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MEDICAL ERA

CH. GATCHELL, M. D.
EDITOR

THIS COPY CONTAINS ARTICLES ON

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ACUTE INTESTINAL OBSTRUCTION;
TUBERCULOSIS;
APPENDICITIS, OPERATIVE TREATMENT;
PROGRESSIVE MUSCULAR ATROPHY.

THE ARTICLES ARE BY

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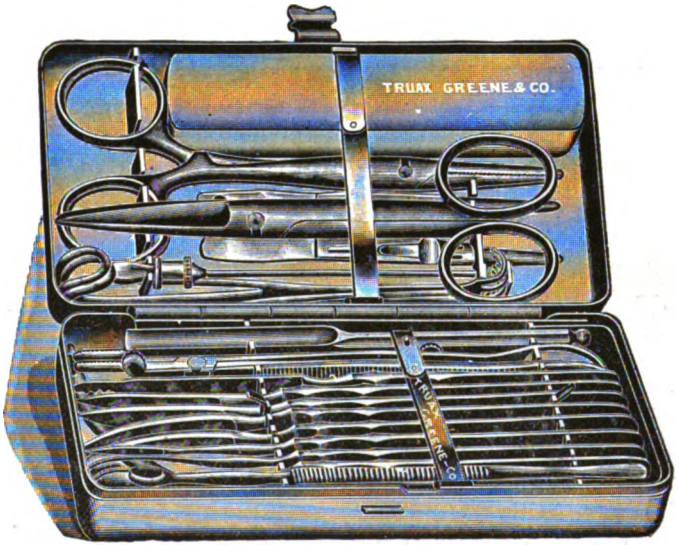

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A

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ON THE

PRACTICE OF MEDICINE

FOR THE USE OF

PRACTITIONERS AND STUDENTS

BY

CH. GATCHELL, M.D.

EDITOR OF THE MEDICAL ERA
PROFESSOR OF DISEASES OF THE CHEST
IN THE CHICAGO HOMŒOPATHIC MEDICAL COLLEGE
ATTENDING PHYSICIAN, COOK COUNTY HOSPITAL, CHICAGO
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The success of Fellows' Syrup of Hypophosphites has tempted certain persons to offer imitations of it for sale. Mr. Fellows, who has examined several samples of these, **finds that no two of them are identical,** and that all of them differ from the original in composition, in freedom from acid reaction, in susceptibility to the effects of oxygen when exposed to light or heat, **in the property of retaining the strychnine in solution,** and in the medicinal effects.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing the Syrup, to write "Syr. Hypophos. **Fellows.**"

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear, can then be examined, and the genuineness —or otherwise—of the contents thereby proved.

Medical Letters may be addressed to

Mr. FELLOWS, 48 Vesey Street, New York.

MEDICAL ERA

CH. GATCHELL, M. D., EDITOR.

VOL. XII. CHICAGO, JULY, 1896. NO. 7

THE MATERIA MEDICA CONFERENCE.

Agitation is a desirable thing. It always precedes reform.

If the Detroit Conference accomplished nothing else, it agitated very thoroughly the subject of the revision of our materia medica.

As a result of the discussion three several things were made apparent:

1. That a revision of our materia medica is desirable, if not demanded;

2. That the members of our school, without exception, are, in their own minds, convinced of the truth of *similia;*

3. That *evidence* of its truth exists in abundance; *proof* is what is wanting.

Too many people in this world mistake evidence for proof.

For a century we have been accumulating *evidence* more than sufficient to convince *ourselves;* what now is demanded is the *proof* that shall convince *others.*

* * *

How shall this work be accomplished?

First, our materia medica must be revised "in accordance with the requirements of modern scientific research," divested of all sentiment.

In order to accomplish this but one thing is wanting—*money!* With money it can be done; without money it is useless to consider its doing.

Ex nihilo, nihil fit. This, being interpreted, means—"Without money nothing can be done."

After the monument is paid for, the profession must set about accumulating a fund to endow an institution devoted to the proving of drugs. This institution should be the property of, as it would be endowed by, the entire homœopathic profession. It should be under the supervision of our representative body, the American Institute. It should be controlled by a board of directors, to be chosen by the Institute. The directors should be such men as DRS. CONRAD WESSELHŒFT, T. F. ALLEN, EUGENE H. PORTER, and there should be added, as corresponding member, DR. RICHARD HUGHES, of England.

The actual workers in this institution should be a corps of young men who should obtain the positions by competitive examination, open to the graduates of all our colleges. They should receive ample salary for their services, and serve for a term of three years, when their places should be taken by others.

The proposed institution should be permanently endowed. In the course of time it would contribute to the world's fund of knowledge material of greater value than comes from any other laboratory in this country or Europe.

If the desired knowledge be not thus obtained, it will not come at all; or, at least, it will be too long delayed, and the deferred hope will make the heart sick.

For the carrying out of the plan here outlined nothing is wanting but *money.**

* There is no sentiment about money.

OPINIONS EXPRESSED.

Hahnemann's memory is worthy of the most magnificent monument that the imagination can conceive or that human skill can devise.—*Dr. Pemberton Dudley.*

Homœopathy is not the only unsettled question in the world.—*Dr. J. S. Mitchell,*

It is absurd to try to settle this question. It is unsettleable. The law is a thing *sui generis.* It was never upset by law, philosophy or religion.—*Dr. T. P. Wilson.*

It is rather late in the day to demand unequivocal demonstration.—*Dr. A. C. Cowperthwaite.*

I do not think we are after an *unequivocal* demonstration.—*Dr. Pemberton Dudley.*

Similia should be proved unequivocally so that others besides homœopaths can understand.—*Dr. Conrad Wesselhœft.*

The united and uniform experience of thousands of physicians, made daily and hourly, I consider as an unequivocal demonstration of the law.—*Dr. W. N. Vandenburg.*

I wish every physician were as thoroughly convinced of the truth of *similia* as I am myself.—*Dr. J. S. Mitchell.*

I find myself unable to get away from the truth of the law of simiars.—*Dr. T. F. Allen.*

Several drugs may be sufficiently similar to bring about a reaction.—*Dr. T. Y. Kinne.*

We have not yet demonstrated the capabilities of the law of similars.—*Dr. C. H. Evans.*

Many times the similimum is in our minds instead of in the patient.—*Dr. H. W. Pierson.*

If the old school in their laboratories prove *similia* without intending it, how much more should we prove it, intending so to do.—*Dr. Conrad Wesselhœft.*

Before we can find the similimum we must seek and find the exciting cause.—*Dr. H. W. Pierson.*

The totality reduces all to the dead level of equal value.—*Dr. E. R. Snader.*

Nothing remains for us but the Hahnemannian totality.—*Dr. T. Y. Kinne.*

The keynote unlocks the way to the totality of the symptoms.—*Dr. W. J. Hawkes.*

The proposition that the totality of the symptoms *must* be our only guide, must be abandoned.—*Dr. E. R. Snader.*

Hahnemann's totality is not a mere examination of the symptoms, but their orderly and systematic arrangement.—*Dr. T. Y. Kinne.*

It seems to me the proposition is axiomatic—prescribe on the totality of the symptoms.—*Dr. A. L. Monroe.*

The "totality" of today must be greater than it was in Hahnemann's day because of the greater sources of knowledge.—*Dr. T. Y. Kinne.*

I do not believe we can properly interpret the value of symptoms without a knowledge of the pathology of the disease.—*Dr. A. L. Monroe.*

If it be so important that our knowledge of pathology be perfect, it is equally as important that our knowledge of drugs be perfect.—*Dr. Pemberton Dudley.*

Foremost as a means of distinguishing between the value of symptoms is a knowledge of pathology.—*Dr. T. Y. Kinne.*

By depending upon symptoms alone, *conditions* may be overlooked.—*Dr. E. R. Snader.*

Because we have not the written record, it is no proof of failure of the law. Clinical verifications are valuable so far as they go, but we require other demonstrations. The ophthalmoscope furnishes this. This instrument shows that drugs specifically affect the circulation of the eye.—*Dr. A. B. Norton.*

A law adapted to clinical use may be judged by a century's experience. —*Dr. Martin Deschere.*

We have no right to continue to make provings under rules laid down a hundred years ago.—*Dr. A. C. Cowperthwaite.*

It is unjust to try to hold ourselves down to the knowledge that was available to Hahnemann a hundred years ago.—*Dr. Pemberton Dudley.*

I believe that every drug should be proved in accordiance with the light that the profession has at the present day.—*Dr. Lamson Allen.*

There is not a discovery in science that does not illuminate and illustrate and confirm the theory of Hahnemann. —*Dr. J. D. Buck.*

Hahnemann was conscientious in his methods, but he was not rigid.—*Dr. Ch. Gatchell.*

Hahnemann has left us a work so vast that not one of his followers has ever equalled it in magnitude.—*Dr. Martin Deschere.*

To our hospitals and laboratories we must look for aid. Private practice will not furnish it.—*Dr. Conrad Wesselhœft.*

I believe in the great value of carefully prepared hospital statistics; I have more faith in them than isolated reports taken from private practice.— *Dr. J. S. Mitchell.*

Physicians should keep a faithful record of what they do, noting everything, both objective and subjective. —*Dr. C. F. Menninger.*

Comparative statistics have demonstrated that we do cure more than the dominant school. I consider that matter definitely settled.—*Dr. E. M. Kellogg.*

You cannot bind men together by wisps of straw. Ten thousand men in this country with *similia* as their guide are working to a common purpose. And in one hundred years how many *facts* have our opponents piled up against us?—*Dr. Pemberton Dudley.*

We are justified in prescribing in accordance with the experience of careful practitioners. — *Dr. J. B. G. Custis.*

Diagnosis alone tells the only kind of treatment that will cure.—*Dr. E. R. Snader.*

The negations of our opponents must be met.—*Dr. Conrad Wesselhœft.*

In the matter of our materia medica, standing still is going backward.— *Dr. T. F. Allen.*

An experimenter in the proving of drugs must, in his methods, be a Pasteur, or a Koch; he should also be independent in means.—*Dr. T. F. Allen.*

The art of experimentation has not been sufficiently cultivated. — *Dr. Conrad Wesselhœft.*

If Hahnemann were living he would be at the head of a great experimental laboratory for the study of pharmacodynamics.—*Dr. T. F. Allen.*

It requires more courage not to dose than it does to give medicine.— *Dr. Conrad Wesselhœft.*

Before you attempt to establish a materia medica, you must formulate a law.—*Dr. Robert Walters.*

To give medicine is a habit three or four thousand years old.—*Dr. Conrad Wesselhœft.*

The curative power of drugs should be demonstrated as truly as the pathogenetic power is.—*Dr. T. F. Allen.*

We have enough to do in the next century to develop the law of similars, without being diverted by every fad of the day.—*Dr. R. N. Foster.*

Our appeal is for a revised materia medica, every one of whose symptoms shall belong to it, and not one that does not belong to it.—*Dr. Pemberton Dudley.*

The human organism is the most difficult and uncertain subject with which to experiment.—*Dr. T. F. Allen.*

THE DOCTOR TALKS.

"Yes," said the Doctor, "I was there. I enjoyed everything connected with the Institute, even the result of the election for v. p. number one. That election came out just as I intended it should. If that office fell to anyone I was determined it should fall either to the one who got it or to me. I went into center field and placed him on short-stop, and he caught the ball. If he had muffed it I would have taken it in, and our side would have been safe. That's all I wanted. The office belonged to an F. P. C. We were both F. P. C.'s, and one of us got it—the other one.

* * *

"But I am not the only person who was at Detroit. There were several others, and I will tell you who they were.

"The man who likes to hear himself talk, was there. He enjoys the sound of his own voice; it is music to his ear and a solace to his soul. He talks early and often, and on all sides of every question. He talks right up to the time limit, and into the next fellow's time without limit. He goes in for a good [long] time, and he gets it. He talks against time, over-time, full-time, and altogether has a high old time.

"He was there.

* * *

"The man who thinks he owns the earth* was there. He thinks that the affairs of Lincoln, Neb., Louisville, Ky., Oshkosh, Wis., Kalamazoo, Mich., and Greater N. Y., are all in his special care. He plants his finger in every pie-plant pie, and tries the temperature. He would be oftener burnt, but for his chronic condition of hypertrophiadermadigitatum, and the elephantiasis of his column of Goll. He tries to regulate the affairs of all parts of the country at once, regardless of the preferences and predilections of the aboriginal inhabitants. He spreads his wings, throws the earth in shadow, and sasses the sun.

"He was there.

* * *

"The man who puts too much sentiment into his remarks on materia medica, was there. He had to be called down and held up by the chairman, as an awful example of what such things may lead to.

"He was there.

* * *

"The man who thinks with his lungs was there. This man does not really think, he only thinks that he thinks, and Dr. R. L. says that to become highly accomplished in this exercise requires a great deal of practice. He expresses himself in words—words—words. But he doesn't put the words together in their proper order. If he would only furnish the long list of words, and hire an able-bodied mechanic to transpose them, so that they might convey less confusion and more sense, he would acquire enduring fame.

"He was there.

* * *

"The man who pronounces it Insti*toot* was there. He was there in large quantities, from the chairman of the Materia Medica Conference to the man who moved final adjournment. The only exception that I noted was in the case of the man from Boston, who, in the midst of his rich Scotch brogue, put the right twist on the penult of the substantive element of the name of our National organization. Good for Boston! The pro*grum* man was there, also. He seemed to take pride in getting it off as often as possible, regardless of consequences. His next effort will be to tell us that one-eighth of an ounce is called a *drum;* hence eight *drums* = one ounce. This rule is *absoloot.* Our friend hails from Chicago —at present.

"He was there.

* But he doesn't, by a large majority. He only owns a hole in the ground, and the hole has neither bottom nor sides.

"The man who 'moves to extend the time,' was there. This man, no matter who is speaking or on what subject, no matter whether a majority of the people present wish to hear him any longer, is the one who invariably rises to his feet—when the chairman calls the time limit—and 'Moves that the doctor's time be extended.' In nine cases out of ten the 'mover' is the only one who cares to hear any more from the long-winded talker; but, for reasons of delicacy, no one is inclined to object, and the dose is repeated, *secundum artem*. This mover is a public nuisance. He assumes too much. But it is impossible to suppress him, and so he continues to disturb the meeting.

"He is always there."

* * *

"But, Doctor," I asked, "is there no remedy for these things?"

"Remedy!" exclaimed the Doctor. "Of course there is a remedy. There is a remedy for everything. Dudley says so. I have a remedy that will reach it. I would place the whole matter in the hands of the presiding officer. He alone should be the one to decide when a speaker's time should be extended. I would arrange it in this manner: I would have a contrivance (it would really be a machine, but I shall call it a *contrivance*) to take the place of the 'man who was there.' This contrivance I would make to resemble, in outward appearance, a man. I would give it arms and legs, a body and a head, and I would dress it up in broadcloth. But internally I would have it a marvel of mechanical construction. It should contain springs, and levers, and cams and rams and jambs; there should be joints in the legs, an electric motor in the chest, springs in the arms, and wheels in the head. This contrivance should occupy a front seat, and a wire would run from the chairman's desk to its spinal column.

"Now, the thing would work just about in this way: When a speaker had consumed his allotted time, if, in the opinion of the presiding officer, a large majority of the members would be more than glad to have his time extended, the p. o. would push a button and my Contrivance would do the rest. It would slowly rise to its feet, open its mouth, and mechanically give utterance to these stereotyped words: 'Mr. Chairman, I move that the speaker be allowed to continue.' That would settle it. The presiding officer would, by this method, command the situation.

"But there is one contingency that I have not provided for. My Contrivance, by strangers, might be mistaken for a real, live doctor, having a heart and lungs and lights and liver and brains. Therefore, in order to prevent the possibility of such error, I would make my Contrivance into a thermometer-doctor, and cover it with degrees. I would call it—

"'Prof. Tertius Contrivance, A. M., M.D., B.A., C.K., Ph.D., Sc.D., Ph.U.L., F.R.S., LL.D., A.B.C., X. Y.Z., *D.F.*'

"With this precaution no one would ever mistake the concern for a man."

All of which is truthfully reported by SELAH.

While Hahnemann discovered a great law he never formulated it.—*Dr. Robert Walters.*

The law does not pretend to say *how* medicines act.—*Dr. T. P. Wilson.*

It should be determined whether it is possible to cure artificial disease by means of drugs.—*Dr. T. F. Allen.*

The true similimum is the goal to be striven for, but rarely reached.—*Dr. T. Y. Kinne.*

It requires but a moment's reflection to convince one that the number of good, all-around physicians is rapidly growing smaller, and that the tendency is toward specialism.—*Dr. Onslow A. Gordon.*

AFTER-THOUGHTS.

Owed to Detroit.

O, Detroit, thy fair fame shall long be enshrined in our memory! We owe thee much, O, Detroit! We owe thee a deep debt of gratitude, and dollars, and shekels, and laurels and roses, without number.

O, Detroit, we shall long remember thy hospitality, thy generosity, and thy liberality. Among other things we shall remember thy Harmonie Hall, thy committee rooms, thy Meissen parlor, thy exhibit hall, thy auditorium, thy *Daily Counselor*, thy badges, thy signs, and thy attendants.

We shall also remember thy boat-ride, thy Rushmere, thy reception, thy Euterpe quartette, thy flowers, thy banners, thy cloak-room and thy malt-nutrine.

We shall remember thy *Free-Press*, thy Cadillac, thy Pingree, thy potatoes, thy Comptroller, thy Grace Hospital, thy trolley-cars, thy scoops, thy 3-cent fares, thy carriages, thy coupés, thy base-ball, thy pavements, thy cleanliness, thy boulevards, thy parks, thy Belle Isle, thy rapid river, thy meandering streets, thy roof-garden, thy cafés, thy tower-lights, thy depots, thy weather, thy climate, thy sunshine and thy showers.

We shall remember thy Miller, thy Lodges, thy Olin, thy Rudy, thy LeSeure, thy MacLachlan, thy Orleman, thy Smith, thy Klein, thy Bailey, thy Sterling, thy Caron, thy Ellis, thy Gue, thy Richards, thy Spranger, thy Knight, thy Wilson, thy Stevens, thy Lawson, thy Mera, thy Morley, thy Sage, and all others* that are within thy gates.

O, Detroit, we are under a thousand obligations to thee for thy generous, thy handsome, thy magnificent hospitality, in our history unsurpassed. We admire thee, Detroit; we trust thee, we like thee, we love thee, we lay flowers at thy feet, O, Détroit, Détroit, *Day-trwa!*

* Save one.

The Place of next Meeting.

The Institute has chosen well. Buffalo is easy of access from all directions. The East, the West, the South and Canada, will all be accommodated. Buffalo has many attractions. It has Niagara; it has the new electric generator that sent a message around the world; it has good water, fine fishing, good hotels, convenient bodegas, a fine climate, beautiful surroundings, and it has F. PARK LEWIS.*

Never before has the Institute come so near choosing at one meeting its next two places of meeting. While choosing Buffalo for '97, it threw an anchor to windward that caught its fluke in Omaha, for '98. This was well done. Omaha will be in line in '98. It will have a trans-Mississippi Fair that will eclipse everything save Chicago's monster. Omaha will be a central point for the vast territory east of the Alleghanies. Omaha has push, and it has pull; it has a fine site, a rapid river, a rich country, a bright past, a brilliant present and an enticing future, and it has W. H. HANCHETT.*

P. S.

It is a most enticing plan being exploited by Dr. B. F. Bailey, of Lincoln, Neb., the holding of the next meeting of the Institute on board a steamship on the Great Lakes. It has much to recommend it.

Meet at Buffalo, and hold the first session on land. There let all the Eastern members meet, and board the boat. Stop at Erie and Cleveland, and pick up all of Ohio. Stop at Detroit, and pick up Michigan. Go around the Peninsula to Chicago; pick up that City, all of Illinois, Missouri, and the entire Southwest. Stop at Milwaukee and pick up Wisconsin. Thence into Lake Superior, and to Duluth. Hold one session on land, pick up the Northwest, and carry the

* M. D.

entire crowd back to Buffalo, holding the last session on land.

Why not? It can be done. It would become the most delightful and the most famous meeting the Institute ever held. The journeyings of the boat would be heralded by the press from day to day, and it would become the best advertised meeting ever known. Frequent access to the land would permit the sending of full reports of proceedings to the press of the country. The local press at each large city would give full reports.

There would be freedom from dust and heat and noise, and an assurance of the attendance of all members at every session, or know the reason why. The plan has much in its favor.

Let's do it.

Present Status of Pediatrics

This valuable little book, issued by Drs. B. F. Bailey and Allison Clokey, deserves special mention. We congratulate the accomplished authors most heartily on their enterprise and care. It is a new departure, and a very welcome one. Here we have a work on the subject given containing recent contributions from the pens of Drs. B. F. Bailey, Howard Roy Chislett, Allison Clokey, Joseph Pettee Cobb, C. D. Crank, Martin Deschere, Mark Edgerton, L. C. Grosvenor, A. P. Hanchett, Wm. E. Leonard, A. M. Linn, Geo. B. Peck, Eugene F. Storke, and C. A. Weirick, all members of the section of Pædology of the American Institute. The profession should thank the bright spirit that suggested this work to our Nebraska and Kentucky friends.

Copies of the book were generously distributed at Detroit, and were eagerly sought for. We think other Institute sections might with profit imitate the very original work of the Chairman and the Secretary of the Section on Pædology of the Detroit meeting.

Mitchell's Appendicitis Paper.

Last month the ERA announced a paper on "The Medical Treatment of Appendicitis," to be published in the present issue. For peculiar reasons we are compelled to disappoint our readers. The residence of the editor of the ERA is but a few steps from that of Dr. J. S. Mitchell, the author of the paper. Whenever a paper is written so near to our own abiding place as this, and we find it out, we are in the habit of claiming it by right of discovery. But this time we counted without our host, for, after having made the announcement of a month ago we were informed that the paper had already been promised to our great and good friend, Dr. Eugene H. Porter, senior editor of that great and good periodical, the *North American Journal of Homœopathy*,* whose pages it will grace, and where every reader of the ERA who knows a good thing when he sees it is advised to look for it, and there and then determine to become a regular reader of the best journal published either in New York or Chicago, to say nothing of the rest of the world.

* Published monthly. Address 1672 B'dw'y, N. Y. Send draft, P. O. note, express order, or money—until after election either silver or gold will be accepted.

The Newly Elected Officers.

For President we elected Dr. J. B. G. Custis, of Washington. There was no other candidate, and, to the satisfaction of all, the office was simply tendered to Dr. Custis as a token of the Institute's confidence and esteem.

C. A. Walton, M. D., F. P. C., of Cincinnati, was made first Vice-President, a position that he well deserves and will worthily fill. He has our best wishes.

Dr. C. C. Miller, of Detroit, the city that entertained us so handsomely, is second vice.

Dr. Eugene H. Porter, of Greater N. Y.—well, the Institute is under greater obligations to him than it can ever discharge.

All the other officers were re-elected, including, of course, our long-time Treasurer, Dr. E. M. Kellogg.

ORIGINAL ARTICLES.

CERTAIN URINARY SEDIMENTS OF INFREQUENT OCCURRENCE.*

BY CLIFFORD MITCHELL, M. D.

PROFESSOR OF RENAL DISEASES IN THE CHICAGO HOMŒOPATHIC MEDICAL COLLEGE.

CHICAGO.

IN this article I shall consider the following† sediments only:

Crystalline calcium phosphate, Calcium carbonate, Crystalline magnesium phosphate, Soaps of lime and magnesia, Indigo.	When found, occurring usually in feebly acid or alkaline urine.
Hippuric acid, Kreatinin, Xanthin.	When found, occurring usually in acid urine.
Fat, Cholesterin, Hematoidin, Melanin.	Not confined to urine of any particular reaction.

CRYSTALLINE CALCIUM PHOSPHATE.

Chemical Constitution: Hydrogen calcium orthophosphate, $CaHPO_4 2H_2O$; (neutral calcium phosphate, neutral phosphate of lime), a combination of phosphoric acid with calcium in which one atom of the hydrogen of the acid still remains; in urinary sediments called *stellate* or *stellar* phosphate.

Synonyms: *German*, neutrales phosphorsaures Calcium phosphat. *French*, phosphate de chaux neutre.

Occurrence: In pale, abundant, feebly-acid, neutral, or alkaline urine. When found, is usually in feebly acid urine verging on alkalinity..

Color and Appearance: Occurs either in the whitish sediment of amorphous phosphates, or together with oxalate of lime in a light colored, flocculent sediment of small bulk.

Solubility:

1. Not dissolved when the sediment is heated.
2. Soluble in acids, even in twenty per cent. acetic acid, especially when shaken with it.
3. Decomposed by ammonia.

Chemical Recognition: If necessary the sediment may be separated by filtration, washed, dissolved in acetic acid, tested for phosphoric acid with uranium nitrate, and for calcium with ammonium oxalate.

Microscopical Appearances: Stellar phosphate occurs essentially as crystalline rods, usually grouped in stellar or rosette form, or in form of lances or wedges, but sometimes lying entirely unarranged. The crystals are colorless, but under the microscope look dark towards the centre of the clusters.

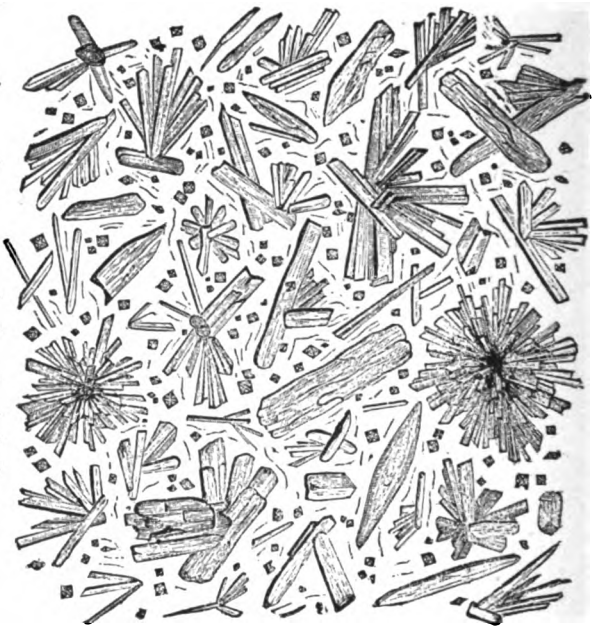


FIG. 1. (*Beale.*)

(Fig. 1.) They can be easily seen with a low power, 150 diameters, but are best studied with higher. From triple phosphate they are distinguished by their form.

Micro-chemical Tests: 1. Easily distinguished from uric acid by solubility without effervescence, when a drop of twenty per cent. acetic acid is placed on the margin of the cover glass. 2. Not dissolved when the sediment is warmed on the slide. (Differentiation from crystalline urates).

Physiology: The appearance of crystalline calcium phosphate depends on an excess of calcium phosphate in a feebly acid urine. According to Bence

* Advance sheets of the writer's book on Urinary Analysis.

† Many more of the rarer ones are considered in the forthcoming book.

Jones this sediment may be produced at pleasure by taking lime-water.

It is said that this sediment may occur in the urine of healthy persons during the summer.

Pathology: Any condition in which an excess of calcium phosphate is found in feebly acid urine.

Clinical Notes:

1. According to some writers the sediment of stellar phosphate is found in cases of serious disorder of the brain.

2. Roberts takes a gloomy view of the sediment; he regards it as an accompaniment of some grave disorder, as cancer of the pylorus, phthisis, and exhaustion from obstinate chronic rheumatism. The crystals are then plenty.

3. My own experience is as follows: Out of 640 urinary sediments recently examined stellar phosphate occurred 9 times, or 1 in 70. The patients were 6 men and 3 women. The cases were (1) chronic prostato-urethritis with impotence and profound mental depression; (2) paresis of the bladder from injury; (3) hyperæmia of the liver; (4) urine following recovery from uræmia; (5) nervous prostration from over-work; (6) renal calculus, removed by Dr. Adams; (7) debility; no other diagnosis; (8) pregnancy; (9) post gonorrhœal cystitis.

But two of these were examined during the summer. The crystals were plenty in all cases.

CALCIUM CARBONATE.

Chemical Composition: Normal or basic calcium carbonate, $CaCO_3$, carbonate of lime, a combination of carbonic acid with calcium, in which the hydrogen of the acid is completely replaced by calcium.

Synonyms: *German*, kohlensaurer Kalk. *French*, carbonate de chaux.

Occurrence: A rare sediment found in alkaline urine.

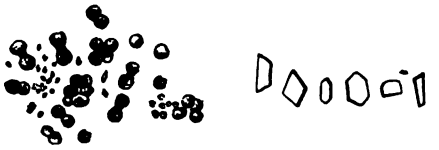
Color and Appearance: Whitish sediment like that of phosphates.

Form: Amorphous and crystalline.

Solubility:

1. Soluble in acids, even 20 per cent acetic acid, with *effervescence* (evolution of carbonic acid gas).

Microscopical Appearances: Should be studied with a high power, 300 to 500 diameters, when it appears as dumb bell shaped masses, and coarsely granular concretions. According to some observers it appears also as minute spherules like the spherules of calcium oxalate. Heitzmann's slide of carbonate of lime shows them somewhat prismatic in form. Fig. 2 gives the different appearances.



a. (*Daiber*). *b.* (*Heitzmann.*)

FIG. 2.

Micro-Chemical tests: Readily distinguished from uric acid and calcium oxalate by solubility with evolution of bubbles, when a drop of 20 per cent acetic acid is placed on the margin of the cover glass (Calcium phosphate dissolves but without bubbles).

Pathology: According to Heitzmann the sediment occurs in cases of bone caries and tuberculosis; also in rickets.

CRYSTALLINE MAGNESIUM PHOSPHATE.

Chemical Constitution: Tribasic, or normal magnesium phosphate, $Mg_3(PO_4)_2.22H_2O$, phosphate of magnesia, a combination of phosphoric acid with magnesium, in which the hydrogen of the acid is completely replaced by magnesium.

Synonyms: *German*, Magnesium phosphat; phosphorsaure Magnesia. *French*, phosphate de magnésie.

Occurrence: A very rare sediment, which occurs in concentrated urine of feebly acid, neutral, or alkaline reaction.

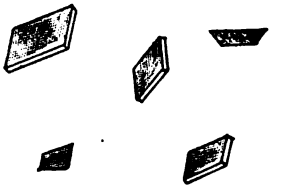
Color and Appearance: Whitish sediment.

Form: Crystalline.

Solubility:

1. Readily soluble in acetic acid and re-precipitated on addition of sodium carbonate solution.
2. In a solution of one part by weight ammonium carbonate in five of water it is in time partly dissolved. (See Micro-chemical Tests).

Microscopical Appearances: Crystallizes in large, highly refracting rather long rhombic tablets or plates. (Fig. 3.) They can be seen with a



a. (*Daiber.*)

FIG. 3. *b.* (*Jaksch.*)

low power, 150 diameters; best studied with 500 diameters.

Micro-chemical Tests: 1. Differentiate from calcium oxalate by ready solubility in acetic acid.

2. From triple phosphate by the action of ammonium carbonate solution which makes them faint and after some minutes eats away the edges. (Triple phosphate not changed by ammonium carbonate.)

SOAPS OF LIME AND MAGNESIA.

Chemical Constitution: Calcium and magnesium salts of the higher fatty acids.

Occurrence: In feebly acid urine.

Microscopical Appearances: Crystals (Fig. 4) closely resembling tyrosin, but not yielding the characteristic reactions of that body.

Pathology: Seen once by Jaksch in

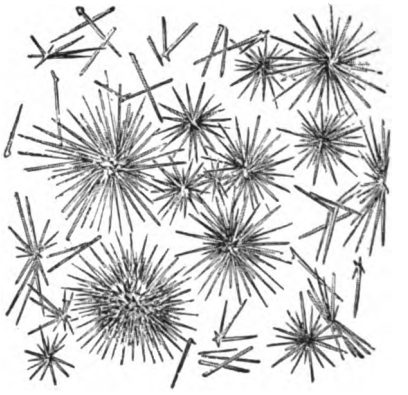


FIG. 4. (*Jaksch.*)

the case of a woman with severe puerperal septicæmia.

INDIGO IN THE SEDIMENT.

Chemical Constitution: Derived from the decomposition of indoxyl sulphate (indican), the indoxyl being oxidized into indigo blue, thus: $2(C_8H_6NOH) + O_2 = C_{16}H_{10}N_2O_2 + 2H_2O$
(Indoxyl.) (Indigo-blue.)

Occurrence: Not rare in decomposing (alkaline) urine which sometimes shows a bluish-red pellicle of microscopic crystals of indigo-blue owing to the decomposition of the indican. Found also at the bottom of the glass.

Microscopical Appearances: Blue rhombic crystals and fine blue needles, (Fig. 5), mostly cohering in clusters; also amorphous in flakes.

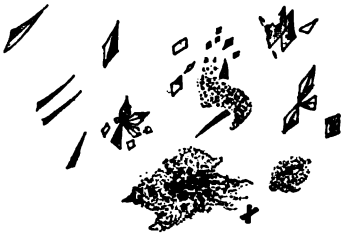


FIG. 5. (*Daiber.*)

Chemical Test: The substance when heated sublinies in violet vapors.

Pathology: Jaksch has found it in remarkable abundance in the ammoniacal fermentation of the urine of jaundice, and also in the *acid* urine of a case of abscess of the liver.

KREATININ IN THE SEDIMENT.*

Microscopical Appearances: According to Heitzmann kreatinin sometimes appears in the sediment of acid urine. The crystals (Fig. 7) are color-

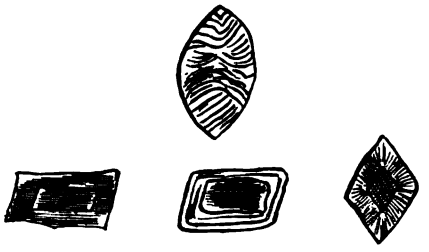


FIG. 7. (*Heitzmann.*)

less or at most light greenish in shape somewhat like those of uric acid, but seen with a power of 500 diameters, have striations both concave and radiating.

Significance: The crystals shown in the figure were found in the urine in a case of uræmia, and are regarded by Heitzmann as an unfavorable sign. Small crystals of it may be found after excessive muscular exertion.

HIPPURIC ACID IN THE SEDIMENT.

Microscopical Appearances: Colorless four-sided prisms (Fig. 6) whose

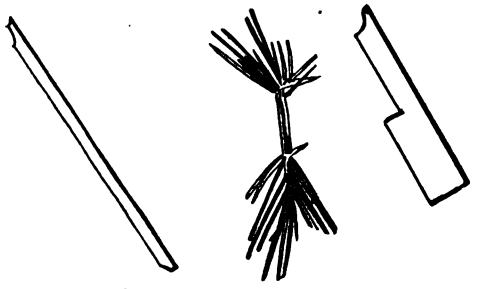


FIG. 6. (*Heitzmann.*)

sides, when seen with a power of 500 diameters, sometimes show indentations. It also occurs in clusters of very fine needles.

Micro-Chemical Tests: Differentiate from uric acid by solubility in alcohol; from triple phosphate by insolubility in acetic acid. The crystals are soluble in ammonia, but insoluble in hydrochloric acid.

Significance: Usually due to ingestion of certain berries as cranberries or bilberries; also to administration of benzoic acid, benzoates, and other drugs. Heitzmann says it is sometimes found in sediment of the urine of diabetes.

XANTHIN IN THE SEDIMENT.

Occurrence: A very rare sediment in acid urine.

Form: Crystalline.

Microscopical Appearances: Lemon-shaped or whetstone-shaped crystals somewhat like uric-acid. (Fig. 8).

FIG. 8. (*Neubauer.*)

Micro-chemical tests:

1. Differentiate from uric acid by solubility in ammonia without formation of ammonium urate crystals, and by solubility in hydrochloric acid.
2. Insoluble in acetic acid.

The chemical characteristics of Xanthin $C_5H_4N_4O_2$ are described under "Normal Constituents of Urine."

Significance: Found by Bence Jones in the sediment of urine in case of a boy who passed a calculus composed of it.

70 STATE STREET.

* The chemical characteristics etc., of these substances are considered under the heading of the same substances in solution.

Era's European Representative.

Dr. R. S. Copeland, who has the chair of O. and O. in the University of Michigan, will be the ERA's European representative this summer. Dr. Copeland sails for Liverpool July 11th. He will attend the International Congress in London, spending his time there, as well as in Edinburgh, Glasgow, Paris and Heidelberg. While abroad Dr. Copeland will give special attention to study of the ear and its diseases. Since the editor of the ERA, being detained by the constant attention that he must give to two books now in press, cannot attend the Congress this year, he is glad to have the ERA represented by Dr. Copeland.

ILLUSTRATIVE CASES OF ACUTE INTESTINAL OBSTRUCTION.*

BY H. R. CHISLETT, M. D.
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CHICAGO.

I HAVE chosen this subject for my paper believing it to be one of the most interesting, as well as most important, to both physician and surgeon. The cases are used, as the title would indicate, simply as a means of illustrating a few of the most common forms of this ailment and the necessity for its early recognition and prompt and energetic treatment.

CASE 1. Acute obstruction from an impacted ileum. Miss S. M., aged 24 years.

HISTORY. During her menstrual period the patient worked very hard, and on the second day the flow ceased. The cessation of the flow was soon followed by severe pains, which began in the hypogastric region, running upward to the stomach. She had a slight bowel movement that day, and, though inclined to constipation, was not aware that she was unusually so. Upon entering the hospital the night after these pains began, a diagnosis of peritonitis was made by the attending physician. The following day she had a sub-normal temperature, a typical peritonitis pulse, was extremely prostrated and continually vomiting a greenish, semi-solid material. The bowels were still obstinately confined in spite of high enemas of saline cathartics and glycerine. There was also entire absence of flatus. The vomiting continued, and on the second day after her admission it became stercoraceous. It was at this stage the patient was transferred to the surgical department and I was asked to see her.

EXAMINATION. A woman of medium size and apparently well nourished. Her face was very anxious in its expression, and rather drawn, from the prolonged suffering. The eyes sunken, the pupils dilated. She was extremely restless, tossing about the bed and vomiting a nasty, septic fluid, almost premonitory of death. The abdomen was very much distended, uniformly so, and tympanitic throughout, save in the right inguinal region where, upon deep percussion, some dullness was elicited.

DIAGNOSIS, acute intestinal obstruction. TREATMENT, operation.

The operation consisted of a median incision three inches in length below the umbilicus. Upon entering the abdominal cavity the dark, distended intestines protruded from the wound. They were almost purple, and had lost most of the normal lustre. The hurried examination revealed an impacted condition of the lower ileum, the bowel being pronouncedly distended at the ileo-cecal valve. The intestine was opened above this impaction and an effort made to evacuate the bowel sufficiently to warrant us in closing the abdomen, after the formation of an artifical anus. The distension, however, was so great and had been of such long duration, that there was no effort on the part of nature to cause the muscular contractions. I therefore opened the intestine at three other places, extending from this lower opening to the duodenum. The abdominal cavity being protected with sterile towels and the loops of the intestine, save at these openings, kept warm by hot sponges, the whole length of the small intestine was flushed with hot sterilized water. After a thorough cleansing of the soiled coils with a sterilized salt solution, the three upper wounds were closed with two rows of continuous sutures of fine silk. The lower one was converted into an artificial anus and sutured at the lower part of the abdominal wound. The abdominal cavity being irrigated with the sterilized salt solution, a drainage was inserted and the patient sent to bed.

RESULT. Although the intestines had resumed a fairly normal color by the time the operation was finished, they

* Indiana Hom. Med. Society.

still appeared completely paralyzed. Neither during the operation nor afterwards did there seem the slightest semblance of a normal vermicular action. The patient did not react at all, even though stimulated to the utmost, death occurring three hours later.

Remarks. It was clearly a case of intestinal obstruction with secondary peritonitis. At no time did the temperature exceed 99 degrees F. At the time of my examination and operation her pulse ranged between 150 and 160, she was covered with cold, clammy perspiration, her temperature, per rectum, being less than 97 degrees F.

Case 2. Acute obstruction from peritonitis. Mr. J. B., German, age, 20 years.

History—Three weeks before admission this patient was seized with a severe pain in the right iliac region, radiating across the abdomen. He vomited for two days, the bowels being obstinately constipated. By the use of active cathartics, however, the bowels moved freely and the trouble seemed relieved. His physician kept him in bed, but allowed a regular diet, and two weeks afterwards he was again taken with the same severe pain. The constipation was obstinate, the patient became very tympanitic, and thinking he had to deal with a case of appendicitis, his physician made an incision in the right inguinal region, but owing to the weakness of the patient and particularly his rapid pulse, the operation was abandoned before the peritoneal cavity had been entered. It was in this condition he was sent to the hospital.

Examination. Temperature, 100 degrees, F.; pulse, 120; tongue dry, yellow and cracked. The lips also were cracked and bleeding and there was a very anxious look on his sallow, drawn face. He fell asleep during the examination and awakened only to vomit. Upon uncovering the abdomen it was found very much distended, tympanitic, and very, *very* sensitive, even to slight pressure. There was a wound in the right semilunar line, extending from the level of the umbilicus downward for three inches. The incision was down to, but not into the peritoneum, and there had been no sutures introduced.

Operation. The peritoneum was opened through the incision already made and, owing to the low condition of the patient, no effort was made to find the cause of the obstruction, but an artificial anus fashioned from the first coil which presented.

Result. The patient reacted fairly well, the pulse kept very rapid and for the next two weeks the patient, though free from pain, kept gradually getting thinner. I then decided, since the patient had had no bowel movement from the natural passage, to make an abdominal incision to relieve the original cause of the obstruction. The patient was prepared in the usual way, the artificial opening having been temporarily sealed with a collodion dressing. Thirty minutes before the time set for the operation, the patient had a desire for a bowel movement, and for the first time in nearly three weeks the bowels moved naturally, just in time to save him from a needless operation. The fistula healed kindly and the patient was discharged cured in six weeks.

Remarks. I think there could not have been a perforative appendicitis, and still the history of the case inclines one to believe that the appendix was the real cause of the peritonitis. However that may be, the obstruction was certainly secondary to the paretic condition incident to the peritoneal inflammation.

Case 3. Acute obstruction from stricture of colon. Mr. P., age, 73 years. American.

History. This man had for years occasional attacks of obstinate constipation attended by great abdominal distension, but for six months prior to his last illness he had seemed unusu-

ally well. One week ago he noticed a feeling of fulness in the abdomen and was unable to get the bowels to move. In spite of cathartics and injections he got worse. After four days, vomiting set in and was persistent for three days, though at no time feculent. During these three days he suffered greatly and was unable to retain any nourishment except a little grape juice.

EXAMINATION. A general tympanites with an area of comparative dullness along the descending colon. This dullness was very marked, the attending physician assures me, before the distension became so great. There was not a great deal of tenderness, the vomiting was less persistent and the pain less intense during the last twelve hours than before. The temperature ranged between 99 2-5 degrees and 100 2-5 degrees F., the pulse being full and round, 85 to 90. The patient seemed in unusually good condition, so it was determined, in the absence of alarming symptoms, and as the methods employed had been largely the giving of enemata, to try large doses of oil. He was accordingly given one-half ounce of castor oil in two ounces of olive oil, to be repeated in four hours if necessary. This dose was given three times without producing the slightest result, although there was no vomiting in the meantime. Eighteen hours later the vomiting returned and the patient began to sink rapidly. The pulse had become rapid and weak, the temperature 101 2-5 degrees F., the vomiting being really in the nature of a continuous regurgitation from the intestines. Although the age of the patient and his exhausted condition made the operation practically hopeless, there was no possibility of recovery without, so we decided upon establishing an artificial opening.

OPERATION. A median incision was made midway between the umbilicus and pubes. A loop of small intestine, greatly distended and very badly congested, presented at the opening. This was carefully sutured to the parietal peritoneum and a longitudinal opening made into the gut. A gush of gas and feces was the result, and after cleansing the parts and applying an adundant dressing, the patient was put to bed, no worse, at least, from the operation.

RESULT. No reaction. Death from gradual exhaustion or intense toxæmia nine hours later.

REMARKS. A post-mortem examination revealed a satisfactory condition of the wound; a pronouncedly distended intestine showing that paralysis had been too complete to be overcome, and an annular carcinoma constricting the descending colon.

CASE 4. Acute obstruction from internal strangulation. Mr. J. B., German, age, 22 years.

HISTORY. Was awakened during sleep two nights before admission with sudden and intense pain in the abdomen. The pain was soon followed by vomiting and gradually increasing distension. When entering the hospital the patient presented a typical picture of intestinal strangulation—a subnormal temperature; a weak, rapid, almost indistinguishable pulse, a facial expression of pain and fear, incessant vomiting of a stercoraceous type, extreme pain and distension and a pronounced restlessness, the patient covered with clammy perspiration, tossing from side to side, moaning.

Accepting the only alternative, we decided to operate. The abdomen was shaved and scrubbed, the intention being to complete the preparation under anæsthesia. A hypodermic of one thirty-second of a grain of Strychnia was administered before beginning the chloroform, as a precaution against death on the table. While preparing my hands, one of the internes called me and said that they could not chloroform the patient, that he became cyanotic and the pulse sinking to nothing upon very slight inhalations. At my request they tried ether, with similar

result. Thinking that they were probably needlessly alarmed, I ordered a hyprodermic of nitroglycerine, one one-hundredth of a grain, and attempted the anæsthesia myself. Before he had inhaled ten drops of chloroform, he turned as blue as any human being could, and I sincerely felt for a few minutes that I had killed him. With fresh air he soon rallied, however, and we put him back to bed rather than to see him die on the table. Death occurred in a few hours, and the post-mortem revealed strangulation from bands of adhesion in the right inguinal region, with perforation and consequent purulent petritonitis. The bands were no doubt the result of an old appendicitis.

Although the reported cases represent four of the most common kinds of acute obstruction, and are for purposes of illustration, yet I do not propose to go into the subject of their differential diagnosis to any great length. Indeed, they are related in order to emphasize their similarity. The fact is, that after a somewhat extensive experience in this line of surgery, I have been forced to the conclusions:

That the clean-cut differences pointed out in the text-books are seldom encountered in actual practice, even by the physician who has the opportunity of examining the patient in the initial stages;

That in the majority of cases in which a surgeon is called to operate the patients have passed the stage where a differential diagnosis is possible, unless with the aid of a *careful* and *personal* observation on the part of the attending physician;

That while in the early hours of the attack such differentiation is of the utmost importance, indicating clearly the line of treatment that should be adopted, in the later stages, where operative measures are the only ones to be considered, it is not so necessary, because prolonged search for the cause is not justifiable, the treatment consisting, in most cases, of a hurried formation of a fecal fistula for the evacuation of the over-distended intestines.

Now, the points I wish to urge most strongly are these:

The early treatment depends upon the *cause*; therefore, its *early recognition* is imperative, being the index whether the case is primarily surgical or medical. Medical treatment plays no part in obstruction which can be recognized as internal strangulation, as stricture, as volvulus, or as secondary to peritonitis. Energetic medical measures must be instituted *at once* in obstruction due to fecal impaction and to invagination. As soon as the physician is satisfied that these medical measures are even of *questionable* value, operation should be advised. This point can be determined in six, or at most, twelve hours, just as well as it can by waiting three or four days. Abdominal pain, with distension and inability to expel flatus, is too often treated as simple colic. It is far better to give an occasional active purge when unnecessary, than to allow even one case in a life-time to drift beyond medical help.

Fecal vomiting is no longer a symptom to be waited for to warrant one in operating. There comes a time in nearly every case of obstruction when pain and vomiting cease. This cessation is too often regarded as a sign of improvement, but is in reality an indication that the intestines have become *tired out*, or even completely paralyzed by the distension. The only cases I have ever saved by operation have been those operated upon while the colicky pains were still present. These pains are the intestines crying for help before they become paralyzed, and if the cry be not answered by the knife, paresis is the next step, and operation will probably be fruitless. I have had four or five cases where operation has been delayed *until paralysis was complete* where I have opened the intestines in several places as described in Case 1, and even

after the flushing with hot water there was not enough elasticity in the gut to collapse. As Treves says, an operation which leaves the intestines still distended, is incomplete. It is no wonder that operations done in the stage of paresis do not afford one success in a hundred cases, and the sooner the physicians and patients learn to appreciate the danger of delay, the sooner will the surgeon be called early enough to be of some real service.

3034 MICHIGAN BOULEVARD.

TUBERCULOSIS—HEREDITY AND INFECTION.*

BY JOSEPH P. COBB M. D.

PROFESSOR OF DISEASES OF CHILDREN IN HAHNEMANN MEDICAL COLLEGE AND HOSPITAL.

CHICAGO.

ENORMOUS strides have been made in medicine and surgery during the last two decades as a result of the practical application of the exact sciences. Clinical observations have been examined in the light of science; new interpretations have been placed upon old records; many theories have been disqualified, and new theories constructed to explain what are now recognized as truths. The microscope, and the patient researches of bacteriologists have not only made modern surgery possible, but they have as well reconstructed the science of hygiene and preventive medicine. No one discovery has been so pregnant with changes in theory, in practice and in results as that which has led to the universally accepted association of the bacillus tuberculosis of Koch and tubercular disease in any of its varied manifestations. Almost all writers and teachers now agree in calling every lesion developed by the bacillus of Koch, tuberculosis. This includes the many manifestations of scrofula, and a host of other lesions including those of bones, joints and visceral organs, which were formerly considered individual forms of disease.

*Homœopathic Medical Society of Chicago.

While the association of this bacillus and tuberculosis is recognized and accepted, their etiological relationship is still at times questioned. The presence of the micro-organism in tubercular lesions is considered by some physicians to be accidental; others would refer it to the domain of a product of the disease rather than an essential etiological factor. It is a noteworthy fact that such observers, as a rule, have no actual practical knowledge of the science, whose teachings they attempt to belittle; neither have they any well considered theory to explain the facts they cannot gainsay. We are bound to hear from the man who has no faith in the "bug or worm theory;" his observations on bacteriological findings are of about the same value as those of the average allopath on the theory of homœopathy: he talks very dogmatically on subjects he knows nothing of.

Within the last few years an attempt has been made to revive the neurotic theory of tuberculosis; the many effects wrought upon the nervous system and the consequent nervous manifestations are tabulated, while the well recognized neurotic effects of toxines are entirely overlooked.

Among those who are ready to accept the bacillus of Koch as the essential etiological factor there is still a wide difference of opinion concerning the influence of heredity; it is to the relative importance of the bacillus and heredity that I wish to call your attention.

Bacteriology teaches that micro-organisms and their toxines have limitations similar to other poisons; these limitations are especially brought out when we deal with their influence upon tissues endowed with various degrees of resistance; one of these limitations is that there is a toxic and a non-toxic dose; that the non-toxic dose for one individual may be a toxic dose for another; that in the same individual a dose may at one time be

non-toxic and at another time toxic. A healthy organism is endowed with defences against invasion by all ordinary routes. For invasion to be possible there must be the entrance of the bacillus, its arrest *in situ* long enough to gain a lodgment, and an impaired tissue to furnish a proper soil or culture medium.

The spread of tuberculosis then depends not only upon the presence of bacilli but also upon the presence of susceptible individuals. The greater number of cases of tuberculosis occur in parts of the country that have been settled for some time, and their ratio of frequency is in proportion to the density of the population. The bacilli are ingredients of the dust in all places where consumptives dwell, and necessarily they are present in greater numbers in densely populated districts. In such places the toxic dose is waiting for the susceptible individual. The susceptible individual is one who has opened an avenue for invasion. The most common avenue of invasion is through the respiratory mucous membrane; a desquamation of the epithelium, particularly the ciliated epithelium of the respiratory tract, makes invasion possible; an excessive mucous secretion, and especially a muco-purulent secretion, offers an excellent *nidus* for lodgment. Any catarrhal inflammation of the respiratory mucous membrane is, then, a predisposing factor. Chronic catarrhal processes offer better opportunities for invasion because they more seriously injure the mucous membrane and because they are accompanied by more tenacious secretions. A tendency to catarrhal inflammations is the almost invariable inheritance of children of tubercular and syphilitic parents.

The third essential factor finds also its expression in this vitiated inheritance; such parents bequeath to their offspring a vitiated tissue resiliency; their natural resistance has been lowered by the disease processes and malnutrition in their parents. Direct inoculation is not a common method of invasion in the human family, but an indirect inoculation exists which is often overlooked. The lymph vessels in those of a tubercular and syphilitic diathesis are unusually active, and recent observations seem to point out the fact that these channels are larger than in other individuals and the rapidity of their currents is correspondingly slower; the structure of the lymph glands in such persons is always physiologically impaired and their ability to act as scavengers for the body is lowered. The lymphatic system drains all of the tissues of the body including the skin and the mucous membranes; dust or any other impalpable substances finding a lodgment upon any surface may enter the system; non-toxic doses are constantly being harmlessly disposed of; but the non-toxic dose may at any time under favoring conditions become toxic and a *nidus* for the disease be established. The forms of tuberculosis called under the old nomenclature, scrofula, are many of them due to this form of invasion in individuals who have inherited a lowered tissue resistance.

The invasion of the bacilli with the ingestion of the food is not a common route in adults, but is undoubtedly the route often used in the case of children. The healthy mucous membrane of the intestine does not offer the same barrier that the ciliated epithelium of the respiratory tract does; on the contrary, it is a readily absorbing surface more like the interior of a gland. Its defense lies in a stomach secreting active acid gastric juice; gastric irregularities, particularly in children where gastric digestion is comparatively imperfect, open the door to the intestinal mucosa and glands. Animal food for adults is mainly sterilized by cooking; cow's milk, an imported food for children, is largely consumed uncooked and not sterile. The tubercular bacillus is a frequent ingredient of cow's

milk and may retain its virulence in cream and butter. Children who have inherited a weakened constitution are frequent sufferers from dyspeptic derangements.

Invasion then, under certain circumstances, is an easy matter, and were it not for the fact that many defences are up to protect us, it would not take long to tuberculize the race. We have seen that vitiated inheritances play an important part in infection both by preparing a favorable soil for development and also by helping to open the avenues for invasion; the tubercular inheritance helps invasion as other forms of vitiated inheritances, and no more; in the preparation of the soil it would seem to have an especial influence of its own.

The actual cases where it has been shown that the disease existed at birth are less than a dozen; if direct inheritance were possible these cases would necessarily multiply; as a matter of fact, tuberculosis is very uncommon during the first six months of life, not frequent during the second six months, but does increase in frequency up to the fourth year of life. The question of food should be considered in connection with this ratio of frequency; infants under six months are nursed, or if artificially fed, the food is usually cooked; micro-organisms are destroyed; after six months of age they are more apt to be fed upon uncooked milk and a greater variety of food is, with succeeding years, introduced into their dietary; they are more apt to suffer from dyspeptic derangements with this varied diet; their excursions, both at home and abroad, bring them into contact with a larger number of bacilli.

The fact that we find a tubercular history in the parents of about fifty per cent. of all cases of tuberculosis does not necessarily imply that this fifty per cent inherited the disease; it does show that such individuals have been more directly exposed to infection than others, and that with the ordinary amount of resistance they would have been more liable to contract the disease.

In direct support of this line of argument are the reports from various health resorts of consumptives, as Thomasville, Ga., Aiken, S. C., Denver, Colo., and others. These places were formerly almost free from tubercular individuals; the belief that the climatic influences, which prevented the spread of the disease, would help those already afflicted, has for years attracted thither many suffering from this disease. Numerous reports show that chambermaids employed in hotels, servants employed in house-cleaning and carpet beating, and persons living near popular resorts and hotels are frequent victims of tuberculosis: to such an extent is this true in some of the older resorts that the value of real estate has been thereby materially affected.

3156 INDIANA AVENUE.

THE OPERATIVE TREATMENT OF APPENDICITIS.

BY CHARLES ADAMS, M D.

PROFESSOR OF THE PRINCIPLES AND PRACTICE OF SURGERY AND CLINICAL SURGERY IN THE CHICAGO HOMŒOPATHIC MEDICAL COLLEGE.

(CONTINUED.)

HAVING stated the conditions for which operation may be required we may now consider the details of the operation itself.

The preparation of the patient will first take our attention. The alimentary canal should be empty, as far as possible, at the time of operation. The stomach should contain no food and the lower bowel be thoroughly cleared by enemata.

For an appendicectomy done in the interval of attacks we may make deliberate preparation as for any intra-abdominal work.

On the day preceding operation the abdominal wall must be shaved, scrubbed thoroughly with green or ethereal soap, washed with ether and alcohol or spirits of turpentine, and covered for

the ensuing twenty-four hours with a compress of gauze saturated with a two and one-half per cent. solution of carbolic acid or a one to two thousand solution of mercuric bichloride; the carbolic, I think, is preferable. The compress is removed after the patient is on the table and the skin washed with ether and alcohol or turpentine again. The field of operation is to be protected by aseptic towels. For the operation of emergency the preparation of the abdominal wall must be made by shaving, scrubbing and turpentine rubbing, what is lacking in time being made up by thoroughness.

The incision to expose the cæcum may be made perpendicularly, at the outer edge of the rectus muscle, or obliquely nearly parallel to Poupart's ligament, terminating at its lower end on the edge of the rectus, *i. e.*, in cases where the operation is made with a view of removing the normally situated appendix. For cases where abscess has formed the incision will be made according to the location of the collection of pus. The length of the incision will vary with the requirements of the case. To deal with extensive and firm adhesions, with a possible collection of pus hidden beneath them, the average operator will need something more than the incision of an inch and a half recommended by Morris. While there is less risk to the patient in free incision than from rupture of abscess walls from lack of room for manipulation, or from undue protraction of the operation with possible damage to the parts concerned, we advocate the smallest incision compatible with safety and celerity in operation. Ordinarily an incision of three inches in length will give ample room for dealing with extensively adherent appendices.

The incision being made through the skin we may follow the method suggested by McBurney in which the next incision passes through the aponeurosis of the external oblique in such a way as merely to split the fibres of the external oblique and not divide any of them across. It is very easy to accomplish this division or separation by making a small puncture and then using the scissors, not as a cutting instrument, but simply as a means of splitting the aponeurosis. The aponeurosis is split for a distance of about four inches, the edges of the wound in the aponeurosis are pulled apart with retractors, so as to uncover the surface of the internal oblique, the fibres of which lie at nearly a right angle with the incision made in the external oblique. Then the direction of the incision is changed from the nearly vertical to nearly transverse and the fibres of the internal oblique and transversalis are separated from one another, but without division of any of the fibres. They are readily separated with a dull instrument and with the fingers so as to expose the transversalis fascia. This fascia, with the peritoneum, is then divided in the line of separation of the fibres of the internal oblique and transversalis muscles. The entrance is not a large one, but is sufficiently large to allow of the removal of the appendix in nearly all cases operated upon in the interval of repose between attacks, and it is for those cases only that this method of operating is specially recommended.

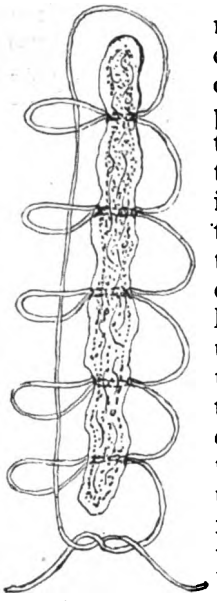
After the removal of the appendix the fascia transversalis and peritoneum are stitched with fine catgut very easily and the fibres of the internal oblique and transversalis muscles fall together in nearly normal position, requiring only a few catgut sutures to make the apposition more perfect, for, owing to the forced separation, the muscular masses show a tendency to fold upward and be loose. The external oblique is stitched from one end of the opening to the other. The skin wound is closed, the subcutaneous space being drained by a small bit of rubber tissue only. The advantages of this operation are: It allows a nearly perfect

restoration of the strength of the abdominal wall, there is less hemorrhage and there is no disturbance of nerve supply to the muscles involved. Its disadvantages are: It requires a large skin wound, there is danger of interfering materially with the vitality of the muscular fibres by much stretching and splitting, and it makes a large exposure of absorbing surface, the last objection of course having no weight if the wound be aseptic. Ordinarily we make section of the abdominal wall down to the peritoneum in the line of the first incision. The difficulty often experienced in recognizing the transversalis fascia or peritoneum may be met by lifting up the cut edge of the deepest muscle and examining its deep surface. If the surface be bare the transversalis fascia has not yet been cut. If the under surface shows a covering of fascia the next membrane will be peritoneum (McBurney).

The peritoneum being incised a suture should be passed through its edges at the upper angle of the wound to save time in picking it up for suturing at the close of the operation. This suture is held in the grasp of a catch-forceps until wanted.

The operator now searches for the appendix. If not readily found and brought into the field of operation the surgeon follows the longitudinal band of the cæcum to its termination in the root of the appendix. The point of origin or any part of the appendix being identified the whole can be enucleated. Should dense adhesions be present masking the parts thoroughly the operator will begin the process of separation at the pelvic wall and thence detach the mass as a whole, when it can in most cases be lifted into the incision and the appendix enucleated (Morris).

In a number of cases it will be found that the tip of the appendix is involved in a mass of omentum thickened by inflammation and occasionally concealing a small abscess or caseous



mass. Where such a condition obtains the operation will be expedited by ligating the omentum around the mass and cutting it away without attempting to enucleate the portion of appendix involved. For the ligation of the omentum in such cases, or the tying of broad thin pedicles in general we have found the ligature here figured very satisfactory. (Fig.) The tissue to be ligated is pierced by a handled needle carrying a gut ligature, the loops are caught and held successively, until the entire breadth of the tissue to be ligated has been traversed at safe intervals. The original free end of the ligature is then threaded through the loops and, after drawing the threads as tight as may be necessary, tied to the other free end at the edge of the tissue opposite to the starting point. This ligature can be applied so as to produce perfectly even compression of the included tissues and, on being tightened, closes any vessel which may have been pierced by the needle. Further, it leaves the ligated stump with a comparatively even edge, avoiding the puckered and lumpy effect produced by the interlocking or double ligature commonly used.

The appendix being clear the next step is the application of a ligature of gut to the meso-appendix, this being so placed as to shut off completely the nutrient artery running in the free margin. Whenever the meso-appendix has been the seat of inflammatory thickening the ligature must include all the tissues up to the appendix itself or troublesome bleeding may take place from the arterial branches running to the appendicular wall. Double liga-

tion may be needed. Whether applied single or double the ligature should be placed as near to the origin of the appendix as practicable.

After protecting the underlying and surrounding parts by sterile gauze the meso-appendix is now cut through, leaving the appendix to be dealt with. Many methods have been suggested and practiced in amputating the appendix; among them are the following:

1. As practiced in the earlier operations, the appendix is ligated en masse at half an inch from the cæcum. This method has been followed by leakage behind the ligature. The appendix is cut off close to ligature.

2. Amputation of the appendix close to cæcum and closure of the open wound by infolding Lembert sutures of fine gut or silk.

3. Ligature of appendix close to cæcum, amputation, disinfection of the mucosa of the stump by curetting, the application of liquid carbolic acid, nitric acid, the cautery or the bichloride tablet.

4. Ligature close to cæcum, amputation, disinfection of stump and subsequent infolding of serous coat of cæcum over the stump by Lembert sutures.

5. Amputation of the appendix at half an inch from the cæcum, cauterization of the mucosa and closure by single or double layer of fine sutures.

6. Amputation of the appendix at half an inch from the cæcum, with separate suture of mucosa and seromuscular coat so as to infold and close.

7. Inversion of entire stump into cæcum after amputation and closure by sutures.

8. Inversion of the entire appendix unopened into cæcum and securing it in place by sutures.

9. The method of Dawbarn, who places a circular Lembert suture around, and one quarter of an inch away from, the base of the appendix the suture ends being left free, then divides the appendix so as to leave half an inch of stump, next with fine forceps stretches the inner coats of the stump, then seizes the free end of the stump and invaginates it, withdraws the forceps and ties the suture, thereby effecting tight closure.

10. In cases where the appendix is too soft and friable to bear ligation, small hemostatic forceps may be applied to remain *in situ* from twenty-four to forty-eight hours, the appendix being cut off close to forceps.

11. The method to be preferred is, after isolation of the appendix to make a circumsection of the serous covering at half an inch from its base. This serous cuff is to be reflected back to the cæcum. The bare musculo-mucous tube is ligated with fine silk as close down to the cæcum as possible, the appendix is then cut away close to the ligature. The exposed mucosa of the stump is then disinfected, the stump depressed by forceps and the serous coat closed over it by Lembert sutures of fine silk or catgut. This method secures occlusion of the appendix without risk of leakage from the cæcum, and also a smooth external surface.

Any raw surfaces left from separation of adhesions should be treated by the application of aristol, as suggested by Morris, with the view of preventing the formation of fresh adhesions, (when we cannot be sure of the perfect asepticity of the parts involved in the operation they should be walled off from the general peritoneal cavity by gauze and aristol, and sutures put in place in the parietes, to be tied after the removal of the gauze on the second day or later as may be deemed proper). If the operation be aseptic the parts exposed should be thoroughly dried and we proceed to close the wound. The peritoneum should be sutured so as to bring rather broad serous surfaces in contact. The muscles and fascia are next brought into accurate apposition by as many layers of sutures as may be necessary, care being taken that no muscular edge is

overlooked on account of retraction after section. The last layer of sutures includes only the skin, and may be applied in the ordinary way or by Kendal Frank's subcuticular method.

The wound may be dressed, after suturing, as suits the operator, the method preferred by the writer being to dust it with aristol and to apply aristol or iodoform collodion. Over the sealed wound is placed a plentiful gauze dressing and binder. The sutures being of catgut will not need removal, and under, ordinary circumstances, the first dressing will need no change for ten or twelve days. The patient should spend fifteen or twenty days in bed and if satisfactory union of the wound take place may go about his business without bandage of any sort six or eight weeks after operation.

I have had no mortality in operating for non-suppurative cases. The foregoing description will apply to operation as practiced in acute cases before the occurrence of suppuration or, as done in the interval for the removal of the previously inflamed appendix.

(TO BE CONTINUED.)

CENTRAL MUSIC HALL.

PROGRESSIVE MUSCULAR ATROPHY.*

Pronounced Incurable by Eminent Neurologists, Examined, Treated and Cured by Homœopathy.

BY T. F. ALLEN, M. D.
NEW YORK.

A YOUNG married woman who is a good *comrade* to her husband, an athlete, has been in the habit of entering into all his out-of-door sports, *golf*, *hunting*, *shooting*, and, especially during the past summer, *swimming* (long distances), complained of pains in her right shoulder which increased until her arm became helpless; the muscles about the shoulder and right side, chest and back wasted, so that the whole region became perceptibly emaciated, the sub-clavicular region especially, sunken; the shoulder drooped, and if the arm were permitted to hang down the head of the humerus would actually slip down out of its socket, often causing extra pain in the axilla and shoulder; it became impossible to put the hand to her head so that she could not put up her own hair, nor could she dress herself. The wasting and powerlessness involved at last the whole shoulder region of the right side of the body, pectoral, scapular, and axillary regions, and the arm, as far as the elbow. Soon the trouble invaded the forearm, and also began to show itself in the right hip and thigh. Eminent specialists were consulted, electricity, galvanism, massage, and many other injurious expedients were recommended and tried with steady decline, and the husband was told that the disease could not be and had never been arrested. Finally, after the recovery of the husband's mother (in the house of an allopathic physician, who was her son-in-law) from pneumonia, complicating chronic interstitial nephritis, the husband of my patient, who had been informed by the attending and consulting allopathic physicians that his mother could not recover, appealed in despair to me to me to try homœopathic treatment for his wife. The symptoms of the case were as follows: 1. Pain in the right shoulder extending from the top down the arm to below the elbow. The pain was a constant dull ache, becoming, on motion, a sharp shooting; this pain was worse at night; in a wind; in the cold; on uncovering; and when lying on the right or painful side. There was a feeling of powerlessness. (She could not raise the arm to her head, nor could she dress herself.)

How is a remedy to be selected? No cases cured are on record, so that clinical data are wanting. No drug has been known to produce such a condition, in its pathology (if there be any satisfactory pathology known), the etiology is obscure; only symptoms can come to the rescue.

* Materia Medica Conference, Detroit.

On *January 4th*, a prescription was made.

January 22d, the record states decided improvement, very little pain, can now lie on the right side with comfort, which, for months, she has been unable to do.

February 15th. Continued gain; the shoulder does not any more slip out of joint as formerly; she is a trifle fleshier now, over the right pectoral and shoulder regions.

February 28th. Can dress herself; (a great gain, naturally noticeable in the household economy); the arm gets tired only after use, but not immediately after; is growing perceptibly stouter.

March 2d. Complains of drawing pain in the front of the right hip and thigh, finds it difficult to go up stairs on account of this pain, which has been getting worse for a week past, the whole right leg feels heavy and weak.

Calcarea Carb. This prescription was effective, at once, as to the lower extremity, but it was followed by aching in the forearms and palms of the hands after any attempt to use the hands or arms with occasional pains about the elbow. *Return to First Remedy.*

March 30th. Great improvement, uses both arms freely now without pain, no pain at night, is able to lie on the right side without any discomfort.

Since that time, there has been no return of the former troubles; an occasional disturbance of digestion, due apparently to inability to exercise as much as she has been accustomed to, has required a corrective, but lately the lady has resumed, cautiously, her active life out of doors, and is rejoicing in her renewed health, and is able to wear her evening dresses with grace and satisfaction.

Symptom—Analysis:

1. Region of the *Shoulder.*
2. Right upper extremity.
3. General weakness.
4. Aggravation from lying on the right side.
5. Aggravation from lying on the painful side.
6. Aggravation at night.
7. Aggravation after becoming cold.
8. Aggravation in the wind.
9. Aggravation from uncovering.

The above points cover essentially the totality of the symptoms. Noting the value of the remedies, on a scale of four (Bœnninghausen method), under each point, (values estimated by the provings, reinforced by clinical experience), we find as follows:

Nux vom., 30; Phosphorus, 30; Silica, 28; Bryonia, 27; Pulsatilla, 26; Mercurius, 25, etc.

These furnish a list for study and comparison. My first impression was to give Nux vom., first, especially in view of the stimulating, allopathic treatment, electricity, galvanism, massage, tonics, etc., but a little study convinced me of the greater similarity of Phosphorus, especially as the mental state of my patient was not at all similar to that of Nux vomica; accordingly I prescribed *phosphorus* in the seventh centess. potency, doses repeated three times a day for three days, after which only an occasional dose was prescribed, except when suspended to administer three doses of Calcarea carb, for the manifestations of the trouble in the right hip and thigh.

In regard to my failure to report, in connection with the above narrative, the results of various tests of sensation motion and the general reactions, I can only say, that such tests in no way affected my selection of the remedy, for none of the provings have noted them, and the diagnosis made by the specialists included all of them and probably many more, which served to establish their diagnosis (and prognosis), but left them wholly in the dark as to the proper treatment. The point here made is that the **totality of the symptoms** and **not the diagnosis,** in this case, at least, sufficed to cure.

THEY SAY

THAT he was there.

THAT -tute does not spell *-toot!*

THAT without money *nihil* fits.

THAT the closer a man is, the harder it is to touch him.

THAT wishes are fathers to the thoughts of the selfish.

THAT the repentance that follows detection is always sincere.

THAT -gram does not spell *grum*, and ham does not spell *hum*.

THAT no error is more common than to mistake *evidence* for *proof*.

THAT politeness goes a long way, but it always gets back on time.

THAT in order to have things come your way you must go after them.

THAT an agnostic is a man who does not believe in doctors until he is sick.

THAT it is a pleasure to shake some people by the hand, and others by the neck.

THAT when an oyster is good it is very, very good, but when it is bad it is horrid.

THAT sentiment is well enough in its place but its place is not in a materia medica conference.

THAT the latest style of novel is of a kind that a daughter cannot permit her mother to read.

THAT it does not matter so much if some people refuse to saw wood, if they will only agree to say nothing.

THAT the trouble with sympathy for another's misfortune is that the misfortune often lasts longer than the sympathy.

THAT they all pronounced it Insti-*toot*.

THAT the pro*grum* man was there also.

THAT the best preventive of snoring is twins.

THAT when a man loses his head he never gives it away.

THAT you can't broaden your views by spreading yourself.

THAT a person who is polished gets some pretty hard rubs.

THAT a rumor doesn't travel very far before it becomes a lie.

THAT necessity knows no law, and neither does extravagance.

THAT we all like to be mistaken for something more than we are.

THAT it is a hard job to be just and to be angry at the same time.

THAT on first acquaintance the devil is always the pink of politeness.

THAT the height of some men's ambition is to pull something down.

THAT in the agricultural race the cabbage generally comes out a head.

THAT those who practice humility are only looking for the under hold.

THAT man's bump of caution ought to have been placed on the front of his head.

THAT it is easy to convince one's self that one's good luck is all well deserved.

THAT a girl with a dimple in her cheek learns how to work it at a remarkably early age.

IMPORTANT ANNOUNCEMENT.

THE ERA PUBLISHING COMPANY, CHICAGO, takes great pleasure in announcing that it will soon favor the profession with a work of exceptional interest—*A Pocket-Book of Urinary Analysis*, by Prof. Clifford Mitchell, A. M., M. D.

DR. CLIFFORD MITCHELL, in his special department, has no superior in America or Europe. His vast experience, embracing a record of three thousand examinations of the twenty-four hours' urine, together with unlimited laboratory and clinical facilities for study, observation and research, has eminently qualified him for his task. His many valuable papers contributed to the pages of the *North American Journal of Homœopathy*, the *Hahnemannian Monthly*, the *Medical Era*, and other journals, have made him widely and favorably known to the profession, while his fifteen years spent as an instructor in class-room and laboratory have served to make his accurate and pains-taking methods familiar to numberless physicians and students.

The ERA PUBLISHING COMPANY, which will have the privilege of issuing this book, wishes to emphasize the fact that DR. MITCHELL'S forthcoming work is one of exceptional interest and value. From what we have already seen of the manuscript and proof-sheets we are in a position to assure the profession that the work, on the subject of which it treats, has no equal in all literature. The amount of original matter that it contains, the subjects considered, the systematic arrangement, the *special features*—never before contained in any book—the convenient tables, the clinical data, the useful hints, the laboratory exercises—so clearly described—the numerous cuts, and, above all, the *absolute reliability* of every recommendation in the entire work, combine to make this book, without exception, the most valuable work on the subject that has ever come from the pen of any author.

By *absolute reliability*, we mean that the author takes *nothing on trust*. DR. MITCHELL has included in the work much that is original, for which he is authority. Aside from this, much of the subject matter entering into a work of this character belongs to the profession's common fund of knowledge. But even this has not been "quoted," or taken on trust; the accuracy of every statement has been tested, and the value of every recommendation has been confirmed by repeated verifications, before being adopted and again offered to the profession through the medium of these pages.

The ERA PUBLISHING COMPANY is doing its part of the work of production in the manner for which it is so well known. It has placed no limit on the number of illustrations that the author may choose to introduce into the pages, but has encouraged him to see that nothing of value is omitted—an injunction wholly needless in the case of one who is so thorough in all that he undertakes.

It will be a pleasure to present to the profession a work so worthy, and of so great value as Mitchell's "*Pocket-Book of Urinary Analysis.*" Our friends of the other school have nothing of the kind that equals it.

ERA PUBLISHING COMPANY.

SEVENTY, STATE STREET,
Chicago, June 1, 1896.

O, How We Love Grover!

At Detroit the Committee on the Hahnemann Monument made a report. Among other matters it reported that the bill appropriating a site for the monument in Washington, and a small sum to build the foundation, had passed the Senate. A report was read, also, stating that the bill had passed the House. All it needed in order to become effective was the President's signature. At the last moment a despatch came stating that

"The President has not signed the bill."

Thus, for want of the President's signature, the bill has failed.

Instead of grabbing a pen to sign that bill, Grover went fishing. Next winter the bill will be re-introduced, and it will become a law, and we shall be under no obligations to Grover Cleveland for our monument. After the ides of March he can go fishing permanently, while we, as we sit and we sing, will thrum our tuneful banjolin, and cry aloud—

O, how I love Grover,
O, how I love Grover,
O, how I love Grover,
With all my heart!

Accepted with Thanks.

We have received the following, written on the reverse side of a postal-card:

CHARLESTON, ILL.
6-12-'96.

Place my name on your subscription list. I think I know a good thing when I see it. The old MEDICAL ERA at the time of its publication was my ideal of a medical journal. I believe the youngster will rival the old.

Resp'ly,
N. STARR.

We have about a bushel of such letters, which have been coming in ever-increasing quantities from April 1st to the present date. Nothing but our extreme modesty—and the fact that we do not want to set a bad example—restrains us from publishing the entire lot. We take this occasion to thank our numberless friends, and to assure them that no effort or expense will be spared to make this the most readable journal published in the great Mississippi Valley.

HEREAFTER when you wish to find Dr. A. K. Crawford, go to the Reliance building. Dr. H. B. Fellows is under the same roof.

Era Publishing Company.

As in the past, so now the Era Publishing Company will spare no expense in getting out the books that it issues. The best that the printer's art can devise will be used in its work. No consideration of dollars and cents will stand in the way. Only the best will satisfy it. It has now in preparation six different books, the most of which will be issued within the year.

Pratt's Class.

DR. PRATT'S ANNUAL CLASS for instruction in Orificial Surgery will be held at the Chicago Homœopathic Medical College during the week beginning Monday, September 7th. For particulars address E. P. Pratt, M. D., 100 State St., Chicago.

At Detroit.

The chairman of the committee on Medical Literature made the following report:

Chicago: MEDICAL ERA; Chas. Gatchell, M. D., Editor.

In April last Dr. Chas. Gatchell resumed the publication of this old and well-known journal.

Children's Diseases.

CAUTION. Don't buy any book on Children's Diseases until you have examined it.

Don't buy until you have examined Tooker's.

Don't buy any but Tooker's.

The New Surgery.

ADAMS AND CHISLETT'S SURGERY. Very good half-tone pictures of the authors of the work on Surgery that is to be published by the ERA PUBLISHING CO., may be found in a little trade circular called "The Book and the Builders."

After a Warm Berth.

As we go to press we learn that there is a rumor in Michigan to the effect that the editor of a semi-monthly journal published in New York and Chicago is aspirant for a position on the faculty of the Homœopathic College of the U. of M. We do not think his chances would bring much in the open market.

IMPORTANT ANNOUNCEMENT.

THE ERA PUBLISHING COMPANY, CHICAGO, is much gratified in announcing that it will have the great privilege of presenting to the profession a complete "*Manual of Surgery*," the work of the joint authorship of PROF. CHAS. ADAMS, M. D., and of PROF. H. R. CHISLETT, M. D.

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