which the miser treads without knowing it; society scorns him or heeds him not.

Thus has many a fine intellect been driven into deep quagmire and has struggled in it vainly till death came, which but for that grim necessity might have scaled the immortal mountains.

Not until the State, true to its duties to the commonwealth, shall conclude to more generously patronize the institutions of learning, among which the medical colleges ought to rank first, not until then shall American thought awake to true intellectual life, and effectually compete with old Europe in the field of original productions of the mind.

Meanwhile let the men of wealth who are not owned by their riches, let those who are conscious of the ominous responsibilities created by their privileged

positions, let those who acknowledge that money is nothing more than a help to higher aims, like the charger that bore Napoleon at Austerlitz, let them extend a hand and come to the rescue.

You now know what our guiding principles are; let me briefly tell you in a general way what we intend to teach you. It will be the province of this faculty to draw before you the lineaments of the various branches of medicine; a word picture illustrated by facts from which each of you may derive a moral and apply it in actual practice.

If you would fit yourselves for the work before you nothing short of the most comprehensive and conscientious survey of anatomy, physiology, and pathology will avail; a scientific tripod from the teachings of which alone can the art of diagnosis be successfully evolved, an art without which no physician is worthy of the name.

No auxiliary science can you afford to disdain, least of all, chemistry, whose fairy wand unveils to the wondering eye the romantic hates and loves of the atoms; chemistry, a solid knowledge of which will follow you as a reliable companion through life.

It will be made apparent to you that sound therapeutics does not merely consist in writing a prescription; that the prescription blank and the buggy case are not emblematic of the healing art.

Hygiene and the art of preventing disease will be presented to you in their practical light, as the crowning effort of medicine. And it is a happy and significant omen that your teacher of materia medica should be at the same time a distinguished hygienist.

Surgery and gynecology will tell you many a wonderful tale, and though you may stand aghast at their daring, do not for a moment believe that they have reached the zenith of their ambition.

Also will the leading specialties lay bare before you the secrets of their different spheres.

Electricity, the latest captive chained to the chariot of man, deserves and will receive especial treatment.

Likewise shall hypnotism be reviewed and discussed before you, as no fair-minded person can any longer ignore its legitimate claims to scientific recognition. When we see a man of Dr. Luys' standing and ability, daily treat with good success hundreds of cases in his hypnotic clinic, in Paris, and even remove growths by means of mental suggestion, our interest should begin to be seriously aroused.

There are no doubt other forces of nature at play around us, of which we do not suspect even the presence, though they permeate and operate our very being. There may be forces above and beyond electricity as there probably are rays beyond the chemical rays of the solar spectrum, as there are Alps above the Alps.

But of these things no one in this faculty, or in any other, can tell you anything yet. You must not conclude from some of my remarks that we are given to a materialistic interpretation of the phenomena of life and nature. We know better.

The experience of mankind is that the more we delve into matter, the more we find the spirit. The day is gone by when the skeptical thought of the eighteenth century viewed the universe in the light of an automatic machine, and man only as an industrious particle in the stupendous whole.

Now the tide is turning, and the fast dying century will pass away with uplifted face, and we think we can discern something like a glimpse of heaven in its fading eyes.

And now, dear fellow students, a few more words. You are most of you at that fortunate period of your mental evolution when the fine impulses of the early prime plant in the depths of your souls those seeds which in after life will bear the fruits of your efforts; do not allow them to lie fallow. Cultivate them with a steady purpose to enhance at every turn the sublime possibilities of your profession, for you may congratulate yourselves that you enter upon the study of medicine at an uncommonly propitious time. Never was the harvest of clinical observation more plentiful or made easier by the help of improved methods.

Never was the bow of promise spanning the sky above the heads of any living generation, of a wider breadth and of a deeper hue.

We live in an age of transition, and the birth of the twentieth century will surely witness some surprising synthesis in the religious, the scientific, and the social order of the world. The very hour is pregnant with hope and expectation. There is strong significance in the fact that it has become permissible without Utopian fancy to forsee the day when in all lines of human endeavor, (and why not in the medical department also?) all strife shall cease, all hands shall join, and one common path shall be struck,

leading up to ever broader and ever more beneficent results.

And when

"Years steal
Fire from the mind and vigor from the limb,"

may the few guiding principles which you will gather in the hall we dedicate to-night, and over which hover the dear memories of many a regretted teacher already departed, may those principles have carried you to the end of the noble calling of your choice, free from unavailing regret over misspent time, or unheeded opportunities, leaving you on the brink of the great unknown, content with a harvest of good deeds and a pure conscience for your reward!

URETHRITIS, SPECIFIC AND NON-SPECIFIC.

A LECTURE BY H. V. HALBERT, M. D., CLINICAL PROFESSOR OF VENEREAL AND SKIN DISEASES IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.*

In the treatment of gonorrhœa or urethritis the aim should be to remove the first apparent symptoms. To do this we must rely entirely upon internal remedies, rest and diet. Realizing that the primary action of the virus congests and inflames the delicate mucous membrane our first object should be, as much as possible, to lessen the virulence of this poison and to relieve the swollen mucous membrane. At the inception of the trouble the irritation is not deeper than the fossa navicularis, and if by remedies and perfect care we can prevent the extension of the irritant and overcome the inflammatory process, it is possible to arrest or limit the disease before the unfortunate and obstinate sequelæ appear. At this stage the symptoms are entirely febrile and congestive, and the treatment should be antiphlogistic and antiseptic. Internal remedies and local cleanliness are all that are warranted. The effort to abort by extreme local astringents is unsatisfactory and dangerous.

For the pain, smarting and burning, there are no remedies equal to cannabis sat., cantharides, camphor, gelsemium or belladonna. They should be given in the tincture—

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*Concluded from page 404.

three or four drops at a dose—at intervals of two hours. At the first sign of abatement the remedy should be raised in potency and given less frequently; when the violent symptoms cease it should be stopped. But one remedy should be given at a time and the individuality of each case will decide which is best. I have at times attempted to prevent the spread of the urethral inflammation by local injections of bichloride of mercury—one grain to six ounces of water—but even this is risky.

Rest is an important factor in the first stage. It should be absolute and continuous until there is a relaxation of acute symptoms. The diet should exclude all stimulating food and drink. Some authors advise a skim-milk diet entirely, and the efficacy of such care cannot be denied. Cool baths at bedtime, the lightest bedclothing and utter abstinence of sexual thought or indulgence are mandatory obligations. The patient should be encouraged to drink quantities of pure, soft spring water, and a saline cathartic should be given to relieve the liver. These measures will lessen the irritability of the salts of the urine and will give the urethra a chance to take care of itself. The ardor urinæ may be relieved by two or three doses of terebinth, three x, in the evening, or by a one grain rectal suppository of the same. If it should be severe and spasmodic hydrangea is a valuable remedy. Temporary relief is always given by immersing the penis in hot water during urination. A copious warm water enema at bedtime will often avert the terror of night dreams and erections.

These or any applications which have a tendency to overcome local congestion will relieve the painful primary symptoms and perhaps abort the disease.

The second, or catarrhal stage, will require entirely different care. As the acute symptoms subside we may resort to different remedies. Silicea, sepia, mercurius, hepar sulphur, sulphur, hydrastis and baryta carb., are all useful, and many times work better in potency. I have never yet succeeded in curing a case which had reached the catarrhal stage, by remedies alone, although such cases are reported by certain specialists. I believe it is better done in the first stage. Vesicaria has done more for me in that line than any other internal remedy.

To all practicable purposes the disease is now a diffused urethritis, and unless the discharge is limited it will invade the surrounding tissues and give rise to the complications before mentioned. It is, therefore, advisable to

resort to bland astringent injections. In these there is the greatest danger of doing too much to satisfy the demands of the patient. For that reason it is advisable, at first, for the physician to administer the injection. The patient should be instructed to void the urine, and then by means of a retrocurrent syringe, introduced well into the prostatic urethra, the irrigation is properly applied from within outwards. If spasms are caused by the instrument it may be best to use an ordinary blunt pointed syringe, or a soft catheter, and apply the injection slowly.

The requirements of the case will decide as to the medication. I have often had good results from simple irrigations of hot water regularly used—a weak solution of bichloride of mercury is sometimes sufficient; or a little later on a diluted solution of bichloride and peroxide of hydrogen (two grains of bichloride, to six ounces of peroxide), will be serviceable. After awhile it is best to use the full strength. Pinus canadensis alb. (one-half ounce to six ounces of water), or perhaps the stronger zinc solutions may be advisable. When the discharge refuses to yield to these the use of sulpho-carbolated zinc (two drachms to six ounces of peroxide of hydrogen), will give very satisfactory results. Lloyd's hydrastis being colorless, is a pleasant remedy, and can be used in variable proportions. A few grains of morphia sulph. added to any of these will relieve the spasmodic pains.

The great avoidance should be not to cause a stricture by too severe astringents. Iodoform powder has been safely introduced by means of a powder blower and a small ear syringe. If this does not irritate it is certainly very healing to the granulating mucous membrane, and is far preferable to the medicated urethral bougies. During all this time we must not cease with our remedies, or dietetic régime, which certainly have a decided effect. Cleanliness, too, must be rigid. The use of absorbent cotton or gonorrhœal bags must be employed to protect the prepuce.

The treatment of the terminal or gleety stage is fraught with much discouragement; the patient becomes weary of the "continuous discharge" which the physician is often baffled to check. The inflammation has now involved the prostatic urethra, the prostate and the neck of the bladder. The cure is a question of local treatment and not of remedies. To do this there are two methods. The first is the gradual but radical dilation of the urethra with the sound.

This relieves the passage from any stricture which causes ulceration. Should the sound not accomplish the result desired, the application of galvanic electricity will. This should be used carefully to avoid the cautery effect.

The second method is to treat the prostate and prostatic urethra through the rectum, for here is located the final irritation which keeps up the discharge. It has been my custom for a long time to follow this practice and, as yet, I cannot record a failure to cure the most intractable case by this combined method. The lotion used must vary according to the conditions. Almost any astringent can be applied to the prostate, while to the urethra it might be an irritant. Tannic acid, zinc sulphate, creolin, or even mild nitrate of silver solutions can easily be applied through the rectum by means of absorbent cotton. As the symptoms become more favorable the treatment should be less frequent, and the application should be more mild in character. If these considerations may receive a careful trial, I am quite sure that these chronic and unfortunate cases will average a greater percentage of recovery.

CLINICAL HINTS.—The appearance of herpes on the lips during acute meningitis is a sign that the disease is nontuberculous, but it is not always indicative of certain recovery, as it is in pneumonia and some other affections.——Congenital fistulæ in the sacro-coccygeal region invariably communicate with dermoid cysts, and should not be tampered with in any way but cut out with the scalpel.——It may happen that exposure to a case of hæmorrhagic variola will occasion only a slight varioloid. ——The possibility, in very rare cases, that the thymus gland may become hypertrophied, throws a doubt on the purely nervous origin of Basedow's disease.——Lysol, like chloroform, is a good vehicle for keeping small instruments bright and aseptic.——Gonorrhœal rheumatism in infancy has the same symptoms as in the adult, but is more rapidly developed, of shorter duration, and more easily cured.

Clinical Society Transactions.

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

SEPTEMBER MEETING, 1893.

The regular monthly meeting of this society was held September 30th, in the new building of the Hahnemann Medical College. There was an unusually large attendance of physicians and students. The chief interest centered in the reading and discussion of the following paper:

XXVIII. THE OCULAR PHENOMENA IN HYSTERIA. By F. PARK LEWIS, M. D., of Buffalo, N. Y.—Hysteria is a neurosis, the ocular phenomena of which are essentially variable. Formerly under this name was embraced a wide range of nervous manifestations. It is now recognized, however, as a clearly and definitely defined morbid entity.

Hysteria is characterized by peculiar symptoms called *stigmata*, of which the most constant are the attack with the special phenomena of the *aura*, the hysterogenic zones (ovarian, pseudo ovarian, sub-mammary and sub-scapular), the abolition of the pharyngeal reflex, cutaneous insensibility in disseminate spots, or assuming definitely the form of hemianæsthesia.

The ocular manifestations, by reason of their frequency and clearness, have an especial value, often in complicated or obscure cases acquiring pathognomonic importance.

The amblyopia alone, with its typical characteristics may enable a diagnosis of hysteria to be made, when other symptoms are uncertain, and not rarely the most marked manifestations of the neurosis are those found in the eye.

We welcome, therefore, with unusual pleasure a remarkable brochure by Dr. P. Pensier, on the "Eye in Hysteria,"* a valuable supplement to Dr. Janot's "The Eye and the Uterus," so admirably reviewed and criticised by Dr. Ludlam in the CLINIQUE† for May. Both of these

* "*Les Manifestations Oculaires de l'Hysterie*," "*Oeil Hysterique*," par Docteur P. Pensier, Paris, 1892.

† See page 214.

works contain much that is new to the English speaking world, and indeed also much of original research. I therefore readily accept Dr. Ludlam's cordial invitation to summarize the thought on the former subject for the benefit of the "Clinical Society."

The increased refinements of diagnosis, coming with each successive year in all departments of medicine, have made the clinician dissatisfied with the cruder results of former times, and it has become imperative, in order that peculiar or complicated cases be fairly understood, and the requirements of treatment intelligently met, that the work of the specialist in one department of medicine or surgery shall supplement that of the specialist in another. It has therefore, become a matter of ordinary and frequent occurrence for the general clinician to call upon the assistance of the neurologist, the gynecologist, the oculist, or the surgeon, before the case can be taken in its fullest relations; and the necessity is imperative for the broadest knowledge on the part of each.

During the past year, in an ordinary ophthalmological practice, I have seen both the extatic and cataleptic forms of hysteric seizures produced while undergoing the ordinary refractive tests; and in my otological work, hysterical deafness, sudden, absolute, persisting unchanged for months, when recovery was as immediate and complete. These cases, therefore, are of sufficient frequency to warrant their study from an ocular point of view.

The recognition of the importance of the eye symptoms in hysteria is not of recent date.

As long ago as 1618 Charles Lepois called attention to hysterical amaurosis, He records a case in which the attacks were accompanied by cutaneous anæsthesia, deafness, and blindness.

In 1740 Maítre-Jean, in his treatise on "Diseases of the eye," observes that hemeralopia—or day blindness—may follow an epileptic attack, and the description that follows is that of retinal hyperæsthesia.

In 1846-1851 Szokalski described the condition which has since become known as *anæsthesia retinæ*.

In 1842 Hocken made a careful study of *hysterical amaurosis*. He described two forms, the acute and the chronic. He notes as a feature of hysteria *intermittent blepharospasm*, and established the differential diagnosis between *hysterical amaurosis* and that dependent upon *lesions of the uterus*.

In 1847 Henrot and Briquet directed attention to the frequent occurrence of conjunctival anæsthesia accompanying hysteria; "next to anæsthesia of the skin," says Henrot, "that of the conjunctiva is most frequently found present."

Briquet is even more categorical. "Conjunctival anæsthesia," he says, "especially of the left eye is met with so frequently that it is rare to fine in hysteria, a clear perception of the finger when it is moved over the conjunctiva." He also directed attention to *achromatopsia*, or imperfect perception of colors, and observed that when the *amaurosis* is unilateral it is rarely recognized by the patient.

Bezencon (1849) established *temporary strabismus* as a feature of hysteria, observed at the conclusion of the attack. He differentiated between *hysterical amblyopia*, which is usually slow in its approach and frequently monocular—and that from lead poisoning—which is binocular, and which develops rapidly." In lead poisoning—the pupil is always changed in its shape—sometimes dilated, sometimes contracted—while during recovery the pupil is irregurarly dilated—with marked hemiopia—phenomena which I have never observed in hysteria"

The invention of the ophthalmoscope demonstrated merely that in hysteria, no marked changes take place in the deeper structures which are apparent to the eye, and notwithstanding the labors of Graafe it has been but recently that the investigations of Galezowski, Lebréton, Charcot and others have thrown much added light upon this interesting subject.

THE NORMAL EYE IN HYSTERIA.

By the normal eye in hysteria we understand that in which the visual function is not modified excepting during an attack. In hysteria the ocular manifestations are not exhibited by marked tangible outward signs. "However," says Robin," even aside from the the attack one is struck by the peculiar appearance of the eye of the hysterical. The lids, if not hyperasthetic are widely opened and rapidly shut with a blinking motion; the globe moves aimlessly from side to side, the movements being as incoördinate as are the ideas of the subject.

Those indications, however, are neither sufficiently definite nor constant to be characteristic of the neuorsis.

The Visual Field: In numerous cases of hysteria, no

defects of vision are present. The normal acuity is found and the field, for *white* presents no unusual limitations.

There is one indication, however, which we have always found present. If we determine successively the field for white and then for colors we find that while the field for white is not modified, that for colors presents constant and typical anomalies.

It will be observed at once that the field for colors has been concentrically enlarged, and that the usual range of field has been no longer maintained in the usual order, viz: white, blue, red, green. The red and blue closely approach the limits of white. The circles of white, red, and blue have almost become tangents. Sometimes their extent has become so greatly increased that blue has become the peripheric circle. Occasionally too, in this enlargement, the colors do not maintain their respective relations, and the field for red may be greater than that for blue, even the red may become peripheric. The field for green is more constant. In but a single instance have we seen this field the larger.

Modification of sensibility in the ocular region: Anæsthesia of the palpabræ is of rare occurrence disassociated with hemianæsthesia. Charcot and Freré find however, that in some instances hysterical insensibility of the tegument may be limited to the skin of the orbit as well as involving the conjuctria.

Monocular or binocular anæsthesia is frequently combined with painful spasm of the orbicularis. The anæsthetic zone extends in a circular direction to the distance of two centimeters beyond the periorbital region. In the same zone byperæsthesia is found accompanying blepharospasm with pain and photophobia. The hyperæsthesia then involves the cornea conjunctiva.

A well-known feature in connection with anæsthesia of the ocular membranes is the preservation of the glandular reflex. Notwithstanding the lack of sensation, excitation of the conjunctiva will produce an abundant flow of tears. The secretion is produced rather more slowly, however, than in the normal eye.

Hysterogenic zones of the ocular region.—There exist in the ocular region—hysterogenic zones, those which excite spasmodic action, and those which produce a lethargic condition. Toward the close of a hysterical crisis if without special purpose, we should blow on the eyes of a patient we may find immediately a hypnotic condition to

supervene. We may have repeated this manœuvre in each attack toward the close of the crisis, and each time with the same result in the same way. Compression of the ocular globes may produce an opposite result, and the hypnotic condition may become the spasmodic.

Ribalkin cites the case of a young girl in whom compression of the eye excited a lethargic condition of the opposite half of the body; while in two cases in the Sal Rietner's, Gilles de la Tourette produced convulsive attacks by compression of the ocular globes.

It is of interest to inquire exactly where these spasmogenic points are located. Lichwitz by careful experimentation has been enabled to locate these zones in the conjunctiva, the cornea, and the lachrymal canal.

If the subject be in a cataleptic condition, touching either one or the other eye will cause a lethargy. A continued irritation of the cornea or conjunctiva will excite a convulsive crisis. The introduction of a probe in the right inferior lachrymal canal will be followed by a cataleptic condition; if in the left inferior lachrymal canal lethargy follows. If the canal be opened and the sac probed a convulsive crisis will result.

Charcot has demonstrated the existence of corresponding hysterogenic zones in the deeper ocular structures, which may be excited by a more or less prolonged action of rays of light.

Prodroma of an attack.—One of the earliest symptoms previous to an attack is the appearance of, or increase in the amblyopia. This precursory amblyopia is characterized by a more or less complete loss of vision for colors, with diminution of central acuity. There will be discovered a transitory narrowing of the visual field.

Roder has observed as premonitory to an attack, a mydryasis over which eserine exercised no influence.

Temporary conditions that follow an attack.—Different contractions of the ocular muscles may persist after the attack has passed. Monocular diplopia has been recognized associated with spasm of the accommodation. Spastic strabismus with conjugate deviation has been also observed.

Roder has noted as a temporary condition consecutive upon an attack, ophthalmoplegia interna and externa (immobilization of the globe by contraction of the extrinsic muscles of the eye).

The visual field continues to be restricted at the end

of a crisis, but not to the same degree as in an epileptic attack.

Glazowski classes the hallucinations of sight among the visual symptoms of hysteria. They are for the greater part psychical; while usually prodromal they may follow an attack, constituting hysterical delirium. They are sometimes present during the lucid intervals. In some subjects the character of the hallucination is invariable. They take the form of a track of flame, of a ball of fire, of grotesque figures, or of bodies of animals.

The hallucinations resemble those of alcoholism, with the characteristic difference that the animals seen are always luminous.

They appear, moreover, on the same side with each hysterical subject, and that the side corresponding with the hemianæsthesia.

The visual condition during the hypnotic condition.—It is impossible, says Richter, to formulate a general rule on the subject of the different senses during the hypnotic condition. They may all be entirely abolished; they may be intact, or they may be diminished or increased to an unusual degree.

In regard to the perception of colors, according to Konigshöfer, it is not the names of the colors that are abolished by suggestion—but in fact the cerebral perception of the color itself.

Richter says that the hallucination for colors is present only when the eye is not achromatopsic. In hysteria it is impossible to make a subject see a color for which he is normally blind. Neither if one eye is achromatopsic can the colors be perceived as an hallucination unless the normal eye be also open.

It is an interesting fact pointed out by Charcot, that when a subject is color-blind from birth, he sees in the hypnotic condition, not the color suggested, but its complimentary color.

"If a subject having congenital green blindness is shown a white card on which he is made by suggestion to see a red cross; in substituting quickly for this another blank card, however, he will declare that he sees a green cross, the complementary color to the one suggested. On multiplying these tests the complementary color will invariably be named instead of the one shown by suggestion.".

THE PATHOLOGICAL EYE IN HYSTERIA.—Hysterical Amblyopia. In the retina we find modifications of sensation

analogous to those observed in the cutaneous envelop, with the added fact that in the eye their study is more exact and their characteristics better determined. As in the more superficial tissues, we find the retina either anæsthetic or hyperæsthetic according to other conditions. *Retinal hyperæsthesia* accompanies painful manifestations of the disease and is then called *kopiopia*.

Retinal anæsthesia constitutes that form of hysterical amblyopia of which Parinand some years ago gave an exhaustive study.

Simple hysterical amblyopia is characterized by a diminution in the acuity of vision with narrowing of the visual field and imperfect perception of colors. It is frequently accompanied by a peculiar disturbance of sight, *polyopia monocularis*, that is multiple vision in a single eye. The initial stages of the disease are not generally recognized and there is usually no suspicion on the part of the patient that any ocular trouble is present. No ophthalmoscopic changes are present. Usually the amblyopia developes insidiously: again it may abruptly follow an attack or appear without any appreciable reason. Its duration is variable, extending from a few hours to a period of years. The acuity of vision is usually modified by disturbances of accommodation. Distant vision is generally defective even after correction with glasses, but a near point may be discovered at which vision is almost normal. In another and less common class of cases both near and distant visson is defective. Here the amblyopia is the result of a complex variety of disturbances. In a third class of cases the acuity of vision will be found absolutely normal, the amblyopia being characterized by dyschromatopsia (imperfect perception of colors) and limitation of the visual field. There is sometimes present also those peculiar phenomena called macropsia, or micropsia, in which objects appear larger or smaller than they really are.

Dyschromatopsia forms an important and interesting feature of hysterical amblyopia. Blindness for a single color or difficulty in distinguishing any are the forms usually observed. The former is the more characteristic. Dyschromatopsia is usually difficult to discover and it may be impossible to exactly determine the degree. The inversion of colors has been noted under the normal hysterical eye. In hysteria the colors disappear in regular order. Charcot in the disappearance of colors recognized two series. In the one the violet is lost first, then in succession, the green,

the red, the yellow, and the blue. In the other series the red is the last color perceived by the subject. In women the preception of red is longest retained, in men, blue. There are numerous exceptions to this rule. Hilbert has recognized a condition which he calls *erythropsia*, in which all objects retain a uniform reddish tint.

Regnard has noted curious characteristics of hysterical achromatopsia in the recomposition of colors on Newton's disc. In hysteria with achromatopsia for green a rotating disc composed of segments of red and green should be seen as red, it is seen nevertheless as white the resultant of red and green.

Polyopia, more than a single image of an object perceived by the same eye, is found in other affections than hysteria. Duchenne, Parmand and Galezowski have observed it in different cerebral affections. Barrat on the commencement of ataxia, and Banchat in an epileptic. It may, as oculists well know, be dependent upon some fault in the structure of the eye. In hysteria refractive difficulties may contribute to the production of polyopia, but are not in themselves sufficient to occasion it.

Hemiopia has in a traditional way been regarded as a form of restricted field common to hysteria. Charcot has always maintained, however, and more recent researches have demonstrated his correctness, that the narrowing of the visual field is always concentric and never assumes the form of *hemiopia*.

The Visual field for colors. — There appear to be two phenomena, so constant as to be pathognomonic of hysterical amplyopia. These are, first the inverstion of the circles for colors as already shown under the normal eye, that is, the usual order of white, blue, red, and green is inverted; and second, the disproportionate limitation of the field for white. The first seems to be invariable, the second occurs so frequently as to make its absence the rare exception. In exceptional instances a peculiar form of scotoma is observed, which has been termed the "para-central scotoma." In this case the scotoma takes the form described be Hirschberg in chronic alcoholism and by Moore in certain cases of *diabetic amblyopia*. Here central vision is preserved, but extending around it is a zone in which visual perception is totally wanting. Beyond this again peripheric vision is found. This form has been met with and described by Finkelstein. *Sympathetic hysterical ambyopia* is a form met with in one eye as a result *of lesions to its fellow*.

Kalt brings to the notice of the ophthalmological society of Paris, the case of a young woman twenty-four years of age, who received in April '91, a tolerably severe blow on the left eye; following this was developed an iridochoroiditis. By the following June, sight had become wholly abolished. The left globe had also become lessened in size. Tension was reduced to —2. In the right eye were no apparent lesions, fundus normal, v=$\frac{1}{20}$.

The visual field normal for white, contracted for blue, achromatopsia for red, which is seen as black, and for green which appears white.

An anæsthetic zone is formed in the neck and forearms, the patient had without any apparent cause two convulsive crises followed by fainting in July and August. Enucleation of the left eye was followed after twenty days by an improvement in the vision in the right eye to $\frac{2}{3}$.

The diagnosis of *sympathetic hysterical amblyopia*, was made by Kalt on the symptoms of achromatopsia, with contraction of the visual field for colors.

Neither of these symptoms would seem absolutely pathognomic, but coupled with the other *hysterical stigmata* the diagnosis is verified.

It would be interesting to inquire, whether in these sympathetic cases all of the characteristics of hystrical amblyopia are present, or if the usual forms are to any extent modified.

Complete hysterical amaurosis.—The continued narrowing of the visual field when the condition is progressive, as it usually is, will result in complete loss of vision. Absolute blindness is unusual however, as the disease is almost always monolateral. The blindess is generally transitory, although in exceptional instances it may last for a long time. In a case reported by Mandel it remained for eight months, while in one reported by Harlan, which, by the way was very unusual, loss of sight persisted for ten years. Parmand and Bernheim have pointed out a marked peculiarity of this form of amaurosis. In one eye the vision may be absolutely lost, while binocular stereoscopic vision will still be retained. This is explained by thc theory that the trouble being wholly functional and monocular, it disappears when the eyes are synergically employed.

The nature of hysterical amblyopia. — Many theories have been offered as to the origin of hyterical amblyopia. The most reasonable would seem to be that of Bernheim. He regards the disease as purely psychical. The retina

may receive an impression which is perceived by the cortical visual center, but the imagination of the subject neutralizes the impression and he makes for himself a negative illusion which is destructive to the impression received upon the retina.

Cohn attributes hysteria largely to menstrual disturbances. He does not assume that hysteria may exist independent of uterine difficulties, but he believes that a very large proportion of the neurotic disturbances met with are directly dependent on derangements of the reproductive organs. Hysterical amblyopia, especially, he strongly believes to be traceable to menstrual difficulties of so light a character as frequently to have been unrecognized. An objection to this theory will be found in the fact that males are quite as subject to hysteria in some of its forms as are females.

Kopiopia.—Foerster has given the name *kopiopia hysterica* to that condition characterized by lancenating pains having their chief seat in the region of the eyeball, with radiations toward the temporal and zygomatic regions. This form of nervous asthenopia has been described by Donders under the name of painful accommodation, and by Nagel as ciliary hyperesthesia. More recently Schenkl has given it the name *hysterical ocular neuralgia.* This condition is most frequently observed in women. "There is no practitioner of experience" says Abadie who has not found among his feminine clientelle those who are unable to use their eyes for a moment without experiencing violent pains in the head and most severe photophobia, with aching in the frontal and periorbital regions. There will also be burning of the lids and a sensation as if there were dust in the eyes. Usually no refractive anomaly is present, nor is there any abnormality of the fundus to be discovered. The women in whom the conditions are most likely to be found, according to Nuel, are unmarried women who are no longer young, or married women who are sterile.

Hysterical ophthalmic migraine sometimes accompanies or takes the place of, the aura preliminary to an attack. It may be produced by the compression of certain points termed *migrainogenic zones.* Hemianopsia has never been found coincident with this form of migraine.

Hysterical involvment of the muscles of the eye are both interesting and peculiar. Nystagmus has been observed only in exceptional instances. Blepharospasm is not infrequent, however, and may assume the clonic, tonic

or pseudo-paralytic form. It may be either with or without pain; in the first instance there will be always present hyperæsthetic zones extending around the orbit; in the latter these zones will be anæsthetic. Insufficiency of conveyence is not commonly met with in hysteria. When it does occur surgical interference is never indicated.

It has been possible to touch, merely, upon the more important features of the ocular manifestations of hysteria. The subject, however, certainly opens a wide field of investigation and study both for the student of opthalmology and general neurology.

Discussion: Dr. Jos. Watry: Although hysteria is not such a serious disease, it is likely to occasion much embarrassment in the mind of the young practitioner because it embraces a multiplicity of morbid phenomena.

The term hysteria is apt to be misleading on account of its derivation from a Greek word which means womb. So-called because the female is more prone than the male to the affection.

It is often improperly applied to cases which do not admit of ready explanation. Analyzing hysterical cases carefully, we find that there is a disturbed or congenitally defective condition of the cerebral substance involving in all cases the highest nervous centres, sometimes extending more or less also to some of those which preside over the lower.

It is certain that there is always a disturbance of either the conscio-voluntary, the sensori-motor or the reflex nervous centers. Hence we may have in hysterical subjects a disturbance of one or more of the five special senses —fibres for sight, hearing, smell, taste and touch. There is usually a tendency on the part of the patient to exaggerate the acuteness of the special senses. A simple cog-junctivitis or a moderate amount of asthenopia is liable to upset several nerve centres and bring about various remote symptoms besides most all the subjective symptoms the eye is capable of producing.

Fortunately I have not had much experience in handling hysterical patients. I have, however, read very care-

fully the history of quite a number of cases reported and I am inclined to be rather conservative in attaching too much importance to the majority of the ocular phenomena. The ocular symptoms of consequence seem to be the following:

A contracted pupil at the beginning of an hysterical attack. In case that the patient goes into spasms there may be an alternate contraction and dilitation of the pupil, even under exposure to bright light. Oftentimes the patient's eyes assume a staring look or wild expression, an evidence of some central interference with the co-ordinated action of the lids and the muscles of the eyes.

Concentric contraction of the visible pathological changes in the fundus of the eye is generally accepted and has been observed by most oculists.

It is important to note that in hysterical cases even when one eye is quite blind or has barely perception of light the reflex action of the pupil, direct as well as indirect, is fully preserved.

Sometimes there is a morbid desire on the part of the patient to feign blindness of one eye either to deceive friends or even the doctor, or to excite interest or sympathy. In order to detect the deception the subject is seated before a lighted candle about fifteen or twenty feet distant and a seven or ten degree prism placed before the admittedly sound eye. If now superimposed double images are acknowledged there is binocular vision and the fraud is detected. It is easy to understand how it is possible for a patient who is laboring under hysterical hallucinations to produce a repetition or imitation of former impressions, or to have an over-excitation, or to have a depression of certain functions, but I cannot understand how it is possible to have nerves or nerve centres assume a function that never existed. Some claim that there is sometimes a concentric enlargement of the visual field for different colors.

According to the undulatory theory of light, which is now generally accepted, there are in the eye three kinds of nerve fibres. Stimulation of the first produces the sensation of

red, the second that of green and the third the sensation of violet. Objective homogeneous light excites these three kinds of fibres in varying degrees according to the wave length. The red perceptive fibres will be strongest stimulated by light of the greatest wave length, the green perceptive by light of medium wave length and the violet perceptive by light of the smallest wave length. We thus see that each set of fibres has its function, and when the eye is fixed on one and the same point it is capable of distinguishing the colors at a limited distance.

Now although there is as a rule an increase in the acuteness of the special senses, it does not seem possible that even if there is an abnomal acuteness of the color sense that there should be a concentric enlargement of the visual field for colors.

Dr. Vilas.—The paper to which we have just listened is especially valuable to the general practitioner, and in conjunction with the one read by Dr. Ludlam at the April meeting, forms a most interesting contribution to this society. Personally I feel much indebted to the gentlemen who have spent so much time in their preparation, for I know the amount of labor required, and I have no doubt their papers are fully appreciated by all present, and will be by those who will read them hereafter. We have little literature on these subjects, the field is broad and pathless, and it requires energy and original methods to successfully cultivate it.

Inasmuch as the two papers referred to are to be considered together, and Dr. Watry has spoken on hysteria, I shall not attempt to further discuss it, but confine myself to a consideration of some points in the first review, Dr. Ludlam having referred to some of the cases in which we have been associated.

At all times the ophthalmologist is much troubled with reflex symptoms from the generative organs with little chance to find out just what may be their cause. For the most part it is only in hospital practice that they can be intelligibly studied by two or more specialists on different

branches of the medical art. Therefore anything that will contribute to our knowledge of these subjects receives a cordial welcome from the oculists.

I have carefully gone over the paper given us by Dr. Ludlam, previously referred to, and can add nothing new of value, though I could confirm much from experience and add many cases. But yesterday I saw a well-marked optic neuritis associated with the climacteric. Glaucoma at this period has long been well known, and the attention of the general practitioner as to the dangers in using atropine in the eyes of persons over forty years of age is specially enjoined.

During pregnancy and the puerperal state, however, we see many of our saddest results. Dr. Janot attributes those of labor to the cerebral congestion that is caused by the struggle and the strain of delivery, and regards them as usually self-limited when not associated with confirmed Bright's disease. But the opposite is true of the early post-partum period. I may not have quoted these conclusions verbatim, but the substance is correct. These conclusions are entirely correct, for the lesions at this period are not only serious but most difficult to cure. It is often very discouraging to be called in as a consultant at this period, for at times there is no remedy for the various troubles. The uveal tract (as the author of the monograph points out) is most susceptible to the entrance of the poisonous germs; destruction is borne upon them at the outset, and those delicate structures composing it, the choroid, iris and ciliary body, become involved in a hopeless tangle. Such cases go far toward confirmation of Delvectar's theory, that all cases of iritis are due to infectious origin, a theory, by the way, that no one thinks of accepting as at all conclusive.

The troubles at puberty are often alarming, but as a rule not dangerous, and are persistent only as the function is delayed. Though seemingly so to the patient, the optic nerve is rarely affected, and I cannot recall that I ever saw it seriously or permanently so. In one case I recall I was

much alarmed, but that is nearly twenty years ago, and the result has proven good. All such cases must be thoroughly examined by the ophthalmoscope, and cases reported of such troubles not so carefully examined are not convincing to me, however good the physician. Direct objective results are much more convincing than subjective speculation, and hence our old-time literature, collated before we had this valuable instrument, throw little light on these dark subjects. On the whole I think conjunctival troubles predominate, and are usually readily amenable to treatment. Far more frequently than is done could an oculist render efficient aid were he called in consultation earlier. The usual method is to await a careful trial of remedies, or a vague hope that nature will relieve the trouble. That the latter is the case so very often probably accounts for the few cases of such troubles which the eye specialist sees, for not very many receive any treatment at all as nearly as I can judge from connection with both parents and physicians.

But I must conclude my remarks on these very interesting papers. The subjects are so interesting to me and so full of really valuable and practical information that I could talk and perhaps have talked longer than I should. In view of all we have heard to-night may I venture to hope that we general practitioners will continue to sow among the laity the knowledge that the oculist's mission is not limited to ordering "washes for sore eyes," and that they are really useful in unraveling the tangled web of general diagnosis. Then when patients are sent they will not be surprised to learn that in different cases some one or more of the viscera may be interrogated by the ophthalmologist to the direct benefit of the patient.

Dr. C. J. SWAN: The paper upon "ocular phenomena in hysteria" has been listened to with interest. In discussing it one is somewhat handicapped by the difficulty in determining which portion is original with the author of the monograph and which with the essayist.

The whole subject seems to me to be one for the neu-

rologist rather than for the occulist, and indeed most of the research upon the subject has been by neurologists as proven by the small proportion of names of oculists as compared with neurologists that have been quoted. Of course the most interesting portion to the oculist is that which treats of the pathological eye in hysteria. However, there is one paragraph under the heading, "The normal eye in hysteria," which will bear some comment.

I refer to the paragraph beginning thus: "The hysterogenic zones of the ocular region," etc., and goes on to state that Lichwitz by careful experiment and investigation has demonstrated the exact points of location of these zones in the eye. They are the conjunctiva, the cornea and the lachrymal sac. As these carefully located points cover the whole of the anterior portion of the eyeball, the mucous lining of the lid, and continue down into the lachrymal sac, he has left very little to be hoped for so far as further discoveries are concerned with regard to the hysterogenic zones of the eye. In regard to the effects of irritation of these zones, while it is easy for an oculist to believe that the opening of the sac and the introduction of a probe may produce convulsions, for he has often seen a near approach to them under like circumstances in children who were far from being hysteric, it is difficult for him to extend a like amount of credulity to the remaining statements. He is apt to look upon them with distrust and to consider them visionary.

The idea of a patient going from catalepsy to lethargy, and from lethargy to convulsions and back again with intervening spasms as a result of a slight irritation of the hysterogenic zones, is rather an astounding proposition to the simple oculist. To the man versed in nerves it might appear as not out of the ordinary, but the oculist who has been taught nothing of the sort by men with whom he has worked and whom he considers authorities, is therefore filled with doubt.

Hysterical disturbances of vision are not so uncommon, and include hysterical amblyopia, amaurosis and astheno-

pia. According to Fuchs, the diagnosis of hysterical amblyopia is based upon two points. The first of these is the absence of any demonstrable change in the eye which might explain the enfeeblement of sight. The second is the lack of agreement between the individual symptoms constituting the disturbance of vision, which, under other circumstance, they would exhibit. Thus, the acuity of vision and the extent of the visual field changes frequently. The relation of the color limits within the field are not in accordance with the rule. Persons whose visual field is much contracted still move without stumbling and with perfect security in a place which is not well known to them. Hysterical amblyopia usually attacks young people, particularly of the female sex. It affords a good prognosis. Ordinarily a complete cure takes place.

The treatment suggested by Fuchs' is the management of the causal lesion, hypodermic injection of strychnine and the application of the constant current. He confesses, however, that the brilliant results often obtained by the use of the last named remedy, are due largely to the psychic influence upon the patient, where the latter has confidence in the treatment and anticipates a cure from it.

In making the diagnosis of hysterical asthenopia or "kopiopia," also called in Berlin, dyslexia, proof must first of all be forthcoming, that there is no refractive error or lack of muscular equilibrium to cause the trouble. Nervous asthenopia is often associated with amblyopia. In several cases autopsy has demonstrated the presence of disease in the left hemisphere, more particularly in the neighborhood of the third frontal sinus.

It seems to me that the essayist shows a lack of consideration for his readers in his remarks at the end of the paper. After quoting numberless authorities and writing of phenomena wonderful both in their number and quality, the reader is just getting his amazement in hand when he is brought down with a dull thud by the suggestion that the subject has only been lightly touched upon, and he

is at once brought to a realizing sense of the much he has yet to learn.

The paper is written in a masterly style and were it not for the unfortunate suggestion at its close, it would be easy to believe that the subject of ocular phenomena in hysteria had been exhausted. While some of the statements will be taken "*cum granum salis*," the whole cannot fail to be read with interest and profit.

Dr. DUNN: The important point to me is, What do you do with these cases? We have had a lot of discussion with but little practical result. To me the hysterical eye is but part of the whole. I believe these cases to depend on some primary lesion, some diseased organ somewhere, not always the uterus, but the rectum, liver, nose, etc. The important point is the association of the primary cause. I do not believe in hysteria, but I do believe that the primary disease develops the nervous symptoms. I have cases sent me where the trouble is not in the nose or mouth, but in the rectum, colon, etc. I had a case of general hysteria, which I cured by operating on several spots in the throat.

I believe diagnosis will be more and more developed until we shall find in each case of hysteria some primary disease.

Dr. H. B. FELLOWS: How many throats have you seen which have these spots that were not hysterical? I have no doubt but that you have seen hundreds. There must be a nervous condition or diathesis back of these spots or else every case would have the same hysterical symptoms. We can explain this only by supposing some peculiarity of the system that would make these spots in the throat affect the system in some peculiar manner. Thus we must suppose that the spots have acted on the peculiar constitution. These local conditions in the throat acting on a system not predisposed to hysteria produce no such results. We are, therefore, obliged as a logical necessity to acknowledge a hysterical condition back of all these local manifestations. It is true that some slight operation on a healthy part,

appealing to the imagination of this class of patients will produce sufficient moral effect to relieve the patient of the hysterical symptoms. Any treatment that does not take into consideration the moral environments of these patients will prove ineffectual.

Dr. W. A. DUNN: In answer to Professor Fellows I would put a parallel question: Why do forty persons exposed to the same draft not all contract the same diseases? One gets pneumonia, another bronchitis, another inflammation of the liver, another stuffs his nose,and the remainder have nothing. I do not believe that either condition depended on a diathesis, but a resistive power of the vaso-motor nerves. In the majority, the vaso-motor system is so tense, so well balanced that it resists such impressions with but a passing shiver or no symptom at all. So it is with local irritations, especially in such localities as the throat where the vaso-motor nervous system is not so freely distributed.

It is different, however, with many other portions of the body. The uterus, rectum, the colon, the prepuce, etc., are freely supplied with sympathetic nerves, and are directly connected with the large sympathetic centers that govern the nutrition and circulation of the whole body. Therefore local diseases or irritations of such localities readily produce reflex symptoms in all or a portion of the body.

I admit the mind has much to do with the manifestation of these reflex symptoms, because the will power is normally in command of the organs temporarily acted upon by the vaso-motor spasms and manifestations. As long as the will power retains its ability to govern these organs nervous manifestations that have to do with voluntary actions cannot take place, but if the sympathetic force reach such a degree of intensity, or the normal psychical force be decreased, then the equilibrium is destroyed and the sympathetic reigns supreme, and continues to do so until the cerebral power is restored or stimulated to action.

So many of these local conditions begin during early

childhood, and develop the reflex symptoms at such an early age that it has been the habit to attribute the condition to a nervous diathesis; but, should we look for causes in early life, and remove them at that time, hundreds of bedridden and invalid people would now be strong and well.

I do not believe in the moral treatment of such cases as having anything to do with the permanent cure, and I am satisfied that no remedies will cure these cases unless directed to some special irritation of the vaso-motor nervous system.

I earnestly expect to see the day when all such manifestations will be as easily curable as are the well diagnosticated diseases of the present time.

Dr. R. LUDLAM said: The existence of an hysterical diathesis, in men and women, is based upon as good clinical evidence as the tuberculous, the rheumatic, or any other diathesis. But its lesions are so inconstant and its symptoms so elusive and deceptive that it is often extremely difficult, and sometimes impossible, of recognition. Its mimicry and mystification of serious disease has often misled the physician in his diagnosis and defeated his attempts at cure. Every experienced and observant member of this society can witness to the truth of this proposition.

Now, if there is any means by which we can identify this mischievous counterfeit, or by which we can be certain that its lesions of function deserve to be classed as accidental, noisy but non-essential, and as belonging to some phase or form of hysteria, let us have it and make use of it. If the uterine, the ovarian, the pharyngeal, the mental, the rectal, or the ocular test will determine the true nature of a difficult case, the key to its intelligent diagnosis, prognosis and treatment is in our hands. For it will often happen, in chronic cases especially, that when the hysterical epi-phenomena are excluded and erased from the pathological picture the case is more than half cured to begin with.

If the changes in the visual field that have been de-

scribed and illustrated in Dr. Lewis' excellent paper, and which have been verified by Charcot and so many illustrious observers, are constant, or even common in hysteria, the fact becomes something more than a curious circumstance. For it is lifted to the dignity of a differentiating clinical symptom that is possessed of great value in a confirmatory way. And so, with his ophthalmoscope, the oculist might be able to tell us if a knotty case was, or was not, wholly or in part hysterical, after which we might perhaps find the eye symptoms very suggestive therapeutically.

So, I apprehend that in searching for the real lesion, whether functional or organic, the general practitioner might sometimes need to know what the oculist only could tell him; just as at other times he would find it to his own and his patient's advantage to consult a "pestilent specialist" of another sort. For the mutual relations and the morbid possibilities of these complicated sympathetic affections often render them so obscure as to defy all the ordinary old-fashioned means of clinical analysis, and we need a new resource.

Having devoted three evenings to the hearing and discussion of as many papers upon the "Morbid and Therapeutical Relations of the Uterus and the Ovaries to the Eye," I cannot escape the conviction that we have done a good work, one that will redound to the credit of this society and to the benefit of the general profession.

DR. O. L. SMITH,
Recording Secretary.

Hospital Notes.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

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

A SUPPURATING CYST OF THE RIGHT BROAD LIGAMENT COMMUNICATING WITH THE BLADDER. REMOVAL. RECOVERY.—*Case 21,028.* Admitted September 13; sent by Dr. B. S. King, of Muskegon, Mich.; æt. 35. Has been married fifteen years, but never pregnant. Began to menstruate at fourteen and the periods have always been irregular, with occasional intervals of three months, the flow being scanty and accompanied by "sick headache." Four months ago she had a severe attack of inflammation of the bowels, which ended with a three weeks' discharge of pus from the rectum. When this had ceased she soon began to have trouble with the bladder. A very painful flow of a thick, dark urine, with a purulent deposit, inability to lie on the right side, with pain in the corresponding inguinal region, about the hip and within the vagina. There is some leucorrhœa, and she is so lame in the right leg as to be unable to walk without help. Local examination detected an oblong, firm, but very sensitive tumor lying in the right half of the lower pelvis.

Operation.—September 16 a laparotomy was made before a sub-class, and a suppurating cyst containing more than a pint of bloody pus, was taken from between the layers of the right broad ligament. It was completely enucleated, the remains of the degenerate ovary lying at the top of the tumor, of which it was a part. Rupture of the cyst, flushing and the Mikulicz drain.

The removal of a tumor that is included in the broad ligament is sometimes a very difficult, and always a serious operation. For it is so located that we must almost always work in the dark, and the relation of the ligament

*Continued from page 439.

to other organs and vessels is so important that it must be done in a delicate manner. Imagine such a sac as this lying distended to its utmost, within the right broad ligament. Its posterior wall would be in close proximity with the large intestine and the mesentery. Anteriorly it might lie almost directly in contact with the bladder, the pubis or the abdominal parietes. Since lifting it out of its bed I have not a doubt that the pus which was discharged by the bowel came from the intra-ligamentary abscess; nor that the subsequent flow of pus with the urine had the same origin. Both these outlets were fistulous, and the first one must have been closed before the second was formed.

Our friend, Dr. B., asks why we did not aspirate the sac and so avoid its rupture? If it had not lain entirely within the ligament, or if it had been such a free cyst as we find in making an ordinary tubo-ovariotomy, I should have done so; but in this case I wanted and needed the outline of the distended cyst as a guide and a guaranty for its complete separation and removal. Considering the nature and extent of the adhesions to the bowel, the bladder, and possibly also to the pelvis and its important vessels, as well as to the ureter (which I felt very distinctly during the operation), this expedient furnishes a safeguard that more than compensates for the risk of a possible rupture.

October 4th. This is the nineteenth day and here is our patient almost well again. Observe that the abdominal wound is closed perfectly except at the site of the drain, which is very slightly open.

A few facts in her case are worthy of note. When the bladder was first emptied by the catheter, after the operation, it contained a considerable quantity of "the same sort of pus" that came from the suppurating sac. Doubtless the manipulation of the sac while it was being enucleated had forced a portion of its contents into the bladder through the fistulous communication which existed between them.

Since that time one drawback to a more rapid recovery has consisted in a sharp attack of ascending nephritis,

which has been almost entirely overcome by the usual remedies; and another was the difficulty of adjusting her diet to the caprices of an exceedingly irritable stomach, but she is all right now.

VAGINAL HYSTERO-OVARIOTOMY FOR UTERINE FIBROMATA AND AN OVARIAN HÆMATOCYST. RECOVERY.—*Case 21,037*, æt., 42, the mother of five children, brought to the clinic by Dr. O. B. Blackman, of Dixon, Ill., was operated upon before sub-class No. 1, October 5th. The menses have become scant and she feels well when off her feet. The tumor, removed by the vagina, consisted of the uterus in the walls and upon the surface of which were about a dozen disseminated fibroids, and both ovaries, the right one having developed into an hæmatocyst as large as a cocoanut.

The complications of this operation, and which added so much to its interest, were the very extensive and vascular adhesions between the uterus, the bladder and the rectum; and the rottenness of this nasty sac, which burst and overflowed the field of operation in the most disagreeable manner. Both these unavoidable conditions, bad as they were in the vaginal operation, would have been much more serious if we had undertaken the removal of these tumors by way of the abdomen. And now we have the added advantage of perfect drainage, which, if we had done differently, would have been impossible.

Wednesday, October 11th. Seventh day. This patient did exceedingly well until yesterday, when, without warning or apparent cause, her temperature arose to 103°, and the pulse to 102. An enema brought a free and natural discharge from the bowels, and the douche a slight but offensive flow from the vagina, after which her temperature fell to 102.° With the douche given this morning came a copious, dark and offensive discharge, and now she is better in every way.

October 15th. Eleventh day. The unpleasant symptoms came just when the menses were due and gradually subsided with the offensive flow. She is now getting well in every way.

ABDOMINAL HYSTERO-OVARIOTOMY FOR A TUMOR COMPLICATED WITH A PAROVARIAN CYST. RECOVERY.—*Case 20,924*, first brought to the clinic by Dr. Maxon, of Harvard, Ill., February 15th, with the following clinical history. She was thirty-two years of age, the mother of one child aged sixteen, and had suffered two miscarriages, one from a fall, and the other from a "congestive chill." With the latter the placenta was not taken until the eighth day, and she was ill for about three months. Puberty at fourteen, the menses being normal until within five years, then becoming very irregular and profuse. Seven years ago she had a severe attack of typhoid fever from which she has never fully recovered. Has pain in the left ovarian region extending down the corresponding leg to the foot; almost constant diarrhœa; vesical tenesmus and burning; frequent syncope, and frequent neuralgic pains in the face and in the right shoulder, which are worse during menstruation. A year ago she first observed an enlargement which began in the left side. Local examination found the uterine cervix very much retracted; depth of the organ, five inches; but the patient was so fleshy, and had so little to complain of locally, except the menorrhagia, that a satisfactory diagnosis was impossible. It was decided not to make an operation at present, but to try the effect of electricity in controlling the monthly hæmorrhage.

October 6th. The patient reported for further examination and operation, if necessary. The electricity controlled the menorrhagia, but the tumor has grown rapidly. The uterine cervix cannot be found within the pelvis.

Operation. Saturday, October 7, the abdomen was opened in presence of sub-class 3. This exposed a parovarian cyst, which was tapped and yielded eight pints of the characteristic spring water fluid. The cyst was very adherent above and behind to the mesentery and to the colon, and its lower third was included between the layers of the left broad ligament, from the depth of which it was carefully enucleated. Both ovaries and tubes were badly diseased, and the uterus was buried in the most intimate adhesions. A careful attempt to separate that organ revealed an extremely varicose condition of the veins in the left ligament. The uterus and its appendages and the sac were all removed in one mass; the stump being secured with the elastic ligature.

Prof. L.'s post-operative remarks were as follows: This case illustrates the impossibility of always knowing beforehand just what we are going to find within the abdomen. Our patient is very large and stout, weighing over two hundred pounds; the abdominal wall was three inches thick, and the uterus was so retracted that it could not be found per vaginam. It also shows the possibility of having to face and to surmount the most serious difficulties in the attempted removal of an abdominal tumor.

There is a general impression that parovarian cysts may easily be shelled out of their pocket, and with little comparative risk to the patient. And so they may be in a majority of cases, but as you have just seen, their possible complications are sometimes very troublesome and mischievous. I might have stripped off the covering of the uterus and left it behind, but what would we have gained since both ovaries had to come out? Besides, the parovarian varicocele, which was more pronounced than I have ever before seen it, was a bar to such an expedient. The true conservative course was to remove the whole outfit, and not to botch the thing by leaving a useless organ behind, and in a very damaged condition. The surgical requirements of the case have been met, aud extraordinaries excepted, I do not see why she should not make a good recovery.

Wednesday, October 11. This afternoon begins the fifth day, and our patient's record is, temperature, 99⅛°; and pulse 83. The dressings have not been disturbed, for she has had no symptoms.

October 15. Ninth day. The dressings were changed two days ago, and there are yet no symptoms, local or general. She is in excellent spirits, and eats and sleeps well.

Miscellaneous Items.

The winter term in the "Old Hahnemann" opened in the new college building, October 3d, with a rousing class and a royal good time.——Prof. Gilman's model introductory on Materia Medica will surely appear in our next issue.——The course on electro-therapeutics now being given by Prof. Neiswanger is very popular, and it remains to be seen who will take the prize of $100 offered for the best examination upon this interesting subject.——We are pained to note the death of Dr. M. H. Baker, class '67, at Highland Park, Ill., Oct. 19.——As work on the new Hahnemann Hospital building is rapidly approaching completion, donations toward furnishing its wards and private rooms will be thankfully received.——The clinics are so full that we need a fresh supply of the right material out of which to make good nurses as well as good doctors. Apply to Prof. Shears, Superintendent of Hospital.——Our former house surgeon, Dr. Henry A. Noyes, was recently married to Miss Harriet M. Nase, of Mt. Carroll, Ill., his present residence.——A lot of clever clinical reviews are crowded out of this number.——Dr. Boetcher has returned safe and sound from Vienna and is hard at work in Prof. Watry's clinic.——Prof. Leavitt has recently made a successful symphyseotomy (the first in Chicago, as Dr. Packard's was the first in New England), saving mother and child, in a woman who had lost her two former babies by craniotomy.——The Homœopathic Hospital in the World's Fair has been a grand success, of which more anon.——The Twenty-fifth Annual Report of the Homœopathic Hospital in Melbourne, Australia, which made an excellent showing for that side of the world, is received.——Prof. Arnulphy's clinical lectures on Physical Diagnosis and General Pathology are almost ready for publication in a separate volume.——The New York papers notice the death of our old friend and former editorial associate, Dr John C. Peters.

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Original Lectures.

THE PRACTICAL STUDY OF MATERIA MEDICA.

BEING A LECTURE INTRODUCTORY TO THE COURSE ON MATERIA MEDICA AND THERAPEUTICS IN THE HAHNEMANN MEDICAL COLLEGE OF CHICAGO FOR THE SESSION OF 1893-4, BY PROF. J. E. GILMAN, M. D.

The great field of materia medica is open before you and while at the first glance at the wilderness of symptomatology as presented in the text-books, it seems almost a hopeless task to master such a vast array of drugs, yet in a measure it can be done, and so simplified that what now is confusing to the mind will arrange itself in order and in a comprehensible form.

I once stood where I could gaze upon an assemblage of some 200,000 people closely gathered together. It was a sea of faces, and in the mass one so resembled another that no distinguishing features were discernible, yet each one had his own individuality and each one differed from his fellow, and with patience and perseverance these differences could be learned, so that meeting the man he could be recognized at once and an intimate acquaintance would reveal to you his soul, his character, and the place he was fitted to fill in the world work.

If we consider the great volume of symptoms collected together in our materia medica in bulk, they are as unrecognizable and as indistinct as the sea of human beings spoken of; but each drug has its own individuality, its own characteristics, and we must learn them just as we would

learn the distinctive physiognomy of each individual in the great crowd and so select him from his fellows. If we do this to such an extent that you have a free range of the subject, then as you gradually form the picture of a diseased condition in its completeness as you examine a patient, the drug picture that forms its remedial complement will grow with it and be ready in your mind for immediate use. The more definitely and certainly you can do this the better prescriptions you can make.

It is the intent in these lectures to map out to the best of my ability the salient features of the different drugs we shall consider, through their characteristic and general symptoms—to point out the tissues and organs they especially affect, the general scope of action, and their value as remedial agents in diseased conditions. I do not expect or wish you to take my ideas or views as final and absolute. Every man must reason the matter out for himself in the light of his own experience and observation.

If you accept any one man's dictum blindly, you are at the best but imitators and add not one bit to the grand total of progress. But if the sentiments advanced coincide with what you can believe, or if the argument is so good that you can find no flaw in it, then receive it, or if it is a matter of which you know nothing, test it by your own powers of reasoning and by observation. In other words be thinkers and observers, and so do your part to manifold medical progress. The Homœopathic law of *similia similibus curantur*, that like cures like, is a broad rule that experience teaches us is a proven truth.

There are many diversities of opinion, however, among the men who adopt this as their method of practice as to potencies and forms of prescription. The potency of the drug that is the most satisfactory for your use must be a matter for each one's decision in the light of his individual experience. The man who habitually prescribes the crude drug, the mother tinctures, or the lowest potencies, and the man who prescribes the very highest attenuations are equally good homœopaths, if they prescribe them according to this law of similia. While the converse is true that the highest potencies or any form of the drug if prescribed contrary to this rule is a nonhomœopathic prescription.

It becomes then a matter of individual belief what potency to use. Some men are very ethereal in their views and are constantly with eyes upturned star-gazing, and can see nothing lower than the faintest glimmering of some

distant planet. Some men are gross and material in their views. These study the earth and strive to get as far underground as their vision will permit, while others are ready to accept whatever of good they can perceive from the subcellar to that flagstaff of elevation the charming degree of dilution designated by its opponents as "Moonshine dosage." Personally I use all potencies in my practice from the mother tincture to the higher ones, but I confess an inability to make any statement as to the point where the medicinal action of the drug ceases. When you reach such a degree of dilution that no chemical or microscopical test will demonstrate any indication of the drugs, how can you definitely prove its presence? It becomes then largely a matter of faith, yet we know by the evidence of the senses that matter is present in the atmosphere or in a menstruum long after it has reached such a stage of attenuation that neither the most powerful microscopes or the most delicate chemical tests can exhibit the slightest trace of its existence. For instance, to use a familiar illustration: A grain of musk will permeate the atmosphere with its odor so that the sense of smell is quite cognizant of its presence. It will continue to disseminate its minute particles in this manner for weeks and the most exquisitely balanced scales will not indicate any loss of weight.

The aroma from the Bridgeport district outlying Chicago, is familiar to the sense of smell, and the detestable odors make the balmy summer evening air redolent of the rendering tank when the western wind wafts its way over the residence portion of the city; yet chemistry or microscopy will fail us in our search for the distaseful elements which the sense of smell informs us are all-pervading. A high potency prescription happily made caused me to become a homœopath, so I cannot refuse to believe in their efficacy.

When you can afford to wait as you can in chronic cases, you will be safe and satisfied I think with some of your results from the high potency prescription. You will gain a belief in their efficacy by use undoubtedly, but whether it is advisable to use them more or less frequently I can give you no advice. I wish you to become careful and competent prescribers, because you understand the intimate nature of the drug and the question of the potency can then be safely left to your discretion. There is a marked difference in the value of drugs for use medicinally. Some are required very frequently, their range of ac-

tion being such that they are applicable to a large number of cases. These more frequently called-for drugs are designated as polychrests. Arsenicum, sulphur, calcarea are samples of this class. Other drugs are needed, perhaps just as urgently when required as these, but the conditions are present to call for them but seldom; for instance by reason of its control of the capillaries, aconite is much more frequently indicated than such a remedy as cactus grandiflorus, which is limited in its sphere of action.

Our materia medica is constantly being enriched by additions and discoveries of new properties of drugs that are being proved. So some drugs that a few years ago were considered of minor importance, have in the light of these investigations advanced to the first rank and we wonder that our predecessors could successfully combat certain conditions of disease without them.

The studies and researches of our school have been largely in the direction of determining the action of different drugs upon healthy tissue. Naturally this would be so, for upon our system of therapeutics is based our value as a school. We have the same training in anatomy, physiology, chemistry and pathology that is demanded in any medical college. Our requirements are as rigid, our investigations carried as far into the minutiæ of these and the collateral branches as any of the other schools, and in addition to this we exact and demand a knowledge of drugs and their therapeutic use so much in advance of any other system, that this branch alone almost or quite equals the combined work of all the other requirements. With this preparation for the labors of the medical profession, I cannot but believe that a graduate of as well-equipped Homœopathic Medical College as ours, is better educated and more fully fitted for his life work in all departments of medical science than any of the so-called regular colleges can produce.

To be a first-class prescriber, a good knowledge of anatomy and physiology is necessary as the foundation of an understanding of drug adaptability to the parts affected. It is also of great importance to know the morbid pathology to which the remedy must be applied. But you may be familiar with these branches so that you can picture out in the most scientific terms the diagnosis of a painful case of disease. You may be able to tell the patient just how it will appear on a post-mortem examination. You may describe with a painful exactness all of the

ravages the malady has made in its progress. You may be able to describe the present condition with a photographic fidelity of detail, and if you cannot outline the remedial measures, the patient will not be half as interested as he would be in the manner of the removal of all his ailments. He very probably would be impatient enough to interrupt you with the query, Can you cure it, and what will relieve this state of affairs? This to him is the all important portion of the whole business.

To be a good prescriber requires a close application to these preliminary branches, and a closer, more painstaking and persistent study of the materia medica. Then the question arises, How shall we best study it? How shall we arrive at that intimate acquaintance with drugs so that a prescription will be a scientific one, and will seem like an intuition?

In a general way I should suggest that you should do just as you would if you wished to know intimately the individuals you meet daily. There are first certain peculiarities of speech or expression, or features differing from others which you recall, special idiosyncrasies which you associate with them, and which at once recall them to your mind.

So with our remedies there are some symptoms which stand out prominently as distinctive or guiding indications, keynotes leading the mind in the direction of the personality of the drug. These are valuable as far as they go, but they are still on the surface. Just as you may know this man has red hair and freckles, and another one has a wart on the nose, and squints. If your knowledge of the individual goes no deeper than this, you will possess but a superficial acquaintance with him.

Many men might have these external peculiarities, and such similar marks not exactly identical perhaps, but so nearly so that you would be deceived in an attempt to discriminate between them. So with our drugs; your knowledge of them must extend to their intimate relation and action on the human system. You must know them better than by the few keynotes, just as you must know an individual's character and habits to be thoroughly acquainted with him.

For instance, a keynote or characteristic of aconite is anxiety and great restlessness. But other drugs have the same as a characteristic also; arsenic has it; so has ipecac, and numerous others, and you must not take this leading

symptom at more than its true value. The totality of the symptoms must be taken. And what is this totality of the symptoms? Whether you choose to admit it or not it is the whole action of the drug considered symptomatically and physiologically just as a disease is considered in its pathological and in its symptomatical condition. A child complains of a pain in the knee when walking, or from over-use. All the pains, all the symptoms are referred to the knee perhaps; the lameness is there and there is a dearth of other symptoms, yet if you examine the joint you are unable to detect any trouble with the knee. There is no soreness or tenderness, on pressure; its movements are free as they can be, and you are unable to detect any reason for the disturbance.

But your knowledge of pathology causes you to investigate the upper part of the femur, and a slight shock or pressure of the head in the socket of the joint gives an acute pain, and you discover that the symptoms are reflected from that point, and you have the beginning of hip joint disease. Your selection of a remedy then would be from quite a different class of drugs than it would have been if you relied entirely upon the few symptoms you could notice or gain by oral methods.

Again, hysteria and hysterical individuals give us a bewildering phantasmagoria of symptoms. You may prescribe one hour for the symptoms as they appear, and two hours later you could find an altogether different combination to meet. It is like chasing a will-o'-the-wisp light. It is here and there and nowhere. You must search for the morbid cause, and a pathological prescription that will not do violence to the symptomatology will do better work than the most careful and painstaking following out of the apparent surface symptoms. I mean by the totality of the symptoms to include the pathology as an essential feature, and a real part of the totality; it is not total without it. You are called to see an infant or small child, presenting the appearance of an excitable, nervous system, a tendency to convulsive action and involuntary movements, sudden attacks of crying, easily drifting into uncontrollable sobbing or screaming spells; the child has difficult urination, or if the urine is free enough in quantity, there is pain on voiding it, and reflex nervous irritation, and there may be the red sand in the napkin, and possibly the four o'clock aggravation of Lycopodium. You have a fair picture of the drug perhaps, and you prescribe it, possibly giving some

relief; but the trouble continues, and you give it in all the potencies and think yourself at fault, or it may lie in the quality of your medicines. Some one else comes in and suggests that the irritation is due to phimosis, and the operation of circumcision removes the trouble at once.

If you were as good a pathologist as a symptomatologist, you, too, would have removed the trouble, and gained the credit. I have seen so many grievous errors and so much mischief from a too close reliance on the one-sided view of what constitutes the totality of the symptoms, that I should err did I not present my views to you as I do now. On the other hand, if you adopt the strictly pathological view of prescribing, you will err as much and perhaps more in the other way. For you must only let this come in as a ground work, a foundation, an element in your prescription. Unite the symptomatical and the physiological drug action to your pathological knowledge, and you will have greater success than in any other way with which I am familiar.

With only the one-sided view your success will be like that of a certain Irishman of whom I heard this story. My friend had a light express wagon which his neighbor wished to borrow to convey a trunk to the depot. So he sent the Irishman over with a horse to get it and after some difficulty the fellow succeeded in getting the animal harnessed to the vehicle and started to drive out of the lane leading from the house to the roadway. Knowing but little of the technique of driving he failed to clear the turn in the lane and over went the wagon, the man was thrown out and dragged by the lines for a few steps before the horse stopped. My friend ran out to help him and reached the place just as he was rising and brushing the dust and dirt from his apparel. The son of Erin gazed at the wreck and called out to my friend, "Did you see thot? If it hadn't been for my skillful driving I should have bruk my neck." So with your prescriptions; you may make wreck of fair lives if your knowledge is of this imperfectly organized type.

You must know the leading characteristics of a drug, this is to direct you only. You must know what tissues the drug reaches and it is also well to know what symptoms have been reported as regularly cured and relieved by the drug. You must know the toxic power of the drug and its increased or diminished range of action as the case may be when developed by potentization. You must know

what is antidotal or antagonistic to it and what it harmonizes with, and what drugs follow well and what ill. Then taking a given case of disease having made the picture of it in your mind, you glance over the list of remedial agents at your disposal for the one which most closely resembles in its sphere of action the morbid condition before you, and you can prescribe with the certainty of a marksman who aims with careful sight his rifle. If you are not thus prepared you are like a man who fires at random in hopes that a chance shot may reach the mark.

Do not believe too thoroughly in the therapeutic value of drugs for all cases. As we read the medical journals and in our materia medica books, we see one drug after another lauded to the skies as specifics for this or that form of disease. There are no absolute specifics. If it were all true that we read the most formidable types of disease would be readily controlled. A drug may have done good work in some cases while in another case which to your eyes presents no different symptoms it fails to aid.

You will find among the new remedies brought forward that many of them have been very much overrated so much so as that their course is like that of a rocket brilliant and admired at first and dismal and neglected as the remains fall to earth unnoticed and uncared for. Men jump at conclusions too readily and formulate as fact what is only hope or a theory. For instance, there have been many drugs brought forward as the great and final cure for cancer. Cundurango was heralded as the great and positive specific. Every physician was demanding cundurango at the drug stores. Then its positive and lamentable failure as a curative agent for carcinoma speedily relegated it to oblivion, now we hear no more of it while another man elevates another ideal in its place. Even well selected prescriptions may fail to cure or even check or change the course of a disease. But if you can record enough of successes to more than counterbalanced failure your confidence in a given drug will enable you to retain it in your case for use again and again and its failure here and there need not make you doubt its general value.

The story is told of Henry Clay that during one of his congressional terms he advocated some measure that gave offense to one of his constituents, a sturdy old backwoodsman and a man of a good deal of influence. When Clay was a candidate for reëlection during the canvas he met this man, who at once expressed his sentiments and said:

"I have always voted for you before but shall not do it again." Clay said "That is a good rifle you have there." (A Kentuckian in those days had a deep veneration and love for his rifle.) "Now," continued Clay, "did your rifle ever miss fire?" "Oh yes, sometimes; all rifles do sometimes." "Well when this one missed fire did you whack it over a tree and throw it away as useless or did you pick the flint and try it again?" The countryman saw the point and renewed his allegiance to the party leader.

The making of a prescription is a complex thing; for instance a man has broken a bone, there is a fracture we will say, of the femur; you have done all that surgery will do for him, and you wish to add the drug effect, which will aid him to a quicker recovery. You have as a physiological action, a lesion calling for repairative material to a greater extent than usual. You would think of supplying some bone-making substance so that the tissues would be able to draw more freely the needed supply. If the individual was of a scrofulous habit or one whose tendency was to unhealthy action, you would look out for such drugs as control suppuration and at the same time bearing in mind the action of the irritated nervous system reacting on itself, and so wearing out the strength of the patient and lessening repair by the depleting influence of the pain. Or if called to see an infant with summer complaint, if you simply prescribe a drug for the pathological condition, or even if you do better than that and take the symptomatical evidence for the foundation of your prescription, if you have done this and no more, you have left undone much that is just as urgently required, and perhaps more so, than anything you have ordered. You must rearrange its diet and possibly its surroundings, the conditions under which the disease found lodgment and vitality, or you may fail to remove the disorder. The causes which operated to induce a disease may, if still continuing, add to its virulence, and render your prescription nugatory. The manifold things which come to a physician's mind as connected with his directions for the remedial agents. cover much more than simply the drugs themselves, and have very great influence on the course of the disease. A great philologist once began the study of another language after he had reached the advanced age of over eighty years. A friend asked what possible cause it was for him to subject his brain to such severe and prolonged toil to gain a language he would never have any opportunity of using.

His answer was, "all knowledge is useful." To you all knowledge bearing upon the subject of therapeutics is useful no matter from what source it is derived. You need first to ground yourselves as thoroughly as you can in the spirit and personality of the therapy as indicated in our pharmacopeia, and you also should know the methods used by other schools, such as the allopathic and hydropathic, eclectic, etc. You wish to know for yourselves which is the best as a matter of needed information. How can you determine that ours is the superior plan if you are ignorant of the others? If you know how these other schools treat disease, how they use drugs, and their views as to the rationale of action, you will be able to hold your own in public examinations and discussions and extract whatever of good there may be in their methods.

More or less of such public examinations will come to you in the course of time, and if you show yourselves well posted in the therapeutics of other schools it will enhance the respect for your own method of practice. In the days of Hahnemann the art of prescribing by the regular school was a very simple and a very stupid one. It largely consisted of calomel on all occasions. One of the very best and most brilliant writers of the latter part of that era, (Watson) says in his theory and practice over and over again, "A moderate salivation does no harm." So his chief and always the first formula was calomel, and his principal agents were calomel again. Tartar emetic, iron, opium, and bleeding and then follow with calomel. Hahnemann raised his voice and influence against this form of practice, and fought it with all his energies. I believe that the change in the range of drugs as now employed by the allopathic school is largely due to the influence exerted by homœopathic profession. Through our efforts the ideas of the so-called regulars have been dug out of the routine pit and their therapeutic range is widely increased and administered with much more judgment and reasoning ability. Medicine now is progressive, and we cannot afford to drop into ruts and routine that will not allow us to see anything but the same narrow and limited range. If there is anything of value in other forms of practice we wish to know it, and if there is anything better than we have, or if we can add any good thing, by all means let us take and use it. It will broaden your minds and not narrow them by taking this more extended course of study. The hydropathist uses water for his sole remedial measure supplemented by rigid rules

of diet. Administered as it is by them, it is very frequently harmful, as well as beneficial. If you do not get too much water in your eyes you can select the cases and form of application from this school which will lay at your command the grand therapy of water. This knowledge wedded to your own similia may make success where one alone would have failed.

I have known of sterling good homœopaths who have struggled with book and brain, and the most carefully considered prescriptions until the patience of the patient was exhausted, and an allopathic physician stepping in relieved the whole difficulty in short order to the lasting disgrace of the unlucky prescriber. The reverse is more frequently the case that the homœopath can and does relieve the patient tired out and worn out with his allopathic dosage, and the reason why he can do so is in the fact of the greater directness and the scientific formulation of his prescriptions.

It was said a few moments ago not to place an under value upon the efficacy of drugs for all conditions of disease. You cannot always give the credit of the favorable change in the course of a malady or its cure as absolute evidence of your skill or the action of the medicine. It may be the reverse. It may be that nature has relieved the patient in spite of the doctor and his medicine. There is one thing we have always in our favor, that is that nature is forever endeavoring to return to a normal standard. Nature is constantly reaching forth her efforts to blot out hereditary tendencies and to regain the regulation standard of health. Diseases with some exceptions are prone to leave the patient with or without medicine, and while you may aid nature you cannot avoid your obligations for her assistance. For instance in the earlier days, in the settlement of this Western country the physicians encountered severe cases of ague. In the New England States there are very few localities where there is any of the malarial influence and so when the doctor, newly arrived, found a patient apparently in good health the previous hour suffering now from a profound chill, followed by a fierce fever, he thought when after the administration of his antiphlogistic medicine the fever was subdued and a profuse sweat succeeded, followed by freedom from any especially untoward symptoms, he thought he had done much toward producing such a satisfactory state of affairs and not until day after day with its recurring sequence of

chill, fever and sweat, would he discover that what he had supposed due to his skill was merely the natural sequence of the disease's progression. If you are called to see a case of quinsy sore throat as one of the prominent symptoms, you will find the lameness and soreness so often associated with maladies arising from taking cold, and for which you prescribe bryonia. The next day your patient is relieved greatly of this general lameness and the trouble is centered in the throat; all the soreness is localized there. In my early days I took this as an evidence of the work done by the drug until I found out that in these cases when I had not seen the patient until the tonsils had become the center of the disease, the same sequel of relief had come without the bryonia. Now I can predict to the patient as I made the prescription, this general soreness will be better to-morrow, but your throat will be worse. Bryonia is the remedy to use, for the symptoms calling for it are generally present undoubtedly, but even without it you have the result you wish to attain as nature's work and not entirely yours.

You should be close observers of all things that may occur, and reason out from cause to effect. For example, I had at one time a case of typhoid fever of an extremely severe type, the temperature had reached a degree that according to all the literature of the disease must be necessarily fatal. The patient was violently delirious. I made a night call and found the patient on his hands and knees in the bed swaying backward and forward. The night was very cold and my hands were chilled but I wished to determine the amount of distension and the condition of the abdomen, so I placed one hand on it and in a moment the lad gradually sank down to the bed momentarily relieved. Quickly, however, the hand was warm and he resumed his former position and I placed the other hand, cold as it was, on the abdomen to see if it was the coldness that gave the relief. Again he was easy until the hand was warm, and then the restlessness returned. Then I sat down by the bedside and began to reason out the why and wherefore and I determined that by the cold application I could control the muscular exertion that was rapidly exhausting him and could abstract some of the heat that was rapidly burning out his vitality. I ordered cloths wrung out of ice water applied over the abdomen. As soon as they were warm they were renewed and the patient was tided over a critical period. There is an old story with a moral attached of a

different type of observation. A medical student went with his preceptor to see a Dutchman ill with a sharp attack of cholera morbus. The doctor made his prescription which was carefully noted down by the young man. The next day the old doctor not being able to go out to the patient's house the assistant made the visit for him. The old Dutchman said he "vas not vell until he got a goot dish of sauer kraut und dat curet him." So the student put down in his notebook sauer kraut good for cholera morbus. A few days after an Irishman suffering from cholera morbus sought the doctor's services. The young medic was sent to see him and ordered a good, sizable dish of sauer kraut. This was duly administered. The following day the aspiring young esculapius wended his way to the Irishman's home to enjoy his triumph over disease as exemplified in the new treatment. But to his dismay found that the patient had promptly expired after taken the prescription. This gave rise to an addition to his notebook. Sauer kraut good for a Dutchman in cholera morbus, but bad for an Irishman.

I told you you should know the toxic effect of drugs. There are cases in which a relief from pain is essential, a relief which you can only give by the use of anodynes. These are not administered as curative to the cause of the disease, but as a means to gain control of the patient, and tide over a period of extreme suffering, or to so allay the nerve irritation that you can gain time to administer the curative remedy. Here the amount given is a matter of grave importance, and if your knowledge of the drug is limited you may fall into grievous error. I know of cases of homœopathic as well as allopathic physicians who have largely overstepped the bounds of prudence in the reckless manner in which they dealt out powerful drugs to patients, and have had to use very prompt measures to prevent fatal effects from such ignorant dosage.

Said a professor to a member of the class after his lecture on croton tiglium: "What dose of croton oil would you administer to a patient?" "A tablespoonful," was the answer. The professor made no comment, but proceeded with the quiz. Later on the student, convinced after thinking the matter over that he had made a mistake, said: "Professor, I wish to correct my prescription. What was that? said the doctor. I said a tablespoonful was the dose for croton oil—it is too much. Oh well, said the professor, looking at his watch—you are too late now; your patient has been dead for fifteen minutes." If you

are making a prescription for the curative effect, the closer you can adhere to the strict homœopathic law the more pronounced will be your success. But there are cases where palliatives are more imperatively demanded than anything else; or you may need to give preventive medicines. When a man is in busy practice he may go a long time without need of palliatives, but cases will come up when anodynes or sleep-compelling remedies are the proper things to use; and it is necessary for you to know well the nature of, and the uses of such drugs as chloroform, ether, chloral, opium in all its forms, and the number of coal oil derivatives, such as antifebrine, phenacetin, etc. You must know the dangers attending their use, either from overdosage or continual use, so that you may prescribe them wisely when needed. You must know the various food remedies, that extensive class that enters into the composition of the human microcosm, so that you can determine the earlier stages of starvation of any tissue, or the impending danger from lack of sufficient supply as indicated in any given case; and furnish them so as to avoid disease which would follow as the result of such deprivation—and with it all must you use common sense and reason if you wish to succeed as physicians in the highest sense of that term. A liberal knowledge of the materia medica, based upon the tripod of anatomy, physiology, and pathology; a materia medica dispensed with judgment and the exercise of good common sense will make of each one of you the foremost benefactor and the most valuable citizen of any community in which your fortunes may give you place.

Clinical Society Transactions.

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

OCTOBER MEETING, 1893.

The regular monthly meeting was held in the new Hahnemann Medical College building, Saturday evening, October 28, when the first two of the following papers were read and discussed:

XXIX. CLINICAL SURGICAL CASES.—BY Dr. HOWARD R. CHISLETT.—My paper to-night is in reality a continuation of that which was read by title at the August meeting of this society and which was published in the September number of the CLINIQUE. As the cases and the specimens sufficiently explain themselves I will spare you a prolonged introductory.

CASE 1.—ACUTE INTESTINAL OBSTRUCTION. OPERATION. DEATH.—Mrs. E. S., age eighteen years, American.

History.—After complaining for two days of a rather disagreeable feeling of tension and pain in the right inguinal region this patient was attacked suddenly during the night with an intense pain in that locality. The pain was accompanied by tenderness, at first local, but gradually extending, in a modified form, to other parts of the lower abdomen. The last menstrual period had been perfectly natural and had ceased three days prior to the onset of the present trouble.

Examination.—I saw the patient first three days after the symptoms appeared and my examination elicited the following facts: The patient sat upon the bed with the knees drawn up to her chin and moaning continuously with the pain. There was a well-defined tumor in right inguinal region, tender, exceedingly so, to pressure and dull upon deep percussion. Bowels obstinately constipated. The temperature registered from 100° F. to 103° F. during the day, the pulse between 100 and 120. My diagnosis was appendicitis and I explained to the mother the necessity of surgical interference unless signs of improvement soon

appeared. The patient being one of Prof. E. Stillman Bailey's, he assumed charge of the case and for two or three days the improvement was very marked. The pulse falling to 92 and the temperature to 99⅕° F. On the morning of the seventh day there was a sudden aggravation of all symptoms, so in the evening we saw the patient together. Temperature then 102½ F., pulse 160 and very weak; patient restless, anxious, emaciated and vomiting incessantly. The last few hours the vomited matter was feculent—in short we had a condition of diffused peritonitis with acute obstruction of the bowels and decided to operate.

Operation.—The operation giving promise of an intestinal one Dr. Bailey invited me to perform it. A four inch incision at the outer border of the right rectus muscle extending from the level of the umbilicus downward. The peritoneum was intensely congested and as soon as opened the greatly distended and almost black intestine presented. The point of constriction was found, the gut below being perfectly collapsed. The obstruction was complete and was due to an acute flexion of the small intestine the opposing surfaces being firmly glued together by lymph deposit. The intestine was opened at the point of constriction and the escape of large quantities of gas and fluid caused a sufficient collapse of the distended tube to enable me to look further for the original cause. This proved to be the black, pulpy tumor which I shall presently show you. It was located in the right inguinal region and appeared to me at first to be a gangrenous vovulus. Further examination, however, revealed its true nature, a necrotic ovarian hæmatoma the strangulation being due to a twice twisted pedicle. The tumor was removed after ligating the pedicle below the constriction with a strong silk ligature. The peritoneal fluid was of that prune juice color and gangrenous odor so the cavity was thoroughly flushed with sterilized water, a glass drainage tube inserted at the lower angle of the wound and the operation completed by the formation of an artificial anus.

Result.—Immediate reaction fairly good though the patient remained extremely restless. Pain and vomiting both ceased and for the first two hours the outcome seemed hopeful. She soon began to fail however, and in spite of stimulation died four hours after the operation.

CASE 2. TUBERCULOSIS OF THE KIDNEY. NEPHRECTOMY, RECOVERY.—Miss A., aged 32 years; American.

History.—For the past eleven months this young lady has had spasmodic attacks of extreme pain in the left renal region and a constant and at times intense headache. There has been a continual discharge of pus in the urine ever since the onset of the trouble. There has never been any hæmorrhage; never any gravel. The quantity of urine now is about normal, but it has at times been excessive.

Examination.—A frail little creature, every feature indicating prolonged suffering. I could not detect the slight-

FIGURE 25.

est enlargement of the kidney either by palpation or by percussion and there was no tenderness elicited by compression.

Analysis of the urine revealed some albumen, much pus and both renal and bladder epithelium. No test for micro-organisms was made.

Operation.—A four-inch incision beginning at the outer border of the erector spinæ muscle, one-half inch below the twelfth rib and passing obliquely downward and forward. Passing through the tissues, layer by layer, soon exposed the peri-renal fat which was separated between two dissect-

ing forceps. This fat was normal except at the upper and lower portions where it was dense and firmly adherent to the capsule of the kidney. The kidney being exposed it was noticed to be quite nodulated and apparently cystic at the upper portion but thickened and dense at its lower end. Systematic puncture with a fine exploring needle, determined cavities but no stone. The structures entering the hilum were transfixed with a strong silk ligature and ligated in two equal parts three quarters of an inch from the kidney. The whole pedicle was then again surrounded for safety and the kidney removed. The upper end of the uterer being filled with slimy granulations it was curetted and sterilized with pure carbolic acid. The wound was then carefully sutured with silk worm gut and a glass drainage tube inserted at the posterior angle of the incision.

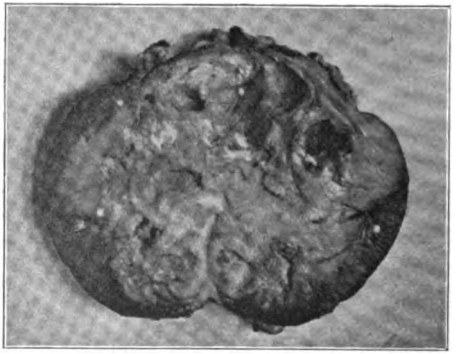

FIGURE 26.

Result.—Recovery: Discharged in six weeks.

REMARKS.—The section as you see from the specimen shows three tubercular foci in the upper part of the gland —to these was due the nodular appearance. Two of these foci were undergoing the suppurative change, the third the caseative. In the lower portion you will notice a large mass of infiltration, the central portion of which is undergoing the suppurative change.

There was considerable pain for the first four or five days, and for eighteen hours not a single drop of urine was secreted. This gave rise to the fear that the other kidney was either badly diseased or entirely wanting. Patients with a single kidney are rather unusual, but I should have

presented such a specimen for your examination to-night only that the husband of our patient was unwilling. The case I refer to was that of a young woman whom I was called to see with a view to operating for acute suppurative peritonitis. Unfortunately the patient died before my train arrived, and the post-mortem revealed the absence of the right kidney. The left kidney was at least five and a half inches long. It was extremely interesting to me, coming as it did so soon after this reported nephrectomy, and I am sure you would have enjoyed the specimen as it showed a typical acute nephritis, the result of the elimination of septic matter.

CASE 3. INTESTINAL PERFORATION DURING TYPHOID FEVER. ABSCESS. OPERATION. RECOVERY.—Mr. T. R., aged twenty-seven years. English.

History.—This was rather an uneventful case of typhoid fever until the end of the third week when a sudden attack of acute pain a little below and to the right of the umbilicus made the attending physician—my friend, Dr. Coon—suspect a perforation. As there was no aggravation of symptoms other than the pain, the circumstance was forgotten until a week later when it was noticed that the fever was returning, and that there was considerable swelling at the place of greatest tenderness.

Examination.—A well-defined and extremely sensitive swelling in the upper inguinal and lower lumbar regions of the right side. Tympanitic upon light, but dull upon deep percussion. The temperature indexed pus, and I advised operative measures believing that we had to deal either with a typhoid perforation and resulting abscess, or with a perforative appendicitis complicating the fever.

Operation.—An abdominal incision three inches long over the most pronounced swelling at the outer border of the rectus muscle revealed a perforation of the small intestine opening into a large abscess cavity. The adhesions were very extensive between the different coils of intestine, and between these coils and the abdominal walls completely separating the abscess cavity from the general peritoneal cavity. The abscess was thoroughly evacuated, irrigated, and cleansed with hydrogen peroxide. The intestine that was perforated was then stitched to the peritoneum at the margins of the incision, the cavity loosely packed with iodoformized gauze and the patient sent back to bed.

Result—recovery.

REMARKS.—The perforation was mostly closed by the protrusion of the mucous membrane. There was however a slight fecal discharge for a few days after which the cavity gradually closed with granulations under daily irrigation and cleansing with hydrogen peroxide.

DISCUSSION: Dr. G. F. SHEARS: I have been very much interested in the cases reported. The first case illustrates to my mind the difficulties which attend the diagnosis of appendicitis and adds another possibility to the long list of conditions which may simulate this interesting disease. Dennis mentions the following list which eminent men have mistaken for appendicitis. General or circumscribed peritonitis; pelvic peritonitis; floating kidney; pyelitis; cæcitis; renal, biliary and intestinal colic; psoas abscess; pelvic cellulitis; suppurative adenitis; typhoid tubercular and stercoral ulcers; rupture of the serratus magnus muscle; caries of the ileum and vertebræ; morbus coxarius; suppuration in the retro-peritoneal and mesenteric glands; ovarian and lumbo-abdominal neuralgia; rupture of the right ureter; rupture of the gall bladder; sprains of the iliacus and psoas muscle; salpingitis of the right tube; abscess of the liver and tubal pregnancy; and this list does not by any means include all of the conditions which might be mistaken for this trouble as the case reported to-night proves. Even if we eliminate many of the unusual troubles simulating appendicitis, the inflammations in the region of the appendix are often difficult to separate. Thus although typhlitis and perityphlitis, appendicitis, and periappendicitis are not identical in etiology or in termination a differential diagnosis is often difficult to make. It is especially desirable that cases of obstruction of the bowel due to impaction of fecal matter should be early diagnosed and the patient not subjected to the dangers of a surgical operation until simpler means of relief have been persistently employed.

I might relate to you a number of cases of this character in which I have been consulted in regard to an opera-

tion, which have responded to medicinal and mechanical treatment. It must be remembered, however, that considering the difficulties of diagnosis that in many of the cases reported in which errors have been made, the operation was in itself a benefit to the patient and was demanded for the condition present if not for the treatment of appendicitis. Thus in salpingitis pyelitis, retroperitoneal suppurations, abscess of the liver and similar conditions, a surgical operation affords the only relief and an exploratory incision is very properly advised. In most of these cases the earlier the operation is made the greater the prospect of recovery. This is particularly true in the case of appendicitis, in which the resultant inflammation produces a knitting together of the parts which makes the operation not only one of difficulty but of great danger. When then an operation becomes necessary it should be made early in the attack, it having been shown that fully 50 per cent more of recoveries follow operations before the eighth day than after it, indeed, if the case is to come under my care I prefer the third or fourth day as offering the best chance for recovery. Dr. Chislett's case of perforation of the intestine in typhoid fever reminds me of two rather different cases which have came under my observation within a comparatively short time.

In the first case a man twenty-five years old had reached what was believed to be the twenty-third day of the fever when a decided tumor was noticed above the pubes in the median line, but inclined a little to the left. Accompanying the discovery of the tumor was noticed a pronounced drop in the temperature and profuse perspiration. I was summoned by telegram, and was told to come prepared to operate. The globular character of the tumor made me distrustful of its nature, and the preliminary introduction of the catheter and the collapse of a distended bladder relieved the apprehensions of all concerned. The patient, I may say, had previously passed the urine regularly, but in small quantities, and the sudden drop in temperature, the appearance of a tumor, and the accompanying sweats

very naturally led to the suspicion of intestinal rupture. The second case referred to was very similar to that reported by Dr. Chislett, and the outcoming equally gratifying. In this connection I may say that in those cases in which general peritonitis has not followed perforation of the intestines, and in which the tumor is circumscribed, it is undesirable to make any attempt to close the intestinal wound. In these cases nature has circumscribed the abscess, and it is no longer peritoneal. The same result has been obtained which we desire to produce in opening the gall bladder, viz.: adhesion of the bladder to the peritoneum previous to its opening. Any attempt to break up this natural barrier to the infection of the peritoneal cavity is fraught with great danger.

Dr. CHISLETT: I regret that there are so few gynæcologists here this evening to review the first case reported from their standpoint. I am one of the group referred to as "modern cranks in surgery," and believe appendicitis is in all of its phases a surgical disease and should be treated as such. Operate without delay is my advice for you never know how soon a catarrhal appendicitis may become perforation and involve the peritoneum in extensive and fatal inflammation.

I have no excuse to offer for my error in diagnosis. It is on account of that error that I report the case. I have had a considerable number of cases of appendicitis and I must confess that none of them have presented a more clear clinical picture of this disease than the ovarian hæmatoma you have just examined. The infrequency of such cases renders it probable that none of *us* will make the same error again, and I believe that cases of such severity, even when we are not positive of *exact* conditions, belong to the realm of operative surgery even if one must stop at the exploratory incision.

XXX. THE SURGICAL CLINIC.—The following cases from Dr. Shears' surgical clinic in the Hahnemann Hospital were reported by Mr. CHARLES E. KAHLKE:

CASE I. ADHERENT OMENTAL HERNIA. OPERATION. CURE.—Mr. I. M., æt., twenty-five years. When eight years of age he noticed a slight enlargement in the right scrotum. It gave him no trouble until nine years later when during a game of tennis it began to pain him. Diagnoses of hydrocele, varicocele, and hernia have been made. A careful examination resulted in a diagnosis of adherent omental hernia (right inguinal). At one time he attempted to wear a truss, but it caused him pain instead of giving relief. An operation for radical cure was advised and made. The operation verified the diagnosis, and in the progress of the operation the omentum, which I now exhibit, was ligated and removed. It seems incredible that a mass of tissue the size of this shown should have occupied so small a space and given so little trouble, and yet the major part of this tissue was outside of the inguinal ring. The mass when spread upon a piece of paper measures eight and one-half inches long and seven and one-half wide. It is now seven days since the operation and there has been no rise of temperature above 100°. He is making a good recovery.

In answer to a query of Dr. L. D. Rogers, Dr. Shears replied that he had had excellent results in the cure of hernia by means of operative procedure and especially in the cure of omental hernia in which the omentum was removed. He believed that the omental stump became adherent to the peritoneum and often presented an insurmountable barrier to further hernial difficulty.

CASE 2. SUPPURATIVE ARTHRITIS OF THE SHOULDER JOINT. EXCISION. CURE.—Mr. C. G. B., aged forty years. In Feb. 1892, this patient had a light attack of la grippe after which he suffered some pain in the right inferior first molar tooth and the right shoulder joint, the pain running from the tooth to the shoulder. An abscess formed above the tooth which when opened, was followed by a free discharge of pus and subsequent relief from pain in this region. The pain in the shoulder joint however, remained about the same until fall when it grew much worse. Accompanying the pain was a marked flattening of the supra and infrascapular region and some swelling of the anterior surface of the shoulder. In April, 1893, a swelling appeared on the anterior surface of the arm. During all of this time for over a year he had been treated for rheumatism, and much of the time he was unable to do any manual work. Nothing but morphine would relieve the severity of the nightpains.

On the 15th of last June he presented himself to Dr. Shears for treatment. The patient was much emaciated, nervous, and unable to move the arm. An operation was advised and on the 29th of June the fistulous tract was laid open and the joint exposed. The head of the humerus was badly disorganized and the articular surface of the scapula diseased. The head of the humerus was excised with one inch of its shaft and the scapular disease removed. The wound healed promptly. The patient gained flesh at once and is now able to use the arm in his daily employment. The patient was exhibited to the society. Dr. Shears called attention to the relation which seemed to exist between the abscess in the tooth and the subsequent development of the shoulder trouble and spoke of the case reported by him several years ago in the clinic, in which destruction of the ankle and subsequently of the knee joint had followed an alveolar abscess supposed to be due to infection from unclean forceps used in the extraction of a tooth. In answer to questions he said that the removal of the articular surface was subperitoneal to which he attributed the amount of control of the arm possessed by the patient and that he had several cases in which the patients possessed all of the motions of the arm in as perfect a degree as the uninjured one. He had recently heard from a case operated upon several years ago and reported in the CLINIQUE in which the patient, so his physician wrote, could throw a stone equal to any one.

DISCUSSION: Dr. CHISLETT: I am very pleased to have seen the cases Prof. Shears has brought before us. To my notion the case of excision of the shoulder joint is rather an exceptional one in its results, the patient having an unusually good arm. What Prof. Shears has said regarding the preference of excision over amputation cannot be too strongly upheld. To perform an amputation is *always* a surgeon's acknowledgment that he cannot do better work.

The history of the case is a common one, I am sorry to say. Other surgeons may be more fortunate, but it seems to me that the most frequnt errors brought to my notice both in private and hospital practice are those deep suppurations of bones and joints that have been misnamed

and mistreated *rheumatism.* There is no doubt in my own mind that the case under discussion was one of primary synovial suppuration, which, had it been recognized early, could have been successfully treated by simple incision and drainage instead of by excision rendered necessary by the late date of recognition.

The early diagnosis of these cases is the essential element of successful treatment, especially in children. If you stop to think that the growth of the humerus is mainly from the upper epiphysis, and that this does not join the shaft until the twentieth year, I think most of you will agree that before this age the bone should not be sacrificed without a fair trial of the merits of free incision and drainage, or of arthrectomy. You at least have the satisfaction of the attempt at saving an arm of normal length, and even if these methods fail in entirely eliminating the disease, they will place the parts in a more healthy condition, so that the healing process, after the more severe operation of excision, will be more rapid and satisfactory.

XXXI. COLOTOMY IN PREFERENCE TO EXTIRPATION OF THE RECTUM. By Dr. J. L. ALEXANDER, of Denver, Colo.*

The case, Mrs. Z., aged fifty-two, married for many years, of constipated habit, first observed trouble in her rectum about two years ago. Noting some difficulty with the passage of the stool, she found by digital examination a hard lump in the rectum. There was no pain at this time, and no symptoms to call the patient's attention to the rectal trouble except the great amount of straining required to pass the stool. Shortly after this a slight hæmorrhage ensued. Becoming alarmed she consulted a physician who told her that the trouble could be removed by internal remedies, and prescribed a series of laxatives, etc.

In this condition she remained until last February, when in the act of straining at stool, "something seemed to give way," and a copious hæmorrhage followed. A physician was called and the hæmorrhage controlled. The doctor then examined the rectum and made a diagnosis of cancer. Since the latter hæmorrhage the patient has no-

*Read before the Denver Homœopathic Club, October 9, 1893.

ticed that fæces passed per vaginum, and there has been a constant oozing of blood. The bowels would only move as the excreta became liquefied—from one to two weeks intervening between stools.

I saw the patient first about three months ago, and upon my first visit insisted upon a local examination which was granted. The bowels then had been confined for about two weeks. She was weak and emaciated, but the cachexia was not very marked. An impacted colon was plainly outlined by palpation, and the sigmoid flexure was hard. Rectal examination disclosed a hard tumor completely encircling the internal sphincter, and it was only with great pain to the patient that the index finger could be passed. The rectal wall as far as we could reach was hard and indurated. Through the anterior wall there was a fistulous opening into the vagina, it being as large as a quarter of a dollar. The posterior wall of the vagina was hard, with two nodules upon either side, including the labia minora. I then used Hall's rectal applicator and found a hard, firm growth just below the sigmoid, the opening of which could only be passed by a uterine sound bent to the curve of the applicator. The slightest contact of instruments with these growths produced hæmorrhage. The discharge was sanguineous, and with the odor so typical of carcinoma.

Having explained to the patient her condition and advised an inguinal colotomy, I gave enæmas every morning for three or four days and succeeded in getting a good part of the excreta to pass, with the aid of cathartics. The patient refused to undergo the operation. I was called again in about two weeks and found her in the same condition as before, but suffering more than usual and confined to the bed. I insisted upon operation and called Dr. Anderson who also advised immediate operation. The patient having consented was removed to the Deaconess Home Hospital and the usual preparations for a laparotomy made. Aug. 28th, the operation was performed as follows: The patient under chloroform, the field of operation was again sterilized. Incision was made about three inches in length, beginning about an inch internal to the ant. sup. spine of the ilium and continued downward in the direction of the fibres of the external oblique—this muscle was divided by blunt dissection and the incision carried down to the peritoneum and after bleeding was controlled the peritoneal cavity was opened. After careful examination of the sigmoid the

bowel was brought forward into the upper angle of the wound until its mesenteric attachment was on a level with the external incision. A silver cylinder was passed through a slit in the meso-colon close to the gut. The peritoneum was then closed and sutured to the gut by catgut sutures engaging the muscular and serous coats. A second row of sutures secured it to the muscles of the parietes. The lower angle of the wound was closed with silk-worm gut and the opening upon either side of the prolapsed gut packed with iodoform gauze. At the beginning of the fourth day the dressings were removed and the bowel incised transversely, the supporting cylinder acting as a guide. The edges of the gut were trimmed and sutured to the integument by means of silk-worm gut. The sphincter ani was then dilated to its full extent, and the lower bowel washed out thoroughly. In five days the sutures were removed but the support was left two days longer to prevent accident from insecure adhesions.

I might be asked: "why prefer colotomy to complete extirpation of the rectum in these cases." Let us refer to the results of these operations. In the case cited the patient made an excellent recovery. Upon the second day the temperature reached 100° F., and at no time after was it over 99. Two weeks after the first operation the patient was allowed to sit up and upon the seventeenth day she returned to her home and to her housework; the pain in the rectum almost entirely relieved. She is now able to walk a number of blocks without fatigue and is gaining flesh each day.

The result, as in the case I have cited, is not the exception but the rule. About the only accident that can happen is the prolapse of the gut through the wound. It may be noted this accident has been reported by Kelsey. The bowel tore loose from the wound and three or four feet of it was found mixed up with the dressings forty-eight hours after operation. This he credits to his having reduced the number of stitches to five or six.

An accident exactly opposite to this is reported by Cripps. After one of his operations, after the gut had been incised, it tore loose from the wound dropping into the

abdomen; had to be recovered. This of course could not happen with the silver support, which is passed through the meso-colon.

Since the advent of modern antiseptic surgery the laparotomy has but a trifling mortality. In colotomies such as these the mortality is below one per cent. The advantages claimed for it are that: It retards the growth of the disease, relieves pain, wards off obstruction and therefore prolongs life. This is due to the physiological rest given the parts and the freedom from irritation by the contents of the bowel causing spasm of the sphincter. The inguinal anus is more comfortable to the patient, is more cleanly. The operation is easier and the mortality is decidedly less.

After paralyzing the spincter ani by complete dilitation that organ does not regain its tonicity so readily as when the fæces are allowed to come down into the rectum and produce irritation. The growth engaged by the sphincters thus receive their portion of rest and is not compressed as formerly.

Statistics show that the patients under these conditions live from six months to two years, and this time is as much as is claimed for complete extirpation of the rectum.

The most popular method of removing the rectum entire is after the method of Kraske of Frieburg. It is a modification of the old radical operation which was for a time abandoned on account of the great mortality. Even at present the mortality rests at about twenty-five to thirty per cent in the hands of our best operators. Kraske's claims for this operation are:

1. It enables one to remove tumors that are too high up for any other method and considered inoperable.

2. It enables one to secure all the cut and torn vessels with certainty.

3. Where disease is limited to the tissues above the sphincters the disease can be cut away, and the ends of the gut brought together again and the sphincters preserved with continence.

Some of the dangers of Kraske's operation are:

1. One must avoid wounding the urethra, the seminal vesicles, and bladder.

2. In removing a part of the sacrum one must be sure that he does not destroy either of the third sacral nerves, as they mainly control the bladder, and cutting them will cause vesical paralysis.

3. He must use care in order to avoid wounding the ureters.

Again, the gut is liable to retract, and the cavity thus formed is prone to fill with solid fæces, and as the skin incision heals, their removal becomes more and more painful and difficult—and future stenosis is to be avoided. This is not unusual after resection. All cases are followed by more or less stenosis or incontinence, and there is never a very useful anus. So that the choice between colotomy and extirpation in these cases is more a choice of the place where an anus over which a patient will have control shall be located, than a choice between a useful anus and incontinence or stenosis.

Colotomy properly performed is never followed by stenosis, and not always by incontinence. When we take into consideration the anatomical relations of the rectum, situated as it is in its bed of loose cellular tissue and supplied with large lymphatics connected so readily with the lumbar and sacral chains—and so intimately situated with other important structures—it is no wonder that complete extirpation of the disease becomes such an enormous task, and a fatal return comes so speedily.

Hospital Notes.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

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

VENTRAL HERNIA AND FISTULÆ AFTER LAPAROTOMY.—*Case 21,042*, æt. twenty-one, married, was presented at the clinic on Wednesday, October 10. Twenty months before she had undergone an operation, in a neighboring city, for the removal of the ovaries, in consequence of which there is a small umbilical hernia, with a fistulous opening at the lower part of the incision that has been discharging pus ever since the operation.

While it is true that these sequelæ of laparotomy are less frequently met with than they used to be, still there are reasons why cases like this one will occasionally occur. And, since they do not always reflect upon the skill or care of the operator who has preceded us, we should be chary of criticism, and charitable in proportion with our ignorance of the conditions under which that operation was made, and of his method of treating the wound.

This woman is young and plump, with plenty of adipose, and her abdominal wall is thick enough to make it pretty certain that a wound through it, below the umbilicus especially, would not heal without suppuration; for, say what you will, the best asepsis and the most perfect technique in the world will not always prevent it. And a cicatrix that has been built up by granulation is always a weak one.

Other causes of these secondary lesions are: failure to close the wound in the peritoneum and the muscular tissues separately, or to use firm sutures if the incision is a

*Continued from page 485.

deep one; neglect of precaution in removing them too early, and of properly supporting the abdomen after they have been taken; too early and too frequent interference with the dressings; the use of wet instead of dry dressings; allowing the patient to turn herself, instead of being turned in bed; lifting her from one bed to another too often and carelessly, so as "to break her in two in the middle;" allowing her to sit up in the chair or to walk about under three weeks or more; letting her go home, or to work without providing that she wear a properly adjusted abdominal supporter for at least six months; and the separation and final discharge of the ligature, or ligatures, from the pedicle through a fistulous opening along the line of incision. All of these conditions must be met if you would avoid such a result as this, and even then your laparotomies will not always show a proper and creditable cicatrix.

Operation.—October 19, the abdomen was re-opened in the presence of sub-class No. 6, and the scar-tissue and the fistulous tract freely cut away, the wound being closed with silver wire sutures. The wire was chosen because in a very deep wound it acts at the sides like splints to hold the edges firmly together all the way through, as no form of a bag-string suture will do.

Wednesday, November 8. I am glad to show you that this wound has now united firmly and by the first intention. The patient has obeyed our instructions literally and has materially helped us to get her well again. She will return to her physician, Dr. Grob, of Milwaukee, in good condition, but will need to wear this support and not to sit or stand without it for months to come.

VAGINAL CYSTOCELE.—During the month four cases of vaginal cystocele were brought before the class. Two of them were of a dozen years' duration and were subjected to an anterior colporrhaphy and a trachelorrhaphy each and with a perfect result. Prof. L. emphasized the importance of a rigid asepsis throughout the operation, and

afterward, and also of keeping the patient on the side and the bladder empty (by a residual catheter) for the first few days, to prevent its pouching downward and thus straining the wound and spoiling the cicatrix.

The other two patients were fitted to their great relief and subsequent satisfaction with a Halsey's cystocele pessary.*

TRACHELORRHAPHY WHEN PRACTICED WITH A DISREGARD OF OBSTETRIC EXPERIENCE.—In making this simple operation, after having drawn the uterus down, if you will take the precaution to pass the sound so as to locate the exact position of its canal you will usually, but not always, find that the cervix has been torn toward the left hip. This left-sided lesion corresponds with the relative frequency of left occipito-iliac positions of the vertex in childbirth; and, strange to say, is often forgotten by those who follow the diagrams in the books and who treat all cervical lacerations as if they were bilateral, foolishly making a new uterine canal in every case.

DELIVERY OF A LARGE UTERINE FIBROID WITH THE OBSTETRIC FORCEPS. RECOVERY.— Wednesday, October 25, Prof. L. said: Here is a large uterine fibroid that I removed a few days ago from a patient of Dr. E. Franz at Berne, Ind. The woman, æt. forty-eight, had suffered for many months from a very copious and almost constant menorrhagia. Finally a tumor presented at the os-uteri and having exhausted other means ineffectually, Dr. F. insisted that an operation was necessary. I found the os as big as the top of a small teacup, its margin thin, firm and rigid. On passing the index finger I separated the adhesions within reach, but this manipulation caused the blood to flow very freely. The cervical ring was then nicked on both sides, but it was impossible to draw the tumor down with either or all three of my trusty and experienced volsellæ. I then bethought me of an expedient which I had used in a case in this hos-

*See Ludlam's Diseases of Women, sixth edition, Chicago, 1890, page 562.

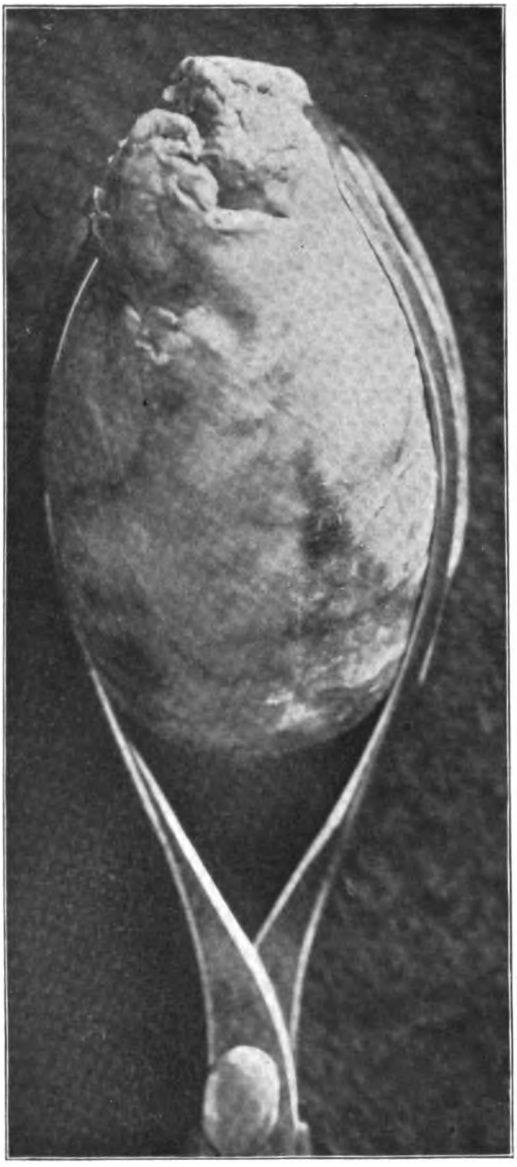

FIGURE 27.

pital twenty years ago, and in which, having severed the pedicle of a fibroid lying outside the uterus, it rolled around so that it could not be delivered by the usual means, the application of the obstetric forceps brought it away speedily and safely. So, in this case I applied the forceps *within the os-uteri*, breaking up the adhesions as they were adjusted, and after a prolonged and powerful effort, just as in the worst possible forceps case of labor, the tumor was brought through the vulva. When it finally came the uterus was found to have been inverted by the traction upon the firm adhesions that had fastened the growth to its fundus. Péan's long forceps were placed across these bands and the tumor cut away; the womb was turned right side out and flushed with hot water; two vaginal lacerations were closed with the continuous catgut, and the torn perineum with silk sutures. She was left in good hands, and with an excellent trained nurse, the same care being advised as if she had been through an exhaustive instrumental labor (See Fig. 27).

Wednesday, November 8. Dr. Franz writes that his patient has in every respect made a most satisfactory recovery.

VAGINAL HYSTERECTOMY FOR CANCER UNDER PECULIAR CIRCUMSTANCES. RECOVERY.—*Case 21,054* was that of a woman, æt. thirty-four, married at fourteen, mother of one child now twenty years old and the victim of one miscarriage. Her general health had always been very good until seven months ago, when her courses became profuse and she discovered "a bunch" upon the neck of the womb. She consulted a cancer specialist who told her that she had a cancer of the cervix, and now for many weeks he has applied a caustic paste to the part with the promise of removing the growth. Locally there is great irritation, ulceration in the roof of the vagina, the cervix has been destroyed and she suffers horribly whenever the paste is applied. The first treatment ordered was the local use of hydrastis and afterward curetting to remove the diseased structures and to determine the extent and severity of the local lesion.

Operation.—October 21, the disease having recurred

and having extended to the vaginal junction of the cervix, a hysterectomy was made before sub-class 9.

November 8. The patient made a prompt and uninterrupted recovery and left the hospital to-day in excellent condition.

LAPAROTOMY FOR A SUPPURATING BROAD LIGAMENT CYST. DEATH FROM PNEUMONIA.—*Case 21,057* was that of a woman æt. 30, who had been married for nine years but had never conceived. Seven years ago she began to fail in health and suffered greatly with pain through the lower pelvis and bearing down, especially at the month. Of late the periods have ended with a terrific headache. She has had much local treatment and worn a pessary for uterine displacement.

Operation.—October 31. A laparotomy was made before sub-class 11, and the right ovary and its tube were taken, and a suppurating cyst of the left broad ligament was carefully enucleated. The wound was properly dressed and the patient sent to bed in good condition.

The following remarks were then made: The circumstances under which I have just operated were somewhat peculiar. The patient had waited in the hospital unavoidably for about a week for me to return from an operating trip to New York. Meanwhile, she and her husband spent some time at the World's Fair, where she contracted a severe cold. After my return I postponed the operation for two days more in order that she might recover her usual health. She was very anxious to have it over with; assured me that she had never had pneumonia or any lung affection; that her cough was not painful, and beside, she felt well enough to be around. These conditions would not be a bar to an abdominal section if the chilly autumn weather of the last week had not caused a very general influenza which my professional friends assure me is already assuming some of the characteristics of *la grippe*. If she escapes such complications as might arise from this cause, I see no reason why our patient should not make as good a recovery as our other cases have all been doing within the last few months.

Wednesday, November 1.—Our patient reacted nicely from the operation, but six hours later developed a

train of symptoms of the most unfortunate kind, showing a fresh invasion of the rascally grippe. Dr. Spaulding telephoned me at eight P. M. that her pulse was 142, and her temperature 100°, without vomiting or any other symptom properly belonging to the operation. There was no cough or bronchial râles, but an occasional desire to be fanned. This morning the pulse is 135, and the temperature 99.5°; the urine is free but high colored, the old cough has returned with increased violence, and there is a sense of weight and oppression in the chest which forbode evil and the almost certain development of pneumonia. This result is all the more threatening because the pneumonia, as secondary to the grippe, is prevalent and fatal just now.

Wednesday, November 8. In giving his customary weekly account of cases operated upon in his clinic, no matter what the result, Prof. L. said: This patient's symptoms went from bad to worse, and despite our best efforts and the most excellent nursing and care, developed as we had feared they would. Everything connected with the operation was all that could have been desired, but the intercurrent pneumonia put an end to her life on the morning of the fourth day.

The immediate advent of this terrible disease and its rapid course, without any possible complication with sepsis or any other natural sequel of the operation, warrants us in supposing that she was doomed to die of pneumonia if it had not been made. Unfortunately, we cannot always know whether a lurking disease may be considered as a bar to the operation, or when our patient may be cut off by an accidental disease of this kind.

INTERSTITIAL SARCOMA OF THE UTERUS. VAGINAL HYSTERECTOMY. RECOVERY.—*Case 21,061*, æt. thirty-eight, brought to the clinic by Dr. Treat, of Sharon, Wis., has one child fourteen years old. The first menstruation was at fourteen, hæmorrhagic, and lasted a fortnight; the second like it and returned in two weeks, and the periods have always been too frequent and copious, with pain and the passage of clots of blood. She has never been well since the function was established; has occipital headache,

bearing-down pains, severe backache, obstinate constipation, and an intractable leucorrhœa, with debility and insomnia. Her father died of cancer of the stomach, and there is a strong suspicion that the enlargement of the body of the uterus, which is evident on bimanual examination, may be due to a malignant growth.

Operation.—November 7, a vaginal hysterectomy was made in the presence of sub-class No. 4, and a very in-

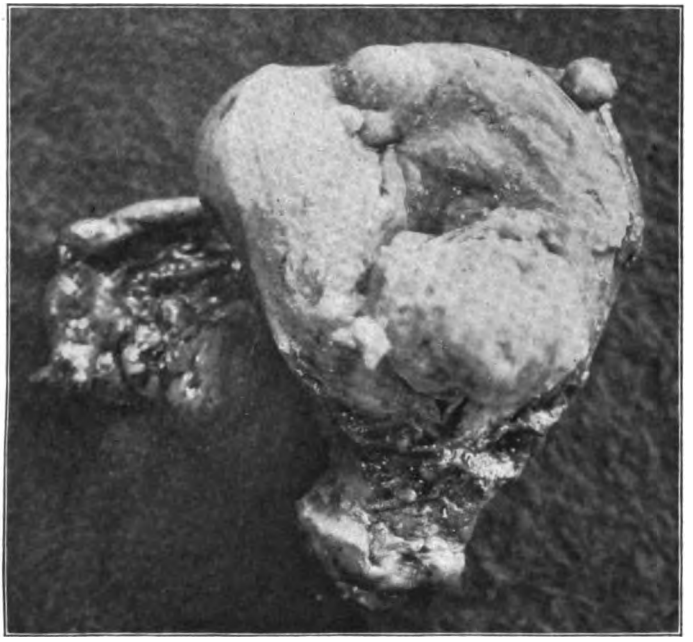

FIGURE 28.

teresting specimen obtained. The uterus proved to be the seat of scattered, budding fibroids, with a disintegrating interstitial sarcoma that had partly forced its way into the uterine cavity, and from which the hæmorrhages and the discharges had evidently come. The position of this growth and its relative size are well shown in the accompanying cut. See Fig. 28

November 17. The patient is at the eleventh day, and is convalescing is a very satisfactory manner.

Clinical Reviews.

A TEXT-BOOK OF OPHTHALMOLOGY. By WILLIAM F. NORRIS, M. D., and CHARLES A. OLIVER, M. D.; 641 pages, 8 vo. Lea Brothers & Co., Philadelphia. 1893.

It is pleasant in these days of many books of doubtful value to find one of real worth, showing in its composition that knowledge and labor so essential to this result. Such a book will be found in this tome, a study of which is recommended to all who desire to find in compact form the best thought and the most generally accepted treatment of the old school oculist.

The illustrations aid the text, and do not seem to have been mostly copied from other works. This is a welcome innovation, for the illustrations of late years have frequently been but reproductions of those already familiar, and often poorly selected.

Fairly judged, this book is an acquisition to our literature, and should be in the library of all who desire works on this speciality. C. H. VILAS.

THE THROAT AND NOSE AND THEIR DISEASES. With 120 illustrations in color, and 235 engravings, designed and executed by the author, LENNOX BROWNE, F. R. C. S. E. Fourth edition, revised and enlarged. Bailliére Tindall & Cox, London. 1893.

Several books upon this same subject have already appeared during the year 1893, and each has been welcomed in its turn. The fact that so much is now being written, and that so little has previously been written on this subject, shows how rapidly it has become one of great importance.

Perhaps in no other author can we trace this development so well as in the one before us. For he has changed and modified his own views radically, since his last edition of some two or three years ago.

In previous editions the subjects of the throat and ear have received most careful attention, and the nose com-

paratively little; whereas, in this edition, the treatment of the nose covers much more space than formerly; and the aural maladies treated of, are those only which are associated with naso-pharyngeal disease.

The work of the publishers needs no comment, as it is done in their well-known excellent style. But there are some points concerning the author's work in addition to the reading matter, which deserve especial attention.

Lennox Browne is known as the "artist author," and this book bears out his right to the title. The engravings are valuable, as in all such works they assist materially in the comprehension of the subject matter. But the illustrations in color, which are painted from nature and engraved on stone by the author, are exceedingly pleasing in their perfection from a medical and artistic standpoint.

These illustrations are so arranged that they can be studied during perusal of the text, referring to them without the inconvenience of constantly turning the leaves. For this purpose it is necessary only to unfold the plate.

Reference can only be made to a few clinical points. Upon the subject of reflexes there is a good deal which corresponds with the ideas which have been particularly prominent in America within recent years. For instance, nervous laryngeal cough, treated by Morell Mackenzie as a distinct affection, is according to the author, due to some reflex disorder—viz.: irritation of enlarged tonsils, ovarian irritation, dysmenorrhœa, etc.

The relations of nasal and pharyngeal diseases to those of the eye have not received as much attention as they may have deserved, but they are here spoken of in no uncertain tone. Follicular conjunctivitis has thus been shown to be dependent upon pharyngeal adenoid vegetations.

"Hypertrophic rhinitis and other abnormal conditions of the nasal-mucosa proper are frequent antecedents of epiphora, mucocele, inflammation of the conjunctiva and cornea, ulceration of these same parts, granular lids, muscular asthenopia, and glaucoma, suppurative catarrh of and growths in the antrum, may in some cases, cause dimness of vision and contracted field, orbital neuralgia and glaucoma."

Lennox Browne has embodied in this work much that is practical in the treatment of vocal defects.

That he is an expert in this field is testified by the fact that the work, "Voice, Song and Speech," collaborated

with Emil Behnke, has already passed through fourteen popular editions.

Upon the subject of diphtheria, the many local remedies, such as carbolic and sulphurous acid, potash, soda, etc., are each discussed in turn. "But truth to say, I am so well satisfied with *lactic acid* that I have been loth to try any other remedy."

Operative measures are generally supposed to be comprised in the one procedure of tracheotomy, but for ten years Browne has adopted the removal of enlarged tonsils and œdematous uvula during the acute stage of diphtheria.

"Tracheotomy is a procedure that is each year viewed more favorably." Intubation of the larynx, although described and recommended when indicated, is not, so far as I can learn, so much practiced in England as in America. C. G. F.

A TREATISE ON TYPHOID FEVER, PNEUMONIA AND OTHER DISEASES, INCLUDING A LARGE NUMBER OF CLINICAL CASES, ETC., BY T. M. SIME, M. D., EAU CLAIRE, WIS., pp. 338.

There is a very natural desire on the part of young physicians especially to get at the experience of those who have preceded them. But, unfortunately, such experience is not often written out and is seldom available. Here is a book that not only treats of several very important, everyday diseases, but it shows how they have been treated by a physician who had to cope with them single-handed and alone, and how he succeeded and how they may also, by the simple and safe methods of our school. It abounds in suggestions of a plain and very practical kind and which, with a little sifting, are extremely valuable. Address Dr. Sime at Eau Claire, Wis.

Miscellaneous Items.

The treasurer, Prof. Cobb, acknowledges the following additional subscriptions to the Alumni fund: Dr. H. R. Diessner, '83, Waconia, Minn., $10; Dr. H. N. Coons, '83, Lebanon, Ind., $5; Dr. J. B. Ellis, '92, Rogers, Ark., $30; Dr. W. H. Eldred, '83, Chicago, Ill., $10; Dr. Margaret Hislop, Washington, D. C. (additional subscription), $15; Dr. D. A. Bissel, '83, Gloversville, N. Y., $40; Dr. Plumb Brown, '93, S. Manchester, Conn., $10; Dr. N. P. Smith, '81, Paris, Ill. (additional subscription), $90; Dr. F. W. Gordon, '66, Sterling, Ill. (additional subscription), $20; Dr. A. A. Goldsmith, Eagle Grove, Iowa, $30; Dr. O. G. Tremaine, '80, Ida Grove, Iowa, $200; Dr. J. M. Hicks, '93, Chicago, $40; Dr. W. H. Woodbury, '66, Chicago, $25. Amount already subscribed and reported, $3,341.60. Total to date, $3,841.60. A few matured notes still remain unpaid and the treasurer desires to urge the Alumni to recall these little matters as speedily as convenient. Having furnished the working part of the college we are now considering the matter of establishing the library and reading-room on a useful basis. There are still several Alumni who have kindly promised to take a hand, and now is the time in which it would be very pleasant to hear from them.—— The thanks of the College are due to Dr. Lewis Sherman, of Milwaukee, for a donation to the Dispensary of his World's Fair exhibit, consisting of 101 four ounce vials of triturations, and eighty-two one-ounce vials of tinctures put up in his graduated glass-stoppered bottles.——*Erratum:* On page 471, the 14th line should read "Concentric contraction of the visual field without any pathological changes, etc."——Prof. E. M. Bruce was married to Miss M. L. Alexander, Nov. 15, with the approval of the CLINIQUE and the felicitations of troops of friends.——Dr. L. S. Brown, who did such good service at the World's Fair Homœopathic Hospital, is now the efficient clerk of Prof. Arnulphy's clinic, and has located his office at the corner of 55th street and Monroe avenue.——*Apropos* of the said Hospital, Prof. Bailey, Secretary, furnishes the following items: Number of cases treated by prescription therein during the Fair, 7,828; do., while resting in the hospital, 1,600; visitors, 103,000; do., calling to rest, 15,000; physicians calling at the hospital, 2,000.

IN MEMORIAM.

We are pained to announce the death of Dr. Joseph L. Leffingwell, who graduated from Hahnemann College in April, 1893, and immediately associated himself with Prof. Shears in his private practice. He was one of the many New England boys who came to Hahnemann to complete his medical education, and possessed all of the good qualities for which the old puritan stock is noted. Dr. Leffingwell was also Prof. Shears' assistant in his surgical clinic, and in announcing his death to the class, he said: "I desire to bear witness to his high character and ability. I believe had he lived he would have become a prominent and successful physician. In addition to his work in the clinic he was my assistant in my private practice, and I there found him possessed of those qualities which make for success in any department of life, and especially in a professional way. He was not only well informed but a hard-working student. No case of importance came under his observation but that the literature on the subject was well looked into before the case passed from him. No day passed by that he did not add something to his store of knowledge. He was scrupulously honest in his relations with every one. He was kind and courteous in the treatment of his patients, rich and poor. I know of no one to whom I sent him but that spoke pleasantly of him; and this ability to secure the good will of those with whom he came in contact was all the more noticeable because he was reticent and retiring in disposition, and made few close friends; but no one can withstand the courteous gentleman, and this he always was. In his death the profession has lost one whom, I believe, would always have been an honor and a credit to it."

THE CLINIQUE.

VOL. XIV.] CHICAGO, DECEMBER 15, 1898. [No. 12.

Original Lectures.

THE MEDICAL TREATMENT OF ABDOMINAL DISORDERS.

A CLINICAL LECTURE DELIVERED IN THE HAHNEMANN MEDICAL COLLEGE OF CHICAGO, SESSION OF 1893–94, BY PROFESSOR A. K. CRAWFORD, M. D.

[NOTE. Rather than risk becoming tiresome with a long discourse on a single subject it seems to me that the readers of the CLINIQUE might suffer less if offered the gist of a Thursday clinic in general medicine, first, because there is a variety of material to work on, and second, because the work done there differs entirely from what it was in former years. For the better or worse, remains for my intelligent brethren in practice to decide. This clinic is now held in the new college building, in connection with its well equipped dispensary, and its numerous sub-clinic rooms.

The mode of procedure is to call a sub-class at 10:30 A. M., and with the assistance of Dr. A. E. Genius, Dr. J. M. Hicks, the interne, and my clerk, Miss L. A. Sager, the business of physical examination and diagnosis is begun. At 11:30 A. M. the bell rings for the medical clinic before the whole class, and we proceed to the arena of the amphitheater and continue there the examinations and the search for the *similimum*. The sub-class and my urbane assistants are still busy throughout this hour, and often away beyond it, investigating other cases, or handing me the chemicals for producing gaseous distension of a patient's stomach, or

making a urinalysis in a suspected Bright's. Samples are furnished from the latter class of subjects for the students to make microscopical investigations in the laboratory up stairs, so that the medical clinic by no means ends with the hour. Perfect freedom is accorded the class to not only question further into the history and diagnostic points of the case, but to make their prescriptions, and as it is expected that they must defend their positions they are liable to learn even more if they are wrong than if right.

From among the numerous cases presenting themselves it is not unusual to bring in two or three patients at once whose maladies are allied, and consequently one day may be devoted almost entirely to thoracic troubles, another to abdominal, etc. As the present one partook largely of the latter variety it has been so named in the headline.—A. K. C.]

CHRONIC DIARRHŒA.—James C., age thirty-four, is an opportune case for study in connection with our didactic course on typhoid fever. He tells us that last summer he had dysentery and bowel trouble lasting four weeks. He was then taken down with typhoid fever. His bowels were constipated during the whole course of the fever. When convalescence was established the diarrhœic passages returned, and he has had them more or less ever since. The number of passages vary from two or three to as many as fifteen per day. Among other medical data which he furnished us was the fact that he had ague several years ago; that it hung about him for nearly a year, and that he was treated with quinine and Smith's tonic. But at present we note a coated tongue which is indented with the teeth; that when water is imbibed there is pain in the stomach and bowels; that he suffers some pain in the left side which catches him when he coughs or takes a long breath; that his bowels sometimes feel as if they were dropping from him, and that when he partakes of food he must go immediately to stool. Croton tig. 3 was prescribed because its symptoms fit closely this intestinal condition. From his non-appearance at the next clinic, the inference is that he was much relieved, but, like such individuals generally, not

persistent enough to keep coming until a perfect cure could be effected.

PERI-HEPATITIS.—Harry K., æt 18, presented himself to us with his diagnosis made out. He said that he was suffering with pleurisy, and he thought that his lungs had been troubling him for a long time. During the last three years he has had six attacks, being confined to his bed with each one. He is just now recovering from the last of this number. The pain is sharp, right sided, aggravated by deep breathing and by motion. So far there was no reason to question the accuracy of the diagnosis. But, now that he is stripped to the waist, there are some points revealed which make it questionable. The sharp pain and the sensitiveness are directly over the area of hepatic dullness, and by the vocal resonance test we are satisfied that there is not even a shelving layer of lung tissue or pleural surface connected with the seat of pain and inflammation. We, therefore, alter the diagnostic term to peri-hepatitis, and prescribe bryonia 3, which would not have been the remedy had the diagnosis been pleuritis. The bryonia wiped out the remnant of the attack.

CATARRH OF THE DUCT. JAUNDICE.—Mrs. L., æt 39. This is such a beautifully developed case of icterus that I have had the woman rolled in, on the table, to give you a better view of the body discoloration. The skin, in its entirety, is of a saffron hue, and the face has, added to that, a greyish tint. The sclerotics are like the skin, and the bilious tint can be detected within the alæ nasi and in the buccal cavity.

As John L. Sullivan said about acting, "it is dead easy," so is it in this case "dead easy" for any one who is not color blind to name it jaundice. But when the cause of it has to be searched for out of thirty-two possibilities, then several John L. Sullivans in medicine are apt to be "knocked out."

Along with the icterus the patient complains of pain in the region of the liver and stomach which is sometimes dull in character and again sharp or stabbing. Also total inappetency, and even nausea at the sight of food. She has had a rash all over the body, not coalescent, but accompanied by a pricking sensation. The stools are now either pale yellow or clay colored. The urine is dark, thick, and has a reddish deposit. There is some degree of general debility. Even this array of symptoms does not help us much to the true diagnosis, because they are present, with more or less intensity, in every case of jaundice. The history she gives throws a little more light on the causation. The jaundice dates back no farther than two weeks. It has gradually become more intense during that time and is much worse the last two days. She says she has been more or less constipated all summer. The stools were dark and hard. She has worked hard in a restaurant feeding World's Fair visitors. The hours have been long, the heat oppressive, and relaxation nil.

In the physical examination which followed the endeavor was to determine whether a tumor existed. An ovarian, omental, pancreatic, gastric, or hepatic might give rise, by pressure, to the obstruction of the bile duct, but none such was found. There was some increase in the extent of hepatic dullness; some fullness and sensitiveness over the region of the gall bladder and an involuntary shrinking on deep palpation in the epigastric region. The edge of the liver projecting below the ribs was perfectly smooth in its outline and gave the ordinary sense of resistence to pressure. There was no history of the imbibition of certain poisons, such as phosphorus, lead, alcohol, and chloroform, which are capable of inducing jaundice. Neither was there any record of one of the fevers which produce jaundice having implicated the case. The organs of the chest, and the nervous system, were free from any marked diseases. There was no ascitic accumulation nor œdema present.

Therefore we have the signs before us of obstruction of

the gall duct due to a chronic but nonmalignant trouble. The chronic condition has evidently been one of gastro-duodinal catarrh, with dyspepsia and constipation as its accompaniments. Her mode of life, of late, has aggravated this condition until the common bile duct became so greatly involved as to obliterate its lumen. And nature in her endeavor to get rid of the excess of accumulation in the liver and gall bladder has loaded the *rete mucosum* with the bile products, to the extent here visible to the eye.

The case affords us a nice opportunity to prescribe one of the well known cholagogues. The mercurials, podophyllum, nux vomica, berberis, chelidonium, carduus or chionanthus might be administered to force the pent-up bile through the occluded duct; but this would not be treating the case from the etiological standpoint. As one of the aphorisms in medical practice is "remove the cause" I would look upon the choice of a cholagogue in such case as unscientific. The remedy to meet this patient's condition must be taken from the catarrhal group, such as pulsatilla, hydrastis, one of the kalis, antimony, etc. The kali muriaticum has received such high commendations from physicians of excellent ability in the treatment of such patients as this one that we will prescribe it in the 3ı0 trituration.

Subsequent reports of the case showed that there was gradual improvement. First the rash disappeared, then the prickling sensation of the skin, followed by a better appetite and more color to the stools. Consequently the same remedy was continued. The jaundice had not then diminished appreciably, nor was it likely to when of such an intense hue as this case presented.

GASTRO-DUODENITIS. — Mrs. B. æt thirty, is another case of gastro-duodenitis, of the sub-acute variety, but with her there is no evidence of bile obstruction. Instead, we have considerable emaciation, the trouble having persisted for ten months to her certain knowledge, and it may have lasted longer. She complains of pain in the stomach more or less constant, and about an

hour after eating she suffers with cramp referred to the same location. Her thirst is constant and intense. About two inches below the ribs on the left side she has pain every evening, and describes it as burning in character. There is alternate diarrhœa and constipation of the bowels. She describes having, at times, a tarry stool of a very bad odor. There is no doubt that the mucous inflammation in this case has gone on at times to ulcerative destruction in the duodenum, but with such a clear symptomatology for arsenic we can prescribe it with considerable faith and hope for betterment. The continuation of this remedy in the third potency completely removed these tormenting and long lasting gastro-intestinal symptoms in little over two weeks.

TERTIARY SYPHILITIC SCIATICA.—Jno. A. M., has been a cripple for a year with pain in the sciatic region running down the right leg, also extending up into the right arm. The right shoulder is stiff and partly paralyzed. He has had very little swelling in the knees but considerable in the ankles. He had inflammatory rheumatism thirty years ago, which lasted four months and was brought on by exposure to wet. He had no sciatica until last winter when it attacked the left leg. Soon after it extended across the loins and involved the right. Since that time he has suffered constantly. Occasionally there is a numb sensation in the limbs. The result of it is that his general health is impaired, he is depressed mentally and walks with difficulty.

The examination of the chest reveals a direct aortic murmur. The partial loss of use of the right arm has changed the contour of the muscles. The belly of the deltoid, especially, being flattened. The question before prescribing is, to what is this man's illness due? After a lapse of twenty-nine years it is hardly likely that the initial attack of rheumatism can be the cause of his present illness. The history as above given is all that the patient voluntarily gave to my clerk. I had a suspicion that

something else in his history remained untold because of the sciatica involving both extremities, and because of a similar involvement of a portion of the brachia. Therefore I asked the patient the direct question:

"When did you have a chancre?"

He answered, "Twenty-five years ago."

"Did you have the secondary symptoms?"

"Oh, yes; but I was all cured of that."

"Then you have never been troubled with it since that time?"

"No."

Here is the key to the situation; he is now suffering from the tertiary form of the malady after its having lain quiescent in the system for more than twenty years. Under this light all of his symptoms become intelligible.

The neuritis of the nerves springing from the lumbar and cervical regions, the deposition in the joint, the atrophy of individual muscles, and even the obstruction at the aortic orifice may readily be traced to the one cause. And, moreover, you might prescribe the ordinary remedies for sciatica from now until doomsday without affecting this case.

The mercuries stand at the head of the list of the anti-syphilitics, and I will choose for him the most potent among them, viz: merc. cor. 2 x trit., three doses daily, and the effect of the remedy on the patient will prove whether or not my diagnosis is correct. * * * * *

It is now nearly two months since this prescription was made. It was continued without interruption, and alone, for one month. By that time a slight soreness of the gums manifested itself, and since then nitric acid 30 has been given in its place. Before the expiration of the first month the sciatica had entirely disappeared. He rapidly regained strength in walking, and no longer bent over like a paralytic. The heart murmur, which was listened to by my assistants and the sub-classes, had entirely disappeared, and the action of that organ was generally improved. In fact the case was cured.

We still keep him on the list to see if we can improve the partial ankylosis of the right shoulder joint.

NICOTISM.—This young man, twenty years of age, represents a class which numbers its thousands, and is met most frequently in the larger cities. He has been examined thoroughly from head to foot with almost negative results. There is evidently some circulatory trouble, but the cause of it is not to be found in the heart or in any of the great viscera. The apex beat occupies its normal position. There are no murmurs. Its action is excitable; that is to say, under slight provocation the number of beats is accelerated, and the character of the beat intensified. The lungs are perfectly healthy. There is not much trouble with digestion or assimilation, excepting trivial and transitory attacks. Within the rectum are found a few sulci in the neighborhood of some hæmorrhoidal enlargements, but there is no sensitiveness nor discoloration of the rectal tissue. Yet, notwithstanding all of these negative conditions, there is a general neurotic look in the patient's face, accompanied with cold and clammy hands. A girl at puberty could not be more impressionable or sensitive than this young man, with his large frame and promise of strong manhood. While I am turning over in my mind how best to elicit from the patient whether he is addicted to the habit of masturbation, or suffers from nocturnal emissions, one of the members of the class suggests that possibly his smoking may have something to do with the case. Upon being questioned the truth is made manifest that he is what we ordinarily term a "cigarette fiend." He was consequently given a lecture on the injuriousness of the habit, and dismissed with a bottle of ignatia 3.

THE SURGICAL CLINIC IN THE HAHNEMANN HOSPITAL.

SERVICE OF PROF. SHEARS.

HARELIP: This little child, twenty months old has been sent to us by Drs. Smith and Linn, of Mt. Pleasant, Iowa. It has, as you can see, the congenital deformity known as harelip. There are several varieties of harelip, the single, in which there is a single fissure of the soft tissues, the double harelip, in which there is a double fissure occupying either side of the median line, and this form is usually accompanied by a projection of the intermaxillary bone; the complicated single harelip, in which there is the complete cleft of the palate. The superior maxilla develops, as you remember, in three parts, the right, left, and intermaxillary. The latter, the small triangular portion which includes the incisor teeth. In the progress of growth if development is arrested, no union of the portions may take place, in such cases we have double harelip with projection of the intermaxillary bone and cleft of the palate. If, however, union takes place on one side, we have single harelip. In this case the intermaxillary bone has united on the right side but not on the left, so that we have single harelip and cleft of the palate. The intermaxillary piece projects on the ununited side some distance above the left maxilla, thus placing them on a different plane. Should the soft tissues be brought together over the projection a marked deformity would result. It is evident then, that some operation must be made upon the jaw to dispose of this projection and also to fill in the space between the right and left maxilla. The first step in the operation is to separate the lip from the gums. This I do freely in order that the lip may move easily from one side to the other. I next remove with the bone forceps a thin slice from the intermaxillary piece and the right superior maxillary in order to freshen both edges of the bony fissure. With mallet and chisel I break through the intermaxillary piece at its junction with the left jaw and

with strong forceps guarded with rubber, twist it into its proper place so that the gap between the two maxilla is filled in. The third step consists in the freshening of the raw edges of the lip and bringing them in apposition. I introduce a narrow bladed knife at the upper part of the fissure and remove a triangular piece from each lip, the object being to remove a larger amount of tissue from the center of the lip than from either the upper or lower portion so that when the middle portion of the lip is brought together there will be a slight projection of the prolabium which will preclude the possibility of notching, a very common condition where the edges are simply freshened. This having been done, I now introduce three harelip pins, one just below the nose, one at the middle of the lip, and one at the lower edge of the fissure. A figure of eight of strong silk is thrown over these pins and the lip comes into good position. The only dressing required in simple cases is a strip of plaster to support the parts, but in this case I will reinforce it with a bandage and compress in order to hold the bony parts in place. The pins will be removed on the third day. The adhesive plaster compress and bandage being retained until the end of the week. (One week later the child was brought before the class showing a perfect union of the soft and hard tissues.)

HYDROCELE; CYSTIC DEGENERATION OF THE TESTICLE. This patient has a tumor which occupies the right side of the scrotum. His history is as follows: Eighteen years ago he was struck by a falling tree and knocked down, bruising the right testicle which produced great pain obliging him to lie down several times on his way home. Three years later he noticed a slight enlargement in the right scrotum. It has gradually enlarged until now it has reached a large size. There is a little pain which he describes as a dragging sensation. The history is such as would indicate a benign tumor, and the elasticity a hydrocele, but the tumor has not the pyriform shape we usually see in uncomplicated cases of hydrocele. That it is not

an abdominal tumor I know, because I cannot only introduce my finger into the external abdominal ring, but I can also isolate the spermatic cord at this point which eliminates the possibility of hernia. On examining it by transmitted light it does not seem to me to be entirely translucent, but this is not always an infallible rule because an hæmatocele which is simply an hydrocele containing some blood may be opaque. Its freedom from pain, its comparative lightness, its smooth elastic feel lead me to think that we have fluid in this tumor, but its irregular outline, its opaqueness and its very slow growth lead me to believe that this is not the entire difficulty, but that we have also some disease of the testicle. That it is not a malignant growth I am sure for the condition has existed for too long a period. There are several methods of treating hydrocele by aspiration and injection, but I have advised the patient that, considering the possible complication of disease of the testicle, the best method is by free incision which will enable us to examine the testicle and determine its condition. I now lay open the tumor from its upper to its lower boundary and there is a free flow of clear fluid and the upper portion of the tumor disappears. The lower and smaller portion remains. This occupies the natural position of the testicle but is very much enlarged if it is that organ. An incision is made into it and the organ found to be in a condition of cystic degeneration. It is evidently worthless and must be removed. The operation of castration is very simple. The degenerated testicle with its enveloping tunic is rapidly dissected from its scrotal wall and the cord tied with strong catgut just below the external ring. The cord is severed and the mass removed. The incision is sewed up with catgut and a small drainage tube placed in the lower angle of the wound. The wound will be redressed in twenty-four hours and the drainage tube removed. (Two weeks later the patient left the hospital the wound being entirely healed.)

DOUBLE INGUINAL HERNIA IN A WOMAN.—This young woman, twenty-six years of age, has had a double inguinal hernia for seven years, for the retention of which she has worn a truss. The left hernia has given her little inconvenience, but the right one has not been perfectly maintained, and has often been the cause of nausea and vomiting after active exercise. Inguinal hernia in women is not very common and the hernias are usually of a small size. This infrequency is probably due to the fact that the inguinal canal is short and transmits only the round ligament. Femoral and umbilical hernias are the more frequent forms. Although the inguinal hernia is usually of a small size, it often causes more or less disturbance because of the relations of the round ligament, which forms part of the sac, to the internal genital organs. Reflex neuralgic pains are quite common in cases in which the ovaries are not noticeably diseased. I shall treat this patient by the method known as the "Radical Cure," but which I prefer to call the operative method, inasmuch as while it is a radical method, it, like other operations in surgery, is not always a cure. The operation consists of three steps. First, the cutting down to and freeing of the sac. Second, the treatment of the sac and the closing of the orifice. The first step is attained by making an incision from the upper, to a little below the external ring, and the careful separation of the sac from the surrounding tissues and in the canal to a point a little above the internal ring. The second step, the treatment of the sac, admits of many methods, but we will adopt to-day the simple method so often and successfully practiced by Championnierre, viz., the high ligation of the sac above the internal ring. In the removal of the portion of the sac below the ligature, it is necessary to divide the round ligament which forms a part of the sac. No bad results follow this division, and indeed it is a benefit, as it allows of the entire closure of the canal. We have now closed the peritoneum, and by our separation of the sac from the inguinal canal freshened its surfaces, and we may now su-

ture the muscular tissues together as we would the same class of tissues in any other portion of the body. The fascia is united by a separate suture, and the integument by another. We have practically closed this orifice by four sets of sutures, peritoneal, muscular, fascicular and integumental. I have advised this operation, first, because I believe the patient does not, under our present antiseptic methods, run any greater risks from the operation than she does from the possession of the hernia. Second, because she is about the age at which the best results are obtained. Third, because she expects soon to be married, and it has been my observation that hernia is usually increased at childbirth. This is especially true of umbilical hernia, and let me say in this connection, that this form of hernia, while a very simple one, is often very troublesome, and trusses are seldom of any use. I therefore advise the prompt operation in umbilical hernia, especially in young women. (This patient was discharged from the hospital in four weeks, never having had a temperature above 99 degrees during the whole period and suffered less inconvenience during her stay there than she suffered for a few hours from the prolapsus of the hernia.)

CARCINOMA OF THE LEFT BREAST.—This woman, aged forty-eight years, injured the left breast a little less than one year ago. A month later lancinating pains were felt throughout the entire gland, followed in a short time by an enlargement of the breast and a sensation of drawing about the nipple. Five months later ulceration took place in the upper left quadrant. On inspection you will see that the breast is twice as large as the right one. The nipple is retracted and a large ulcerated raised surface is found toward the axillary portion of the breast. On examination the breast is found to be hard and firm, although not sensitive. Two enlargements may be felt in the axillary space. I believe this tumor to be carcinoma of the scirrhous variety. Although large size and rapid growth are not common indications for scirrhus, this variety more

frequently decreasing the size than augmenting it, nevertheless cases of large size and rapid growth are occasionally seen, and this I believe to be one. I will make a large elliptical shaped incision, removing all of the suspicious integument dissecting the integument back to the median line, above almost to the clavicle, and below almost to the waist line. Having removed every portion of the gland tissue, and with it the sheath of the pectoral muscle, the incision will be extended up into the axilla and the axillary glands removed. An incision at right angles to the axillary incision will be made through the integument toward the back, and the integument dissected up from the chest. By this means I hope to be able to cover the large denuded space by sliding and stretching the skin. (The operation was made as planned and the denuded space entirely covered. The tension of the skin was relieved by relaxation stitches and supported by lead plates. The patient made a good recovery.) I have not promised this patient that the disease will not return, indeed I have told her that the prospects are that it will, and yet I have advised the operation, First, because it will relieve her, I believe, from the sharp pains from which she suffers, and because it will for the time, at least, relieve her anxiety. Second, it offers her, I believe, a *chance* of permanent cure. The disease is at first undoubtedly, local, and if completely removed will not return; the difficulty, however, is in the complete removal of the diseased tissue, especially after it has left its original seat, and involves neighboring glands. Even where the axillary glands are not involved the disease is often more extensive than we would suppose from an ordinary examination. Research has proven that the abnormal activity which produces a cancer in a locality often affects the adjacent tissues for a considerable extent. A gland which shows evidence of activity in one part, while it may not show evidence of cancer in other parts, *does* show signs of increased functional activity and there is no doubt that such conditions are more liable to originate cancer than the structures not so involved. One is often liable therefore, to leave

dangerous tissue if every portion of the gland is not removed. The removal of the entire mammary gland is not so easy as one might think from first appearance. It is not so circumscribed as it appears. Its lobules are often widely diffused and sometimes quite separate. Neither has it the semispherical form which it seems to possess. It has been shown to project toward the upper and lower axillary borders, almost winding around the border of the pectoralis major, and toward the sternum as far as the median line. It is very easy, therefore, if the breast is simply removed by the dinnerplate incision to leave one or more of these prolongations. The lymphatics which supply the breast are found in the loose areolar tissue which separates the gland from the pectoral muscle. These lymphatics are often diseased and their removal, with the sheath of the muscle to which they are often attached is an absolute necessity. When the axillary glands are diseased it is also quite probable that the whole chain of lymphatics from the breast to these glands are diseased, and they, with the areolar tissue in which they are embedded must be carefully removed. These considerations, while they lead us to be more careful in our prognosis in advanced cases, and more thorough in our removal in all cases, also leads us to urge most strenuously that the operation shall be made at an early date, at which time the complete removal of the growth may, in competent hands be reasonably expected.

Clinical Society Transactions.

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

NOVEMBER MEETING, 1893.

The regular monthly meeting of this society was held in the amphitheater of the new Hahnemann Medical College building, on Saturday evening, November 25. An unusually large number of members, physicians and students were present to listen to the following paper:

XXXII. A CASE OF SYMPHYSEOTOMY, WITH BRIEF REMARKS, BY SHELDON LEAVITT, M. D.—In summarizing improvements in the obstetrical field for our recent Congress, I drew attention to symphyseotomy as the most important of them all. At that time I had had no experience with the operation, and indeed very few operations had been done in this country. Even now the obstetric surgeons who have reported cases wherein this new procedure was adopted, could readily be counted on the fingers. This evening I wish to report my first symphyseotomy, which is at the same time, so far as I know, the first one reported from this part of the country.

CASE.—On the morning of September 1st, I was summoned to Washington Heights for the possible performance of Cæsarean section. There I found Mrs. S., a German woman thirty years of age, of medium height and stout build, under the care of Dr. John D. Wood, in her third labor. In her first confinement, which occurred in May, 1890, she was attended by Dr. Louis Lowenthal, of Washington Heights, and Dr. Carl Faber. In her second, which happened in August, 1891, she was under the care of Dr. Wilson A. Smith, of Morgan Park, and Dr. Carl Faber. On both these occasions the forceps were tried in vain, delivery being effected only after craniotomy. When I saw the woman she had been in labor twenty-four hours, the os uteri was fully dilated and had been for several hours, but the head was still free above the brim. Upon

careful examination I found the head decidedly out of proportion to the size of the pelvis, the conjugate of the latter at the brim being only about three inches. The woman herself was exceedingly desirous to have a living child, and did not shrink from any operation which afforded good hope of giving her one. Symphyseotomy was immediately decided upon, and Dr. Helen M. Heffron was brought in to administer the anæsthetic. A table was speedily prepared, and the woman anæsthetised and laid upon it. The usual antiseptic precautions were observed, including shaving and washing the *mons veneris*. An incision about two and a half inches in length was made in the median line, extending downward to a point a little below the crest of the pubes, a few fibers of the recti muscles were severed in order to make room for the finger, which was then passed behind the symphysis. With an ordinary probe pointed bistouri the articular soft structures were easily divided, when the bones immediately separated to the extent of half an inch. The wound was packed with iodoform gauze, the forceps were applied, and delivery was effected with ease.

The sensation, and even sound of the moving bones during traction, were grimly anomalous to me. The child was slow to take up the respiratory act, but did so heartily in response to a little stimulus. During delivery the articular surfaces were nearly an inch and a half apart, and a separation of at least an inch continued after delivery when pressure was removed from the hips. The placenta came away promptly. The wound was then carefully dried and prepared for closure. Two silkworm gut sutures were made to take a firm hold of the fibrous structures covering the bones, were well tied and then cut short. The remaining wound was closed with silk over a short drainage tube and dressed like other abdominal wounds. The hips were supported by Dr. Wood until a tight muslin bandage had been securely fastened. On the succeeding day I removed the drainage tube, redressed the wound, and took my final departure. I directed Dr. Wood to procure at once a new surcingle, take a strong reef in it so as to bring it down to suitable length, and apply it over the other bandage, so as to make sure of sufficient support. The urine was easily voided, there was neither rise of temperature nor other abnormality, and at the end of four weeks the woman left her bed. The doctor informs me that she is now feeling well, and is free from disability.

Complications.— Symphyseotomy is liable to be complicated by osseous union of the bones, in which case the chain saw may be required to make the disarticulation. When the pelvic deformity involves an oblique, as well as the antero-posterior diameter, it may be necessary to make section through the transverse and descending rami of the pubis.

Danger of wounding the urethra and bladder.—This is but slight under the hand of one who is accustomed to surgical work, and has a perfect knowledge of pelvic anatomy. I can see no special advantage to be gained from forcing the urethra aside by means of a sound, while on the contrary such efforts may prove harmful.

Special knives.—Such have been devised, but an ordinary probe pointed curved bistouri answers every purpose, provided section is made from above downward.

Buried sutures.—I believe it wise to put in two or three sutures which take hold firmly of the fibrous covering of the bones, and, after tying them carefully with a square knot, cover them with the soft tissues. Silkworm gut is best suited to this purpose, since, if aseptic, it will prove non-irritating. It is possible that catgut would hold sufficiently long, but I should fear to trust it.

No further use for perforator on a living fœtus. A head of standard size can be delivered with safety by means of symphyseotomy through a pelvis, the antero-posterior diameter of which at the brim is as small as 2¾ or possibly 2½ inches. When the measurement falls below these figures, Cæsarean section is demanded. Cephalotripsy is the preferable operation on a dead fœtus when the pelvic diameters are between 2½ and 3½ inches.

It will be observed that this leaves no place for craniotomy on a living child.

Pelvic dimensions alone not a safe criterion. We cannot safely be guided alone by the size of the pelvis in our choice of delivery methods, since we are confronted by the fact that fœtal heads are not all run in the same mould, and therefore, with uniform pelvic dimensions, cannot be

managed precisely alike. There may be a large head or a small head to drag through a contracted pelvis, the forceps alone being required in the latter case, but symphyseotomy prior to the forceps in the other. The size of the fœtal cranium, then, is a factor of the utmost importance in all cases. It is therefore evident that symphyseotomy may be required in exceptional instances, even when the pelvic dimensions are of standard proportions, while on the other hand it may not be indicated when contraction has reduced the diameter at the brim to three inches.

The clinical test is the important one, and the point which I wish to make is that, no matter what the pelvic measurements, it is far better to perform symphyseotomy than to apply powerful traction and compression for a prolonged period to a head which refuses to pass the pelvic brim. Why? Because in such cases the danger to fœtal life is extreme, while the danger to the mother is nearly equal to that associated with a well performed symphysotomy.

DISCUSSION.—Dr. LUDLAM: It is fitting and appropriate that such a report as that to which we have just listened should emanate from the "Old Hahnemann," and I congratulate the essayist on having done the first symphyseotomy in this great city and immediate vicinity. His case, with the surgical reports to this Society by Drs. Shears and Chislett, and my own successful Cæsarean section will help to sustain the prestige of our old school and hospital; for it will show that we are not in our dotage, but, to say the least, are doing as good work as our neighbors.

In regard to the possible necessity for symphyseotomy the disparity in the size of the upper and lower pelvis of bipeds adds greatly to the risks of parturition. The dog and other quadrupeds, excepting those which like the bear sometimes walk upright, is better off than the woman whose compensation is that certain of her own kind may study obstetrics and officiate as midwives. The

spontaneous separation of the pubic bones of the Guinea pig, when the animal in labor is placed upon its back; the "slipping" of the sacro-iliac articulation in the cow, when her calf is about to be born; and the open os pubis of birds, excepting the ostrich and the brown eagle, are specimens of what might be styled a physiological symphyseotomy. They suggest the idea of operative interference when the pelvic diameters are inadequate, as the tears suggest the aseptic value of a saline solution.

I regret that Dr. Leavitt has not given those present, and the readers of the CLINIQUE indirectly, a more elaborate paper upon this very interesting subject. It may therefore be proper for me to state that this operation, which was originally devised by Sigault, a Frenchman, was abandoned because of its high rate of mortality without aseptic precautions. At the close of 1891, however, it was revived and practiced successfully by Morisani, in Naples. In January and February, 1892, it was successfully done by Pinard, in Paris. Thence in a few months it spread to Germany, Austria and Russia, the first operation being made in America, September 30, and the first in England, November 30 of the same year. From the date of its revival in Italy to March 31, 1893, Varnier has collected eighty-two cases; for France, forty-nine; the United States, twelve; Germany, seven; Austria, seven; Russia, four; England two, and Canada, one. These with the forty-two Italian cases aggregate 124, of which 112 mothers survived and twelve died; while ninety-two children were saved and thirty-two died. But, deducting the cases in which the mother was infected before delivery and in which the operation was not strictly aseptic, Varnier's figures give only **1 maternal death in 117 cases.**

There is a manifest contraindication for symphyseotomy as it is usually practiced whenever we have the oblique oval pelvis of Naegele, for in that case the sacro-iliac hinge on one side, or both perhaps, will not open backwards. The two sides of the brim are asymetric, and anchylosis of the posterior articulation is the rule to which there are few ex-

ceptions. In such a case Faraboeuf's operation of ischiopubeotomy is the only safe recourse; for section of these bones with the saw will give the needed scope and they will afterwards heal as if from a transverse fracture.

Some authors have described the pubic articulation as fitted with a bursa between the ends of the bones, which sac would theoretically become distended in advance of labor, and so wedge them apart as to facilitate delivery. And, whether from this mechanism or not, there is sometimes quite a separation at the symphysis under these circumstances. I can recall at least three marked cases of the kind in which I placed my finger, or fingers, between the ends of these bones during and after delivery; and more than as many others in which women who had recently been delivered could not stand or walk without a peculiar sensation of "slipping" at the symphysis pubis. With care and rest they soon recovered.

Dr. SHEARS said: I desire to congratulate Dr. Leavitt both on the enterprise which led him to adopt this practically new procedure, and upon the successful result of the operation. I say new procedure, although it was first practiced more than one hundred years ago, but like many other surgical plans it was practically abandoned, and it is only within the last few years that it has again been considered with favor. In an article upon the subject published in 1888, the statement was made that no operation of this character had been performed in the United States. Its history is much like that of the suprapubic operation for stone in the bladder, which, it will be remembered, was quite popular in the latter part of the 18th century, but which was finally almost abandoned in favor of the perineal operations perfected by Cheselden. Latterly the high operation has again become fashionable, and is advocated by some as perferable to all other methods. So with symphysotomy. First devised by Sigault in 1768, it was for a time quite popular, being urged by its advocates as destined to utterly supplant the Cæsarean section, and so high did medical opinion run that two camps were

formed, the Cæsareanists and the Symphysotomists, but eventually it met the fate of the suprapubic operation and was practically abandoned. Its revival, like that of the suprapubic method, is due, I believe, to the immunity which antisepsis now gives to operative procedures, as one of the causes of its abandonment was sepsis, and the gangrenous condition which so frequently followed its performance. That it has come to stay I now believe; first, because antisepsis makes its performance a safe procedure, and second, because its sphere of usefulness is being accurately and scientifically defined.

Dr. W. A. SMITH: Hearing that Dr. Leavitt was to report the case, I called upon the patient before coming here, and as I had not seen her for some time and found she goes about caring for her child, and is in good health. There is still some tenderness in the pubic region. The wound healed perfectly by first intention. I have her wear an eight inch linen band as yet around the hips.

Dr. LEAVITT: I had one case similar to those recounted by Dr. Ludlam. There was considerable prominence of the iliopertineal eminence, encroaching upon the pelvic inlet, thus making it a difficult forcep case. After labor on moving she complained of much pain at the pubis, and upon examining I found there was marked separation of the articular surfaces. I at once applied a tight bandage and the case made a nice recovery. At first she was compelled to push a chair along in front of her when endeavoring to walk, but locomotion ultimately became normal.

XXXIII. A CASE OF INVERSION OF THE UTERUS. By SHELDON LEAVITT, M. D. *Case* ——. I recently delivered Mrs. B., æt. thirty-two years, primipara, of a large fœtus, by means of the forceps, without unusual difficulty, and removed the placenta by means of slight traction on the cord, and firm compression of the uterus. Firm contraction of the uterus ensued, and I watched the case carefully, as I always do, for some minutes, the hand resting on the

contracted organ as easily felt in the hypogastrium. It presented the usual feel for a time, but later appeared to have relaxed greatly so that its outline became lost. Fearing hæmorrhage I examined and discovered too free loss of blood. I accordingly ordered a hot water douche to be made ready, and as I introduced the tube my fingers came in contact with what at first felt like a fibroid growth lying within the vagina, but which, on closer examination, proved to be an inverted uterus, which I proceeded at once to remedy. Reduction was not easily accomplished, introduction of the whole hand being required. I never before met the accident in my own practice, and but once in consultation. Recovery was perfectly normal.

XXXIV. A RARE SYMPTOM IN CONCEALED UTERINE HÆMORRHAGE. By Dr. G. F. SHEARS.—*Case.* As a supplement to Dr. Ludlam's remarks on the necessity of careful examination in the case of any unusual symptoms following labor, I may relate the following incident: Sometime ago I was called several hours after labor to see a patient who had been confined by another physician. A short time after his departure the patient began to have eructations of gas. These became more and more frequent and the physician was recalled. He gave a remedy and departed. The symptoms increased in severity until the patient was in a constant state of eructation. I was called in, and found the patient in great distress, pulse faint, covered with cold perspiration, and said that everything looked dark. She still continued to belch gas. The discharge was normal in quantity. I made an examination and found the uterus unusually enlarged and full of blood. I introduced my hand into the womb and cleared out the contents, compressing it with the other hand on the abdominal wall. Hypodermic injections of brandy and ergot were administered by an attendant. Gradually the eructations ceased and the pulse improved. I have never before or since met this peculiar symptom accompanying flooding.

VOLUNTEER PAPERS. XXXV. TATTOOING A CICATRICE OF THE CORNEA FOR ITS COSMETIC EFFECT AND FOR THE IMPROVEMENT OF VISION. By C. J. SWAN, M. D., of Chicago.

Case. Miss M——, a young woman 23 years of age, came to me on the 10th of May, 1893. Upon the cornea of the right eye was a dense white cicatrice or leuconia, involving the lower and outer one-third of the cornea, and extending over more than two-thirds of the pupil. There was anterior synechia, the iris being involved in the scar to the extent of one or two millimeters. The lens I found to be untouched and perfectly transparent. Vision was $\frac{5}{3\,6}$ in the injured eye, or $\frac{1}{7}$ of normal, and normal in the uninjured eye. The uninjured eye was the fellow of what would have been called in popular language "a beautiful pair of black eyes." The opacity was the result of a perforating wound inflicted by a flying splinter of wood.

The patient wished to know if anything could be done to mitigate the ugliness of the disfiguring scar. I suggested tattooing, explaining at the same time that the operation was not entirely without danger.

The idea was not at first received with approval, but by the end of a week the feminine desire to appear to the best advantage had overcome all objections, and she was ready for the operation.

Operation.— After thoroughly anæsthetizing the eye with a few drops of cocaine grs. xxv. in merc. bichloride sol. 1-5000 ℥j, a stop speculum was introduced and the conjunctival sac plentifully irrigated with the merc. bichloride, sol. 1-5000. The ocular conjunctiva was then seized with a pair of fixation forceps. (These forceps must be made expressly for this purpose with hard rubber jaws in order to prevent laceration of the conjunctiva and the possibility of some of the coloring material getting into the laceration and tattooing an unwished for spot.) DeWeckers' needle, previously loaded with India ink, was next pushed obliquely into the cornea, care being taken that perforation was not made.

At the first sitting I thought it best, on account of the anterior synechia and consequent danger of setting up an iritis or iridocyclitis, to make but a few punctures. I made six, bandaged the eye carefully after again irrigating, and sent the patient home with instructions to return next day. Upon the removal of the bandage the following day I found very little reaction, but delayed the next sitting for a week, making the third and final tattooing ten days later.

The cosmetic result of the operation was good. At a distance of a few feet it would be a difficult matter to discover anything unusual about the eye. There was also an improvement in vision from 6/36 to 6/24, and the haziness had largely disappeared. From the above it will be seen that the cosmetic effect is not always the only improvement that may be hoped for as a result of this operation.

Remarks.—Tattooing the cornea was first performed by De Wecker, of Paris, in 1874, at the suggestion of one of his pupils, and has lately grown to be a common operation in the European clinics.

Among branches of the profession not especially interested in eye work, there has been rather a confused idea of the meaning and scope of this operation, the idea being prevalent that an eye could be tattooed any desired color, and eyes that were not mates in color could be made to correspond by tattooing the iris. It is scarcely necessary to say that such an operation as the last has never been attempted. With regard to the former proposition, experiment is now being pushed in Vienna and other medical centers in an effort to discover brown and light blue coloring matters which may be made to answer this purpose. Thus far, however, India ink is the only stain that has been successfully used.

There is yet another operation for the removal of corneal opacities, the history of which may prove interesting, viz: the removal of the opaque part of the cornea and the transplantation of transparent corneal tissue from the eye of a rabbit or cat. This operation was first attempted several years ago by Hippel, of Halle, but without success. Since then there has been repeated efforts in the same line by him and by other operators, and, although frequently a successful transplantation has been made, the transplanted piece invariably became opaque during the process of healing.

About six weeks ago, however, an operator in Hamburg (his name has escaped my memory) made a completely successful transplantation. He used a trephine the size of the opacity, cut down through the first three layers

of the cornea, took out the piece, and replaced it with a button from a rabbit's eye cut with the same trephine. The motive power of the trephine was electricity.

When the opacity is the result of a perforating wound, this operation will not serve, as in that case there would be no transparent layer upon which to place the graft.

Slight opacities may sometimes be removed by internal medication, local irritants or the constant current. Lately an oculist has suggested the local injection of papoid, thus digesting the scar, and claims good resuls. If papoid has a special affinity for scar tissue and an antipathy to normal tissue, it might be made to work very well, but at present I accept the papoid proposition with a good many mental reservations.

In regard to the improvement in vision noted in the case under discussion I will say, that if in this case the *opacity had not encroached upon that portion of the cornea covering the pupil,* or if, on the contrary, the *opacity had covered the entire pupil,* tattooing the opacity would have had no effect upon the vision. Improvement in vision is only gained from tattooing a cicatrice which *partly* covers the pupil. The explanation is as follows:

The location of the leucoma in this case allows certain rays of light to pass uninterruptedly to the retina through the unobstructed part of the pupil, while the continuity of other rays is partially broken by the leucoma. In other words, part of the cornea over the pupil is transparent and part is only translucent. Hence the image upon the retina is partly clear and distinct, and partly hazy and diffuse. The India ink renders the opacity truly opaque, entirely breaks the continuity of the partially interrupted rays, and thus the image upon the retina is formed alone of rays which pass through the transparent portion of the pupil. The image therefore has a good definition. The patient sees distinctly. That there was not a better acuity of vision than $\frac{6}{24}$ in this case was due to the irregular astigmatism produced by the wound and its healing.

Hospital Notes.

THE CLINIC FOR THE SURGICAL DISEASES OF WOMEN.

SERVICE OF PROF. LUDLAM.

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

A LARGE PAROVARIAN CYST WITH A CYST OF THE OVARY. REMOVAL. RECOVERY.—*Case 21,062.* Wednesday, November 8. Mrs. ——, sent to this clinic by Dr. F. W. Gordon, of Sterling, Ill., was fifty-three, the mother of four children. She first noticed a growth in the abdomen three years ago. There was much bearing down and restlessness late in the night from general aching all over the body; pain in the left renal region and the left hypochondrium. The appetite and general health are good. The menses are regular, free and without discomfort. Although the abdomen was very large, physical examination before the general class resulted in the diagnosis of a probable parovarian cyst.

Operation.—November 9. A laparotomy made before sub-class No. 9, and a left-sided parovarian cyst containing thirty-six pints of the characteristic spring water fluid was taken. Attached to this was a cyst of the ovary as large as an ostrich egg, which was also removed.

It is seldom that we find so very large a parovarian cyst as this. You will remember that my diagnosis turned largely on the tenuity of the fluid as recognized by the peculiar fluctuation. But it will not always do to depend upon this as a sign of parovarian dropsy, for in case the abdominal wall is very thin from over-distension, and the cyst is a single one, you may possibly have the same symptom in a true ovarian cyst. Hence my diagnosis of a "probable" parovarian tumor.

December 1. Having made a prompt and complete recovery, this patient left the hospital for her home.

*Continued from page 523.

HYDRORRHŒA GRAVIDARUM. *Case 21,063*, referred to us by Prof. Arnulphy, was examined before sub-class 7 on November 14. Her age is thirty-seven and she thinks she has never conceived. The menses have been regular until recently, but now they have been substituted by an almost continuous watery discharge, which at times is very copious, thin, and the napkins have a urinous odor. She expected to undergo some sort of surgical operation, but a careful examination revealed the existence of pregnancy and a diagnosis was accordingly made of hydrorrhœa gravidarum. The differential points insisted upon and demonstrated to the class were: the appearance of the cervix, of Jacquemier's and of Montgomery's signs, with the peculiar feel and form of the uterus upon bimanual examination.

Wednesday, December 13. This patient remained in the hospital under constant observation for nearly a month. The copious watery flow continued unchanged, and perceptibly exhausted her strength. Once she had brief pains in the loins and muttering signs of labor. She finally became so weak and wretched that it was determined to empty the uterus of its contents. This resulted in the expulsion of a fœtus of about four months, which was badly developed, poorly nourished, and almost mummified, with the right side of the abdomen disorganized and disintegrated. Here it is for your inspection. The placenta was removed piecemeal.

Yesterday afternoon her temperature having reached 103⅘°, and the pulse 120, it became evident that the vaginal douches and the usual aseptic precautions were insufficient. I then curetted the uterus and flushed it very thoroughly. In a few hours the temperature came down to 99°, and the pulse accordingly. This morning she is doing well, and we have heard nothing more of that very troublesome hydrorrhœa.

POST-OPERATIVE ENTERO-PERITONITIS.—Wednesday, November 29. For the average medical student there is such

a fascination in surgical operations, and we have had so many of them lately, that I must not fail to direct your attention to the equally important question of the after-treatment in the surgical diseases of women. Two of our patients have been so very ill with a similar form of post-operative peritonitis that without the proper care they must have died. I therefore feel constrained to speak of their points of resemblance and of difference.

The case (21,059) that you have just seen is one of them. She underwent a tubo-ovariotomy for pyosalpinx, November 6, before sub-class 2. The other one was case 20,995 upon whom we also made a double tubo-ovariotomy before class 8, on November 17. She had a hæmatocyst of the right ovary, cystic degeneration of the left one, and a double hæmatosalpinx.

The first of these patients was very weak, anæmic, and badly nourished, a victim of chronic invalidism; and the second was the most pronounced hæmorrhagic subject upon whom I have ever operated. All the intra-pelvic tissues were extremely vascular, and disposed to bleed on the slightest touch; and you remember our dependence upon the Mikulicz drain as a safeguard against hæmorrhage and sepsis. In her case, on the second day after the operation there was a free uterine flow, or a pseudo-menstruation, which continued for forty-eight hours. Later on she developed a subacute peritonitis for which Dr. Stettler prescribed terebinth 2, with apparently good result.

Now, the first of these two women did well for three days, when her pulse arose to 142 and her temperature to 101°. There was local pain in the cæcal region which persisted until the bowels were freely opened by the saline enemata. Then, with a very offensive diarrhœa, with dark and frequent stools, came relief to this condition. The local pain returned, however, and alternated with the diarrhœa, and was manifestly limited to the cæcum and the right colon. This state of things continued for more than a week, the wound healing promptly meanwhile, the patient being in a very feeble adynamic state. For two

days she has taken muriatic acid 3 with marked benefit, the stools are natural for the first time, and she is really convalescing. This attack was the sequel of a laparotomy in a very unpromising case.

Wednesday, December 6. The case of entero-peritonitis that we had on this table a week ago has improved so rapidly that I have allowed her to go the house of a friend near the city. She is practically well again.

But here is the other one, who also is so improved that she is on her way to the convalescent ward. A peculiarity of her case was that none of the usual remedies, neither the enemata would move the bowels; the gas passed so freely that peristalsis was not inhibited. Her appetite was so fickle, and her prejudice against milk and alcohol in any form so strong that she became very weak. She ran along with a pulse above 100 and a temperature plus 101°, until three days ago, when there was a decidedly critical hæmorrhage from the bowels, for which Dr. Spaulding at once, and very properly, gave nitric acid 2, with the effect to control the loss of blood and to put an end to the passage of coagulæ. This flow, which continued in a passive way for two days and nights, brought the temperature and pulse down to the normal and established her convalescence. You can see, as the wound is exposed, that it has healed perfectly except at the site of the drain, which is almost closed.

Wednesday, December 13. There has been no recurrence of the old symptoms. This patient's color, appetite and strength are improving so that she will leave for her home to-morrow.

The lesion proper to entero-peritonitis is a very peculiar one and is more common with puerperal than with our surgical patients. It is always due to sepsis, but with a strictly aseptic technique can only arise from auto-infection. When recovery is possible it must come about through some form of critical discharge. Thus, of our two cases, one was saved by a diarrhœa with stimulation, and

the other by an active intestinal hæmorrhage without either.

SCLERO-CYSTIC OVARIES AND NEUROTIC DISORDERS.—Wednesday, December 6. Here are two ovaries and tubes that I removed from a private patient two days ago. They present certain peculiarities with which you should become familiar. The sclerosis, o r hardening of the interior stroma, and also of the envelope of the ovary, is very pronounced, especially in the larger of these two organs, which was the left one. And so also is the follicular degeneration, which as usual, has taken the form of hæmato-cysts. The tubes are almost as large as my index finger. (See Figures 29 and 30.)

This sclerotic change, which begins in the center and at the surface of the ovary, in the stroma and in the tunica albuginea, is analagous to a cirrhosis of the liver, or of the kidney, in that the organ first becomes hypertrophied and afterwards atrophied, beside being functionally disabled. It is possible that for a time a portion of the ovary shall escape this hardening process, and so ovulation may proceed and recur in a more or less natural way ; and that is what happened with the right one in this instance. But with the left one, which is wholly sclerotic on its exterior, there could be no extrusion or escape of the ripened ovule. Hence the absence of scars, or cicatrices, on its free surface. We find no score, or stigma of menstruation here, and if its fellow had been as completely changed, that function must have gone by default.

The morbid sclerosis that is possible during menstrual life is very anolagous to that which naturally follows the menopause. And this is why the neurotic disorders of not a few young women are identical with such as often accompany or follow the climacteric. It sometimes gives rise to menstro-mania, or more properly to oöphoro-mania, to intractable forms of hysteria, and to a sexual erethism which is incurable by any other than surgical means. My patient has been sorely afflicted in that way.

The secondary degeneration of the ovarian follicles in these cases may be ascribed, in part at least, to the formation of the shell at the surface of the organ, which results in the retention and the destruction of the ovule, and the substitution of an apoplexy (*l'apoplexie folliculaire*) for the normal corpus luteum in the ovisac.

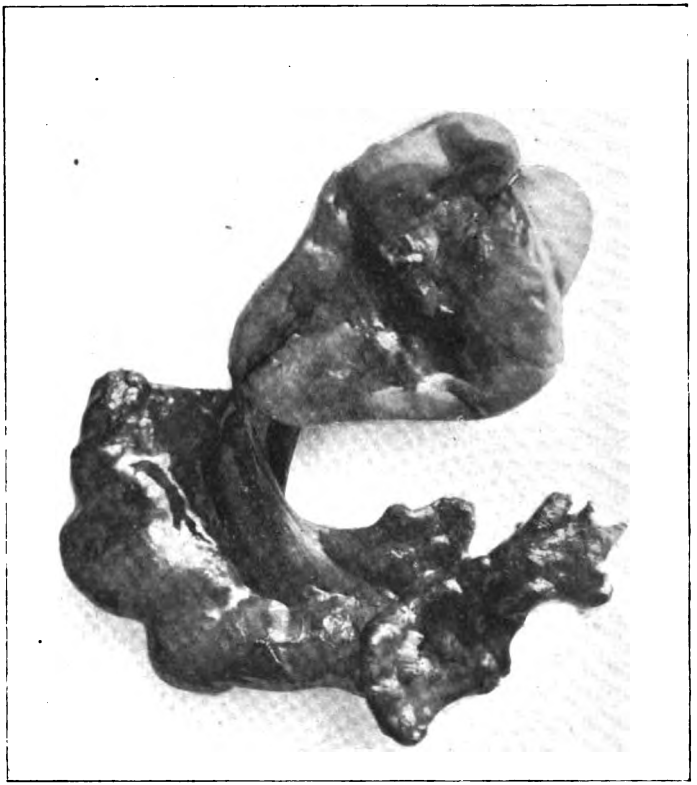

FIGURE 29.

This intra-follicular hæmorrhage is the starting point for the development of cysts which may vary in size but which, like those in our two specimens, are always hæmatic. Indeed, we sometimes have severe hæmorrhage into the peritoneum, or hæmatocele, from the rupture of these cysts.

But how shall we recognize this form of ovarian disease and be enabled to decide upon the propriety of removing these sclerotic, or the sclero-cystic organs? It is not always possible to do so beforehand, for you may fail to find any absolute physical signs thereof, even by the most care-

FIGURE 30.

ful bimanual exploration. In this instance I was forced to depend upon the previous history of the case, which was an enigma, and upon the detailed result of all sorts of treatment, which had been very persistent but futile. The case was so pressing and the appeal for relief was so strong that,

after due deliberation, I consented to make an explorative laparotomy in order to complete the diagnosis and to determine whether an operation was justifiable. The result is before you.

Having opened the abdomen, as I did in this case, how shall we identify the lesion of which we have been speaking and of which you all have seen such an excellent illustration? When you seize the sclerotic ovary during the menstrual life of your patient, and draw it up to the wound for inspection, it will be white, dense and firm in its structure, and, except for the swollen follicles that may bulge, or project upon its surface here and there, it will also be smooth and shining. Besides, the sclerotic portion will lack the wrinkles and the seams, or scars, that you would find in a healthy ovary before the catamenia had ceased, excepting of course during pregnancy and lactation, when these scores are apt to have been erased.

Concerning the cause of sclerosis of the ovary there is no deposit of any peculiar kind in its structure, as Laennec supposed there was in the cirrhotic liver. It is neither cancerous nor tuberculous, nor will it become so. It may be post-inflammatory, or traumatic; or it may be connected with the history of repelled eruptions, especially of variola or scarlatina when they have occurred at puberty, or at the beginning of a monthly period, in a young woman especially. So there may be a clinical significance in the fact that my patient had a desperate attack of scarlet fever when she was a child, the effects of which did not disappear for years afterward, and that she has also had the measles three or four times.

Wednesday, December 13. She is at the tenth day, and, barring a slight irritation at the neck of the bladder, her convalescence is perfect.

INTRACYSTIC TUBERCULOSIS IN A TUMOR WEIGHING TWENTY-SEVEN POUNDS. OVARIOTOMY. RECOVERY.—Wednesday December 6. *Case 21,071.* Miss ——, æt. eighteen, brought to the clinic by Dr. F. Henry Dodge, of Lake Mills, Wis., began to menstruate at thirteen. Her monthly

flow was painful and profuse. One year ago she first noticed a growth in the right inguinal region where there was a tender spot, with a radiating soreness in the opposite ovary. The swelling increased slowly until after an acute illness, the nature of which is unknown to her, about eight months ago, after which it grew rapidly until the body had attained its present girth of thirty-nine inches. At first there was much vesical irritation, but of late that has disappeared, the urine being somewhat scanty in amount.

Operation. December 7. A unilocular ovarian cyst weighing twenty-seven pounds was removed before subclass 12. The entire parietal surface of the tumor was firmly adherent, and many fibrous and omental adhesions were tied off with catgut. The right fallopian tube was so enlarged and elongated as to extend over the side of the tumor as high as the umbilicus. After tapping the bottom of the sac was torn while being separated. The pedicle was very broad and vascular. Flushing and the Mikulicz drain.

Wednesday, December 13. This patient was carefully examined and made the subject of some remarks in my clinic one week ago. My diagnosis of a unilocular cyst was confirmed, and you have just had the details of the operation. The patient is now at the end of the sixth day and without any symptoms. She is convalescing as if from a simple incised wound. But the most interesting feature of her case was disclosed when we afterward examined the cyst. On turning it inside out the remains of the old partition walls that had once divided it into compartments, and which had been broken down by pressure, were plainly visible. This shows you how a polycyst may become a monocyst, and that the dictum that a single cyst is not strictly ovarian does not always hold good.

Besides you will observe, as the specimen is passed for your personal inspection, that the inner surface of the sac was studded with granular deposits, singly and in masses, throughout nearly its whole extent. These deposits are tuberculous, and what is strange about it is that none of them are to be found on the outer surface of the

cyst. Nor were any to be felt or seen anywhere within the abdomen or the pelvis. The other ovary was sound and healthy, and because of the youth of the patient was not removed. There is no history of tuberculosis in her family, nor has she ever had any symptoms of it whatever. If this local expression is all there was of the disease in her case, or in other words, if this deposit was not secondary, it is probable that she will be entirely cured by the operation.

TRAUMATIC CYST OF THE OVARY. OVARIOTOMY. RECOVERY.—*Case 21,069.* Mrs. —— æt thirty-one, married nine years, conceived almost directly, but aborted at the second month because of a strain in lifting a tub of water. She "felt something give away" and soon had a profuse flow which lasted a week. She took no care of herself, kept about her work, and has been in miserable health ever since; has lost much flesh, is very nervous and in every way a wreck. Menstruation recurs in two, four or six weeks, and she suffers greatly before and during the flow which latter is becoming more scant. Pain in the top of the head and through the left chest, some dyspnœa and indigestion with constipation. Local examination found anteflexion of the uterus with a cyst as large as an ostrich egg low down in the right side of the pelvis.

Operation.—December 11, an ovariotomy was made before sub-class 11. The cyst which was wedged into the posterior part of the right side of the pelvis, behind the broad ligament, yielded a pint of the olive green ovarian fluid. It was very adherent with a broad pedicle. The left ovary was healthy and was left behind. In separating the bottom of the sac it was ruptured and a small portion of the fluid having escaped, the pelvis was flushed and drained.

Wednesday, December 13. The position of the ovary makes it possible for a cyst like this one to develop in the pocket behind the broad ligament. Doubtless many of them begin to grow there and enlarge upwards; but when they remain, as this one did, for years, so low in the pelvis, they not only cause great and constant suffering, but their removal is sometimes very difficult. They become anchored by old and vascular adhesions to the bladder, and

perhaps to the ureters, to the uterus and to the rectum, so that it is ticklish and dangerous to separate them. Sometimes they push the vault of the vagina downward so that the tumor may even force the uterus out at the vulva. I have seen and operated upon several very distressing cases of this kind. By examining this sac very carefully you will see how very adherent it was over its whole surface.

If such a cyst, or an old abscess occupies the posterior ligamentous compartment on the left side of the pelvis you will remember that its contents, when they escape or are drawn off, are pretty sure to have a fæcal odor. This does not imply that the sac has necessarily had a fistulous communication with the bowel, or that you have torn the latter open with your manipulations; but it is explained by the fact that the offensive gas may escape by osmosis from the gut into the sac and so impregnate its contents.

Wednesday, December 20. Despite the risk of sepsis from such a denuded pocket as was left in this woman's pelvis, the drain has worked so well that she has reached the tenth day without any symptoms of mischief from that or any other source.

Miscellaneous Items.

The compliments of the season to our friends and readers everywhere.——The *Pulse* beats quick and lively, the current issue being the best of all.——The new College building is a beehive; its chemical and microscopical laboratories are complete; and the library has received donations of 174 books, which formerly were a part of Prof. Hall's library, from his late associate in practice, Dr. A. G. Bailey, and of 185 volumes also from the library of Prof. A. E. Small.——*Apropos* of this item, Prof. Cobb will pay express charges on similar donations to the College library.——Dr. Florence A. Davidson '93, was married November 29, to Dr. Barnes, of Kearney, Neb., and will locate in Old Mexico.——Prof. Dunn is at home again, also Dr. O. L. Smith; and Prof. Arnulphy has a mid-day office hour in the Venetian building, 34 Washington Street. ——The recent death of Drs. W. H. Holcombe, of New Orleans, H. M. Hobart, '76, and W. F. Knoll, of this city, involves a very serious loss to the homœopathic profession of the South and the West.——Dr. E. M. P. Ludlam has returned to Chicago; residence, 699 Washington Boulevard, office Venetian building.——Professors Gilman and Evans are winning golden opinions in the department of materia medica; ditto Prof. Crawford in his medical clinic. ——Our thanks are due Dr. Bojanus, of Russia, for a copy of his *Homœopathic Therapeutics and Operative Surgery*, including the Photographic Atlas accompanying the same.—— The Journal of the British Homœopathic Society, Vol. 1., No. 4, for October, Dr. Richard Hughes, editor, is also very welcome.——The calendar indicates that this is the season when the prudent and earnest physician will see to it that the twelve numbers of THE CLINIQUE for the closing year are bound and put away for ready reference.— *Selah.*

VALEDICTORY FOR 1893. Vol. XIV. of THE CLINIQUE, which closes with this issue, has furnished twenty original lectures, of which eighteen were clinical and two introductory; thirty-five separate papers that were presented and discussed before the Clinical Society during the year; 148 new and selected clinical cases, and ninety pages of hospital notes, besides its clinical reviews, illustrations and correspondence. This with the contents of the previous volumes, aggregates *seven thousand* pages of practical, clinical matter, to the exclusion of chaff and controversy, that have been gleaned and saved to the profession and to our literature by this single publication.

As showing how some of our best physicians appreciate this kind of work, and what it brings, we take leave to insert the following from an old friend and correspondent:

3401 WASHINGTON AVE., ST. LOUIS,

Mr. Editor: NOVEMBER 30, 1893.

I have received the October number of THE CLINIQUE, which I find, as usual, very interesting, because it is entirely made up of original matter. I have been a subscriber of your CLINIQUE for fourteen years, and it is a welcome visitor. The profession owe you a debt which they can hardly repay for the publication of so many practical lectures, and the reports of the many hundred clinics held at the hospital of the Hahnemann Medical College, of Chicago. I know of no medical journal in our school that contains so many interesting cases in gynecological surgery, and I frankly confess that I regard it as a most excellent exponent of practical medicine and surgery. In the publication of the hospital clinics, as also the discussions before your Clinical Society, the great influence of the "Old Hahnemann College" is kept constantly before the profession.

THE CLINIQUE has proved itself to be a dignified publication, free from all polemics, and in its tone has shown a just and conservative ethical course, and ever by its influence has advocated a higher medical education. I am quite sure that it has "come to stay." May it as well as the "Old Hahnemann" live long and still advocate the motto, *qui non proficit deficit.*

As ever, yours sincerely,

T. GRISWOLD COMSTOCK.

With increased facilities, resources and experience, our determination is to deserve such praise in the future, and, so far as possible, to develop a growing taste for practical things on the part of those who are expected to write for, to pay for, and to read and preserve our clinical journal. For a journal that is only fit for the waste basket is not fit to have around.

The form, style, price and date of issue of the CLINIQUE will not be changed for 1894, but its pages will be made even more instructive and interesting than they have ever been.

If those subscribers who are in arrears will kindly forward their dues without delay, it will enable us to multiply our illustrations and develop the interests of the publication very greatly. Surely, "a word to the wise is sufficient."

All business letters should henceforth be addressed to Dr. J. P. Cobb, publisher of THE CLINIQUE, 3156 Indiana avenue, Chicago.

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