



This is a digital copy of a book that was preserved for generations on library shelves before it was carefully scanned by Google as part of a project to make the world's books discoverable online.

It has survived long enough for the copyright to expire and the book to enter the public domain. A public domain book is one that was never subject to copyright or whose legal copyright term has expired. Whether a book is in the public domain may vary country to country. Public domain books are our gateways to the past, representing a wealth of history, culture and knowledge that's often difficult to discover.

Marks, notations and other marginalia present in the original volume will appear in this file - a reminder of this book's long journey from the publisher to a library and finally to you.

### Usage guidelines

Google is proud to partner with libraries to digitize public domain materials and make them widely accessible. Public domain books belong to the public and we are merely their custodians. Nevertheless, this work is expensive, so in order to keep providing this resource, we have taken steps to prevent abuse by commercial parties, including placing technical restrictions on automated querying.

We also ask that you:

- + *Make non-commercial use of the files* We designed Google Book Search for use by individuals, and we request that you use these files for personal, non-commercial purposes.
- + *Refrain from automated querying* Do not send automated queries of any sort to Google's system: If you are conducting research on machine translation, optical character recognition or other areas where access to a large amount of text is helpful, please contact us. We encourage the use of public domain materials for these purposes and may be able to help.
- + *Maintain attribution* The Google "watermark" you see on each file is essential for informing people about this project and helping them find additional materials through Google Book Search. Please do not remove it.
- + *Keep it legal* Whatever your use, remember that you are responsible for ensuring that what you are doing is legal. Do not assume that just because we believe a book is in the public domain for users in the United States, that the work is also in the public domain for users in other countries. Whether a book is still in copyright varies from country to country, and we can't offer guidance on whether any specific use of any specific book is allowed. Please do not assume that a book's appearance in Google Book Search means it can be used in any manner anywhere in the world. Copyright infringement liability can be quite severe.

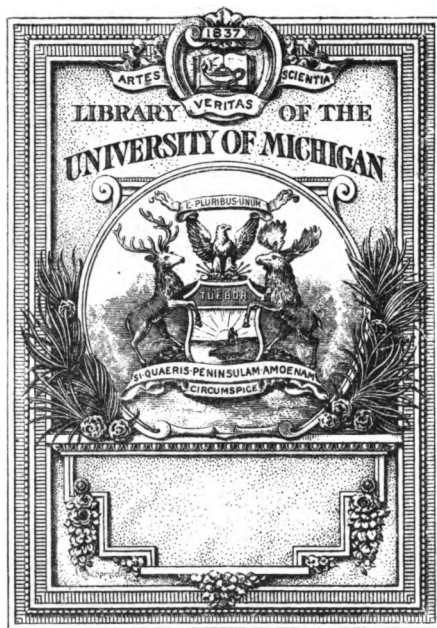
### About Google Book Search

Google's mission is to organize the world's information and to make it universally accessible and useful. Google Book Search helps readers discover the world's books while helping authors and publishers reach new audiences. You can search through the full text of this book on the web at <http://books.google.com/>



# *The Clinique*

Hahnemann Hospital of the City of Chicago, Illinois  
Homeopathic Medical Association, Homeopathic ...



Hemipatus Penobscus

H 610, 5

C 643









# THE CLINIQUE.

5-8699

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

VOLUME VI, 1885.

PUBLISHED BY AUTHORITY OF THE HOSPITAL BOARD.



# INDEX.

**A** BSCESS and fistula, 326.  
 Acne of the uterine cervix, 354.  
 Acromion, fracture of the, 170.  
 Address, President Smalls', 111.  
   by Rev. F. M. Bristol, 115.  
   Valedictory, by Prof. W. J. Hawkes, 116.  
 Alumni, Dr. L. A. Bishop, 187.  
   of Dr. Fellows, President of Clinical Society, 228.  
 Alkaloids used in eye affections, 57.  
 Alumni Association, second annual meeting, 185.  
 American medicinal plants, review of, 206.  
 Amenorrhœa with anæmia, 383.  
 Amputation of fingers, tetanus, 317.  
 Anatomy, review of Holden's, 75.  
   surgical, review of, 107.  
 Anæmia, 278.  
 Ancient subglenoid dislocation of humerus, 314.  
 Aneurism of left subclavian artery, 281.  
 Anus, fistula of, 319.  
 Apis mel. in vaccination erysipelas, 848.  
   in diphtheria, 370.  
 Arndt's Encyclopedia, review of, 204, 349.  
 Asthma, 282.  
   and emphysema, 282.

**B** AILEY PROF. E. S., septic absorption and retained placenta, 351.  
 vicarious leucorrhœa at climacteric, 351.  
 climacteric endometritis, 353.  
 acne of the uterine cervix, 354.  
 on whooping cough, 201.  
 on catching cold, 322.  
 on uterine displacements, 457.

Bennett Dr. A. E., cases from practice, 363, 417.  
 Bishop Dr. L. A., alumni address of, 187.  
 Blackburn Dr. G. E., on boracic acid, 202.  
 Bladder, fibroid in, 253.  
 Boyd Dr. W. A., pelvic cellulitis in girl of 10, 161.  
 Boracic acid in otorrhœa, 202.  
 Bristol Rev. F. M. address of, 115.  
 Bronchitis, post-diphtheritic, 279.  
   chronic, 282, 386.  
 Burt Dr. W. H., zizygium in diabetes, 274.  
 Bureau of skin diseases, 96, 437.  
   clinical medicine, 191.

**C** ANFIELD DR. C. T., on hystero-epilepsy at climacteric, 301.  
 Cancer, colloid of uterus and ovaries, 82.  
 Carcinophobia, case of 247.  
 Cases from practice, 363.  
 Cellulitis puerperal with abscess, 305.  
 Cellulitis pelvic, in girl ten years old, 161.  
 Cerebral tumor, 162.  
 Cervical glands adenoma of, 80.  
 Cheeseman Dr. W. O., endo-cervicitis, etc., 306.  
 Charles Dr. E. W., dislocation and fracture, 303.  
   menstruation at seventy-four, 204.  
 Children's diseases, report of bureau, 333.  
 Chloasma, 72.  
 Climacteric, hystero-epilepsy at, 301.  
   leucorrhœa at, 351.  
   endometritis at, 353.  
   purpura at the, 31.  
 Clinical hygiene bureau of, 260.

- Clinical Society, President's address, 228.  
 report of delegates to American Institute, 231.  
 Cobb Dr. J. P. on poisoning by carbonic acid gas, 272.  
 Cocaine in eye affections, 59.  
 Commencement exercises, 1884-85, 110.  
 Cooke Dr. N. F., autopsy, 73.  
 Cords vocal, paresis of, 237.  
 Crawford Prof. A. K., on physical diagnosis, 278.  
 enlarged thymus, 278.  
 anæmia, 278.  
 post-diphtheritic bronchitis, 279.  
 fatty degeneration of the heart.  
 acute pneumonic phthisis, 280.  
 aneurism of left subclavian artery, 281.  
 chronic bronchitis, 282.  
 asthma, 282.  
 asthma and emphysema, 282.  
 chronic phthisis, 283.  
 themometric record of phthisis under phenic acid, 316.  
 Cysto sarcoma, 77.  
 of uterus and ovaries, 418.  
 of the ovary, 89.
- DAVISON, Dr. W. M.**, apis mel. in diphtheria, 370.  
 Dean's report for 1884-85, 110.  
 Diabetes, zizygium in, 274.  
 Diphtheria, apis mel. in, 370.  
 Dudgeon, Dr. R. E. on the spymograph, 23, 64.  
 Dyspepsia, ovarian, 82.
- EMMET'S** operation, exceptional failure of, 216.  
 Endo-cervicitis, dyspepsia and angina granulosa, 306.  
 submolution, etc., 346.  
 Enuresis, clinical analysis of, 333, 443.  
 Epithelioma of lower lids, 316.  
 Epilepsy, menstrual, 422.  
 Eyelids, pseudo erysipelas of, 418.  
 Eye affections, the alkaloids in, 57.  
 Eye affections, cocaine in, 59.  
 Eye and ear clinic, 207.
- FELLOWS, Prof. H. B.**, on myelitis, 357.  
 on insomnia, 165.
- address to clinical society, 228.  
 Femur, amputation of lower third., 171.  
 Fibroid in the bladder, 253.  
 interstitial uterine, 217.  
 Fistula recto-vaginal, 249.  
 rectal, 308.  
 of anus, 319.  
 Flatfoot, case of, 172.  
 Foreign bodies in larynx, trachea, etc., 13.  
 in trachea and bronchi, 18.  
 in the globe, 409.  
 Forceps, axis traction, 149.
- GASTRALGIA**, 332.  
 Gee, Dr. W. S., on puerperal hemorrhage, 154.  
 Genital phthisis, 419.  
 Gilman, Prof. J. E., on hygiene of the infant, 1.  
 on sanitary condition of Chicago, 260.  
 on rest and exercise, 177.  
 on puerperal cellulitis with abscess, 305.  
 on typhoid fever and its treatment, 390, 425.  
 Glover, Dr. H. G., on chloasma, 72.  
 Graduates for 1884-85, 112.  
 Guaiacum in ovarian dysmenorrhœa, 215.  
 Gurnsey, Prof. H. N., death of, 312.  
 Gynecology, report of bureau of, 291.
- HALL, Prof. G. A.**, on foreign bodies in pharynx, 13.  
 cysto-sarcoma, 77.  
 abscess of prostate, etc., 78.  
 fibrous nasal polypus, 79.  
 hemorrhoids, 79.  
 rectocele, 79.  
 adenoma of the cervical glands, 80.  
 ovariectomy, 80.  
 sarcoma of both mammae, 81.  
 removal of the kidney, 161.  
 luxation of head of the humerus, 168.  
 femoral hernia, 168.  
 harelip, 169.  
 lithotomy, 170.  
 fracture of the acromion, 70.  
 fatty tumor, 171.  
 amputation of the femur, 171.  
 flat foot, 172.

- Hall, Prof., diseases of, the rectum and anus, 286, 321.  
 inflammation of rectum in children, 325.  
 abscesses and fistulæ, 326.  
 yellow atrophy of liver, 364.  
 Harelip, 49, 169.  
 Hawkes, Prof. J. W. gastralgia, 382.  
 snake in the stomach, 388.  
 amenorrhœa, with anæmia, 384.  
 chronic laryngitis, 384.  
 chronic bronchitis, 386.  
 valedictory, 119.  
 rheumatic paralysis, 452.  
 icterus, 452.  
 suppressed ague, 453.  
 intercostal neuralgia, 454.  
 dyspepsia, 454.  
 Hay fever, with treatment for, 244.  
 Heart starvation, 76.  
 Heart diseases, antecedents of, 191, 238.  
 Heart, fatty degeneration of, 279.  
 Heffron, Dr. Helen M., hydatid mole, 197.  
 Hemorrhage retinal, 411.  
 Hemorrhage persistent, sub-conjunctival, 412.  
 Hemorrhoids, 79.  
 Hepatic abscess, 104.  
 Heroism, professional, address on, 115.  
 Holmes, Dr. H. P., intestinal obstruction, 232.  
 Hoyne, Prof. T. S., on skin disease, 96.  
 on ring worm, 96.  
 Hospital notes, 31, 77, 163, 207, 247, 278, 314, 351, 382, 418, 452.  
 Humerus, luxation of head of, 168.  
 with fracture of acromion, 208.  
 Hydatid mole, 197.  
 Hydrocele and phymosis, 318.  
 Hygiene of the infant, 1.  
 Hystero-epilepsy with pseudo-paralysis at climacteric, 301.

**I**NFANT hygiene, 1.  
 Insomnia, 165.  
 Introductory lecture, 1885-86, 372.  
 Intestinal obstruction, 232.  
 Items, 277.

**K**IDNEY, removal of, 161.  
 King, Prof. J. B. S., paresis of vocal cords, 237.

**L**ABOR, instrumental in mother of thirteen years, 199.  
 Lanning, Prof. C. E., clinical analysis of enuresis, 333, 443.  
 on nerve inhibition, 141.  
 Laryngitis, chronic, 384.  
 Leavitt, Prof. S., axis-traction forceps, 149.  
 Lectures, original, 149, 89, 141, 177, 222, 253, 286, 321, 357, 389.  
 Leucorrhœa at climacteric, 351.  
 Linn, Dr. A. M., rectal fistula, 308.  
 Lithotomy, 170.  
 Liver, yellow atrophy of, 364.  
 Localized compression, 368.  
 Ludlam, Prof. R., women's clinic, 31, 82, 172, 215, 247, 351, 386, 418, 457.  
 colloid cancer of uterus and ovaries, 82.  
 ovarian dyspepsia, 82.  
 cysto-sarcoma of the ovary, 89.  
 supporting fibroid of the uterus, 172.  
 menstruation at the seventieth year, 173.  
 pelvic peritonitis with retroflexion, 174.  
 spurious pregnancy, 175.  
 guaiacum in ovarian dysmenorrhœa, 215.  
 on failure of Emmet's operation, 216.  
 interstitial uterine fibroid, 217.  
 the turkish bath in uterine diagnosis, 218.  
 carcinophobia, 247.  
 recto-vag. fistula with laceration of the cervix and the perineum, 249.  
 contra-indications for a uterine pessary, 250.  
 a fibroid in the bladder, 253.  
 urinary affections, and uterine cancer, 291.  
 ovariectomy, tumor forty-eight pounds, 303.  
 ovariectomy double, recovery, 305.  
 introductory lecture, 372.  
 vesical exploration for diseased ovaries and tubes, 386.  
 cysto-sarcoma of uterus and ovaries of 75 pounds, 418.  
 genital phthisis, 419.  
 the electric light in uterine diagnosis, 421.



- tuberculous peritonitis, 420.  
 muriate of cocaine in gynecology, 422.  
 menstrual epilepsy, 422.  
 ovariectomy, recovery, 458.  
 epithelioma of uterine cervix, 458.
- M**AMMÆ, Sarcoma of both, 81.  
 Manhood, the decline of, 244.  
 Matriculates for, 1884-85, 129.  
 Medical clinic, 382, 452.  
 Menstrual epilepsy, 422.  
 Menstruation at seventieth year, 173.  
     at seventy-fourth year, 204.  
 Miessler, Dr. E. G. H., forceps delivery in mother of thirteen years, 199.  
 Miscellaneous items, 86, 85, 109, 176, 220, 252, 284, 320, 356, 388, 424, 436, 460.  
 Muriate of cocaine in gynecology, 422.  
 Myelitis, 357.  
 Myxoma, mucous polypus, 316.
- N**OSE, mucous polypus of, 316.  
 Nichol, Dr. Thos., apis mel. in vaccination erysipelas, 348.
- O**BSTETRICS, report of bureau, 149.  
 Ophthalmology and otology, report of bureau, 57, 389.  
 Operations, from eye dept. of H. hospital, 399.  
 Opening exercises, 1885-86, 371.  
 Original Lectures, 1, 49, 89, 141, 177, 221, 253, 286, 321, 357, 389, 425.  
 Ovaritis traumatic. 33.  
 Ovarian dyspepsia, 82.  
 Ovary, cysto-sarcoma of, 89.  
 Ovariectomy, 80, 303, 307, 458.  
     double, 304.  
     tumor weighing forty-eight pounds, 303.
- P**ARESIS of vocal cords, 237.  
 Pertussis, Ver. vir. in sequelæ of, 201.  
 Peritonitis, tuberculous, 420.  
     pelvic, with retro-flexion, 174.  
 Phenic acid in phthisis, 310.  
 Phthisis, acute pneumonic, 280.  
     chronic, 283.
- Phimosis and hydrocele, 318.  
 Physical diagnosis, clinic, 278.  
 Placenta retained, with septic absorption, 351.  
 Poisoning by carbonic acid gas, 272.  
 Polypus, nasal, 79.  
 Pregnancy, spurious, 175.  
 Prizes, presentation of, 127.  
 Prostate, abscess of the, 78.  
 Pseudo-erysipelas of eyelids, 413.  
 Ptyriasis versicolor, tinæ versicolor, 440.  
 Puerperal, course for, 1884-85, 87.  
     hemorrhage at climacteric, 31.  
     secondary hemorrhage, 154.  
     cellulitis with abscess, 305.
- R**ECEPTION and banquet 128.  
 Rectum, diseases of, 285.  
     inflammation of, 325.  
 Rectal fistula, 308.  
 Rectocele, 79.  
 Recto-vaginal fistula, etc., 249.  
 Rest and exercise, 177.  
 Ringworm, 96.  
 Rowe, Dr. W. C., inversion of the uterus, 159.
- S**ARCOMA of the hand, 369.  
 Shears, Prof. G. F., on foreign bodies in trachea, 18.  
 ancient sub-glenoid dislocation of head of humerus, 314.  
 myxom, mucous polypus of the nose, 316.  
 epithelioma of the lower lip, 316.  
 amputation of fingers, tetanus, 317.  
 hydrocele phimosis, 318.  
 fistula of the anus, 319.  
 chart of tumors, 348.  
 localized compression, 368.  
 lecture on harelip, 49.  
 sarcoma of the hand, 369.  
 Scarlet fever cases, 442.  
 Skin diseases, report of bureau of, 96, 437.  
     contagious, 437.  
 Small, Prof. A. E., President's address, 111.  
     report on clinical medicine, 191.  
     diseases which generate cardiac lesions, 238.  
     the decline of manhood, 244.  
 Spaulding Dr. S. M., cerebral tumor, 162.

Spreng, Dr. T. F. H., endocervicitis, etc, 346.  
 Sphygmograph, clinical uses of, 23, 64.  
 Stevens, Dr. F. A., foreign body in the globe, 409.  
   retinal hemorrhage, 411.  
   persistent recurrent subconjunctival hemorrhage, 412.  
   pseudo-erysipelas of the lids, 413.  
 Students, annual reception, 381.  
 Surgical clinic 77, 168, 314, 364.  
 Surgery report of bureau, 18, 364.

**T**ABULÆ anatomicae osteologie, 349.  
 Tetanus, from amputation of fingers, 317.  
 Thermometric record of phthisis, under phenic acid, 310.  
 Thymus gland, enlarged, 278.  
 Transactions of clinical society, 13, 57, 96, 149, 228, 259, 333, 364, 399, 437.  
 Trichinosis, case of, 99.  
 Tuberculous peritonitis, 420.  
 Tumors, chart of, 348.  
 Tumor, fatty, 171.  
 Turkish bath in uterine diagnosis, 318.  
 Typhoid fever and its treatment, 389, 425.

**U**RINARY and renal disorders, review of, 243.  
 Uterine cavity, casts of, 33.  
   diagnosis, electric light in, 421.  
   cancer and urinary affections, 291.  
   fibroid interstitial, 217.  
   diagnosis, Turkish bath in, 218.  
   displacements, treat. of, 457.  
 Uterus and ovaries, cysto-sarcoma of, 418.  
   inversion of, 159.  
   suppurating fibroid of, 172.

**V**ERATRUM V. in sequelæ of pertussis, 201.  
 Vesical exploration for diseased ovaries and tubes, 386.  
 Vilas, Prof. C. H., operations from eye department of Hahne-mann Hospital, 399.  
   on alkaloids in eye affections, 57.  
   eye and ear clinic, 207, 399.  
 Von Klein, Dr. E. H., anatomical atlas, 349.

**W**AGGONER, DR., trichinosis, 99.  
 Woods, Dr. J. C., on hepatic abscess, 104.  
 Women's Clinic, 31, 82, 172, 215, 247, 351, 386, 418, 457.



# THE CLINIQUE.

---

VOL. VI.]

CHICAGO, JANUARY 15, 1885.

[No. 1.]

---

## Original Lectures.

### *HYGIENE OF THE INFANT.*

A LECTURE DELIVERED BY PROF. J. E. GILMAN, M. D., PROFESSOR  
OF SANITARY SCIENCE IN THE HAHNEMANN MEDICAL COLLEGE  
AND HOSPITAL, OF CHICAGO.\*

Nature makes few abrupt changes in the development of organic life, but in the birth and change that takes place in the organism of the infant not only is this change abrupt but it is an astounding revolution. In adult life you know the heart is a double organ, the right side receiving and responding to the stimulus of the venous or dark blood, and sending that fluid to the lung it returns oxygenated and reddened as arterial blood, and the heart feeling its impulse on the left side sends it over the body on its life-giving errand. These two sides of the heart are kept as distinct and separate from each other as two houses divided by a partition wall; and the advent of venous blood through the septum separating them, would speedily cause death if the quantity so passing through should be considerable enough to have the influence felt by the nerves of the invaded portion. But in the fœtus the circulation is radically different. The mother breathes for the child, and the blood with its supply of oxygen enters through the umbilical blood-vessels, and by a "cut-off artery" prevented from reaching the lungs, it passes directly through the dividing wall of the heart through an opening called the foramen ovale. During the latter stage of pregnancy a valve has been growing that will, when needed, be sufficient to cover up the foramen. The child is born, the cold air, the rough handling it receives, the discomforts of one kind and another that it endures, make it discontented, and it enters its protest against the world in an effort to cry. To make the noise the lungs fill with air; this constitutes them

---

\*Published by request of the College Class.

into suction-pumps that draw the blood up from the heart through the pulmonary artery and return it through the pulmonary vein. The valve closes over the foramen, shutting off the former circulation of the blood, and the sudden increase in the size of the lungs produces a compression of the blood-vessels and organs, depresses the diaphragm and exerts pressure that aids to cut off the umbilical circulation.

The ductus arteriosus Botalli that served as the cut-off from the lungs shrinks so rapidly that in a child a day old it will hardly admit a probe, and the umbilical artery that but the moment before was throbbing forcibly with the full power of the foetal circulation is now plugged with thrombi and pulseless, and the infant has entered into a stage of separate and independent existence. But suppose no effort is made to cry or to breathe? Then we must be ready to work rapidly, for then "is the hour and time of need."—Irritation of the cutaneous nerves will produce reflex action and by reflex action we will succeed. We must then clear the mouth and free the child from any mucus that may have entered the fauces that would interrupt free ingress of the air. This can be done with the finger or a fine soft napkin or linen rag, and removing any folds or turns of the umbilical cord that may have been made about its neck, we use the most common method known of inducing obedience in refractory juveniles—namely, a spanking. The doctor gives generally the first corporeal punishment the youngster receives, and the result is very satisfactory in most instances. But in those cases where the respiratory movements are not made in response, and you can see the blue look of the deoxygenated blood creep over the body you use other methods in addition—you use friction—more forcible slapping, and follow it with the movement described in Marshall Hall's method in asphyxia, in raising the arms above the head so the thorax is expanded, and then bringing them down by the side of the chest, and compressing it between the hands so as to force the air out. You apply stimulant or irritant fluids to the skin—vinegar, brandy, cologne or ether as you may have them handy. Calling for warm water you immerse the infant in the bath and then expose him to the effect of cold air or cold water, repeating this alternate action of heat and cold a number of times. You can continue the movements of the arms, stimulating respiration in the meanwhile. A plug of ice inserted at the rectum will have a great reflex action on the respiratory nerves.

By this time you have found it necessary to cut the cord, which you have done without tying, as the bleeding of the vessels will sometimes aid matters. Insufflation or forcing air into the mouth is recommended, and while very little air would be apt to reach the lungs by your placing your mouth over that of the child and blowing gently, still it may excite action of the epiglottis, and in the emergency you cannot afford to waste anything which may accomplish the result. You may also use injections of brandy or other

stimulant substances. It has also been recommended in these cases to have the mother take long and strong inhalations of air, and this will force a little freshly oxygenated blood to the suffocating tissues. These measures repeated will generally be successful if there is any life in the baby. You may also try electricity, placing the positive pole over the cervical vertebræ, the negative one over the pit of the stomach. If you cannot with this ally induce the respiration, there will be but little hope. But you will continue active measures as long as you can feel or detect the beating of the foetal heart, or you may have the experience detailed by a physician in my hearing, who, after he had done what he supposed was a sufficient amount of resuscitative work with no apparent result, wrapped the infant in a cloth and laid it on the floor of a closet, informing the family of its death, a statement that in a few minutes the terrible youngster contradicted himself with considerable vociferousness. I never like at any other time to hear a child cry, but in the first few moments of its advent into the world, it is sweet music to my ears, and I enjoy it, and if it does not cry long and loud and hard enough, I stand ready to make it do so with great satisfaction at the results. You know the lungs in foetal life were just a mass of unused vesicles, and these vesicles must be fully expanded so the air can reach every one, for if only partly opened the result is a condition technically known as atelectasis pulmonum, and the child with its almost inarticulate cry, its cyanotic hue, its rapid breathing irregular and imperfect, finds relief from all this if the air vesicles receive their due distension *ab initio*.

Respiration established, what do you do? If the circulation through the umbilical cord has ceased, and its pulsation subsided, you will take two strong threads and tie the cord in two places—one for the sake of cleanliness on the mother's side, the other for the protection of the infant—about an inch and a half to two inches away from the umbilical insertion. This must be tied tightly to prevent hæmorrhage. There was, a few years ago, a great discussion on the comparative advantages of ligation and non-ligation, the advocates of the latter method holding out as an argument that the animals severed the umbilical cord and were not troubled with hæmorrhages, and the advantage claimed for the non-ligation was, that the infant would have less trouble with colic. If it was advisable to follow the example of the animals strictly, it would also entail upon the mother, or upon the doctor, the unpleasant duty of gnawing off the cord, so that the lacerated end might receive sufficient contusion to accomplish what is easier done by ligation. Experience proves that the freedom from colic was imaginary, gripes having as free range in the intestine of an infant artistically non-ligated, as in those treated in the old manner; and the danger of hæmorrhage exists in a greater degree from the lack of ligation. Before tying the cord, be sure you do not enclose any tissue from the abdomen—a fold of the intes-

tine, for instance—and so produce a strangulation of the bowel at once. The cord I generally use is made of coarse white thread, using a sufficient number of strands to enable me to pull with great force without breaking it. Then with a pair of shears you cut the cord between the two ligatures, and taking the infant by the hands and feet, swing it into the blanket prepared for that purpose, and, rolling it up, you pass the child to the nurse, leaving you free to give the further and final attentions to the mother.

The next step for the child is the examination for malformations, such as spina bifida, imperforate anus, birth-marks, etc. Look at the hands and fingers and see whether there are the regulation number present. You may find an excess or some deformity you may desire to keep from the mother until after the shock of her parturition is past. Then in a warm room prepare for bathing. The child has existed previously in an equable temperature, varying not more than a degree or two day or night. Now it is launched suddenly into the cold, cold world, and there must be a considerable shock in so remarkable a change as an instantaneous drop from 100° to surroundings with a temperature 25° lower. It has been dependent upon its mother for vital heat, and in that dependence possesses very feeble powers for developing heat for itself, so external warmth must be supplied or the child will receive injury from its lack of warmth. Many children in their first bathing receive such a chill that, blue and benumbed, they regain but slowly the vitality with which they are born. The infant is often thickly coated with an unctuous material, that cannot be readily removed with soap and water alone. The ordinary method is to use lard or oil, and after a little rubbing remove with warm water and castile soap. Some use the uncooked yolk of an egg, and with satisfactory effect. I prefer to have the first bath of the child made with warm oil as much as possible, and use as little of water in the first application as may be found compatible with a fair amount of cleanliness. Use plenty of warm oil—there is no evaporation to chill the stranger—it is the best material to unite with this sebaceous substance for its removal. It is soft, bland and unirritating to the skin, and it serves as a protection from other irritants. So see that the nurse is not sparing in the use of it. If she seems afraid to use it, dip your own hand in it or pour it on, and show her it is to be used as freely as water. The first washing of the infant is necessarily an imperfect one. If the nurse is too particular to remove all dirt she will find an infant excoriated for the next washing. Its skin is not tough enough to bear much rubbing.

After this oil bath, wipe off all that can be dried readily with a soft cloth and dress the navel. This is done best with a little wad of soft, absorbent cotton, but that not being on hand use soft linen as follows: Take a piece of linen somewhat larger than the hand, fold it so there will be two or more thicknesses of it, cut a hole the size of the diameter of the finger in the center. Pass the cord through this opening

and fold the cloth over it so the stump is well covered—then put on the bandage technically called the “belly-band.” Be sure that there are sufficient layers of the linen between the abdominal walls and the cord to prevent any soaking through from the stump to the skin. The object of this dressing is to protect the skin from contact with the decaying umbilical cord which would set up an irritant action. This cord will slough off from the fourth to the sixth day, and occasionally will remain as late as the tenth or twelfth day. A daily examination is advisable after the third or fourth day until it is removed. The use then of a large raisin previously stoned, placed over the umbilical stump, and a soft cloth folded in several thicknesses to produce a slight compression, is advisable. After the dressing of the umbilical wound a bandage should be applied to keep it in place. The child then is ready for its clothing. The clothing should be of fine, soft material without rough edges or coarse, irritant surfaces.

The sensitive skin has known nothing rough in its fashioning. Its previous covering was softer and smoother than a delicate rose leaf, and further the fetus was protected from injury by lubricants so that in no motion would there be any friction, and its tender skin should be shielded by all means in our power from the rough world into which it has made its advent until it has become a little accustomed to its surroundings. Nothing in the clothing should constrict or press the child so as to interfere with its respiration or circulation. The old country idea that an infant must be compressed into as small a compass as bandages would accomplish, or the Indian idea of leaving the eye-lids and lips the only spots unrestricted of motion are bad in theory and practice. Cotton batting is sometimes the best dressing you can use at first. This of course only in those cases of premature birth or very weakly infants, where it would be a risk to undertake even the oil bath.

After the child is dressed and duly admired, it is packed away in warm covering for a nap. Such an experience is fatiguing to the young traveler and he requires rest; in fact, for the next few days sleep claims the most of his hours, and if wakeful there is something going on for you to remedy. You lay the infant on its right side. The object of this is to interpose the law of gravitation, to prevent the venous blood from pressing too forcibly on the newly closed foramen ovale, and while the arterial blood may pass through slightly without effect, all the venous blood must be rigidly excluded. The position, therefore, favors the exclusion of the venous blood from the left side of the heart. Be sure that the covering is warm enough. Children suffer from cold but not from any heat they are likely to get. And after the child and its mother have, in a measure, recovered from the effects of their labors, that is, when the child awakens from its first nap, place it to its mother's breast. This is a simple act, but it sets in train considerable consequences. Its effect on the mother is to aid in the contraction of the uterus to its normal dimensions, which it



does by the reflex action of the nervous tissues, there existing most intimate relation between the mammary glands and the uterus. And while the infant fails to extract very much from the breast it serves to excite a flow of blood and of nervous energy to the mammaræ that will presently develop the secretion of lacteal fluid freely. In addition to this it wakes into active life that mighty and wonderful instinct known as the mother love. The mother may have very little affection for the infant and might mourn but little for its loss until it is placed at her breast, but in drawing its nourishment the child entwines a hold on the mother heart that nothing can ever release. There is something in the act of nursing the infant that stirs into action the most important influence for its well-being, an influence that however hardened and corrupt the unworthy recipient may become, yet he will always soften and be for the time better if he has experienced it. And the mother never loses it while the breath of life remains.

The child placed against the warm, palpitating bosom receives vitality, and basking in the tender affection is soothed and quieted. Often a child crying with nervousness and pain—restless to the last degree—will be stilled and soothed to sleep speedily by this contact. The infant is peculiarly sensitive to impressions, and its nerve fibre seeming to reach out to examine all with whom it comes in contact, and finding its own, absorbs ease and comfort. You put the child then to nurse. This is one of the instinctive movements that nature has made automatic in the infant, and if put to the breast without any previous imprudence in the way of spoon abominations, the child will nurse freely unless it is unable to do so from inability to secure the nipple between the lips and then make the suction. There may be a number of things that interfere with this, and these demand some attention. First, the nipple may not be large enough, or not sufficiently developed for the infant to seize it. Or the child may be tongue-tied, that is, the frenum linguæ is extended so near to the end of the tongue that the movements of that organ are impeded. Or there may have developed a ranula, a cystic tumor with fluid contents on both sides of the frenum. Or there may be a more or less well developed case of hare-lip. In nursing the mouth and lips form a suction pump. When the continuity of the lips is broken the gums may supply its place, but when the hard palate is fissured also, nursing is almost impossible, for while some milk enters the mouth it will quite likely escape through the nose. Holding the child in an upright position in this case would favor retention of the fluid. Only a surgical operation can remove this. If the child is unwilling and not unable to nurse, let the milk trickle down the breast into the mouth of the child applied to the nipple. In its efforts to swallow it presently will nurse and instinct will continue the effort even if the supply is not so great.

After its first nap I told you to put the child to the breast.

Nature does not fill the breast with its full supply of milk until the third day of life, but in its place there is secreted a thin, watery fluid called colostrum. This is the appropriate food for the infant for its first hours. It loosens the bowels slightly, and washes out the thick tar-like stools that are incidental to foetal development. It stimulates gently the action of the kidneys, and it furnishes all that the average infant should have. The liver, the kidneys and all the other organs are taking up their duties, and as new machinery needs running a little before it is set to work—if you expect good work from it—so the infantile organism must start in motion slowly, and not be overcrowded with nutrition too early in its career. Not until the child develops a good, solid appetite should anything foreign, anything not supplied from the mother be given it.

There are some children that are born hungry, and who present such claims to be fed in such an imperative manner that you must comply for the comfort of those in the house and in some instances of the whole neighborhood, also. In such case do as little hurt as you can, and give water sweetened with a little sugar, and if this will not satisfy for any time use two drops of sweet cream—not milk—in the sweetened water, and so pass the time away. You will not need more than this a few times repeated, for any case you will be likely to meet. For the first three days it is not necessary to have any regularity about diet, but afterward the child should be fed regularly every two hours during the day, and at that or a little longer interval at night.

This rule is imperative, for after the absorbent organs are fairly at work there is such a demand for material to build up the tissues, that unless it is supplied with considerable regularity the child becomes weak and exhausted. It may even sleep its life away, and if sleeping soundly when its hour for nursing arrives, it should be aroused to take nourishment. Its soiled napkin also should be promptly removed, for if left long in contact with the tender skin, the cuticle may become quite inflamed and sore, and as it wakes there is more liability to the operation of its natural functions. Discourage as much as in your power lies, any tampering with the nutrition of the child; nature's plans are best, and in all your obstetric practice and care of children, learn first what nature's methods are, and copy them as closely as you can. The nearer you do this the greater success you will have.

In this first developmental period disorders of alimentation cause the largest proportion of deaths, and in this connection I wish to speak of one danger through which the infant must next pass, namely, that of urinary infarction, or a filling up of the urinary tubercles with uric or lithic acid, as the result of the rapid oxidation of the tissues. You will often see this red, sandy deposit on the napkin of the infant, "the washed-out uric acid." When the child, in the first few days of life, cries and screams and writhes as if in

agony, and is relieved after a flow of water, the water, however, being scant in quantity, look for this difficulty. Your remedy for it is to supply a soft water, or a water of diuretic effect, like the Waukesha water, giving it in frequent doses, and apply moist, hot poultices over the region of the kidneys, and your Professor of *Materia Medica* will call your attention to the pathogenesis of *Lycopodium* for a very good similia to this condition.

Where this infarction is considerable in extent it is a serious matter, for, according to Vogel, it is found in two-thirds of all children who die between the second and tenth day of life. You can see in this one strong reason for denying the newly-born child any nourishment, only as nature has pointed out. For with the danger that exists of clogging up the action of important organs from the work that necessarily devolves upon them to do, if we add to this, material that must find its digestion, absorption and exit through these same organs, already overtaxed, the result is rendered more uncertain. Nature supplies in her laboratory food that man so far has failed to imitate successfully, and the mother's milk remains the food, the best possible food, for the infant. The larger the supply of good breast milk, and the more exclusively it is given, the better a child is developed and the better chances of life it possesses. The mother who refuses to nurse the child on account of the confinement it makes for her, takes a fearful responsibility in her hands. She puts the life of her child in great peril and "God's Providences" can be no comfort to her in the face of facts such as I will exhibit to you.

Collecting a large number of statistics from a number of English towns, the facts deduced are as follows: that the cause of the summer diarrhoea so fatal among children may be summed up, and the conclusions drawn from them:

1. You would suppose neglect of infants in large manufacturing towns would be a marked factor, but in Leicester, Nottingham, Oldham, Preston, Rochdale and Halifax women are largely employed in factories, and the neglect of children is pretty much the same; yet the death rate at Oldham, Rochdale and Halifax is very low, while that of Leicester, Preston and Nottingham is exceptionally high. Now this cannot be laid at the door of dirty feeding-bottles, for at Leicester exceptional care seems to have been taken of the feeding-bottles, and these bottles are used the whole year round, so that if this was the cause the disease should prevail at all times, at all places and at all seasons.

Temperature has its effect, yet the acme of the diarrhoea is not always at the acme of the temperature. Often the acme of the disease is reached before the acme of the temperature.

Sewer gas and sewer exhalations.—Facts are opposed to this as a factor of consequence. Summer diarrhoea prevails in towns without sewers. For instance, it prevailed extensively at Winchester in 1876, a town then without sewers. It is well known to exist in

country villages where sewers are unknown. Filth, and especially excremental filth—facts are again opposed to this cause. In Nottingham there is less excremental filth nuisance than in any town in England, yet summer diarrhoea has been very prevalent. There is hardly any town in England less careful about surface pollution than Helston, in Cornwall, yet in Helston summer diarrhoea is not prevalent. Plymouth is filthy, yet summer diarrhoea does not occur there as in other towns. In Leicester, Dr. Ballard states that it occurred in families whose sanitary surroundings were good. All these causes, with sufficient cases to prove the facts as stated.

Now, look at the food question. In Leicester of 341 fatal cases, only two per cent were suckled from the breast alone. The majority of them had some kind of artificial food. In Leicester sixty per cent used cows' milk. As Cardiff has a very low prevalence of diarrhoea, Dr. Ballard asked the health officer how it was that diarrhoea was so slight, and especially among the Irish people. The reply was that the Irish of Cardiff got very little of cows' milk. Cows' milk then, and artificial food, is the cause of so many deaths. Of a large number of patients in the Clinical Hospital for Children, Stevenson Square, Manchester, the records of which institution are very highly commended by Dr. Rauth as very truthful and accurate, the difference is marked in the result. In one table, of 150 children having had breast milk alone to the ninth month or longer, some to the fifteenth, eighteenth or twenty-fourth month, there were stated to be 94 well developed, or 62.6 per cent; 35 medium developed, or 23.3 per cent; and 21 badly developed, or 14 per cent. Now, note the difference with 50 children fed entirely by hand: There were only 5 well developed, or 10 per cent; 13 medium, or 26 per cent; and 32 badly developed, or 64 per cent—nearly the same proportions as in the first case, but reversed. The good condition being almost in strict ratio to the adherence to the mothers' supply of milk. In England in 1872 there were 825,907 births. The number of children that died under one year of age was 123,596, or one death in six births. In London the mortality is somewhat greater. In France rather more than 1.5, or 21.7 per cent of the children die under one year of age; while in Paris about one-half of the 54,000 children born annually die before they reach the age of four years; and if we include the children sent out to nurse, half die before the year is over. Among the classes in circumstances of poverty, the mortality is 75 to 80 per cent. In Munich, Frank reports the percentage of children raised on breast milk at 10.6, 16.1 and 17.6, and those fed by hand 89.4, 83.9 and 82.4. In our own country the records are not very dissimilar in proportionate results. Every day of suitable nutrition improves the infant's chance of living; every hour lessens the mortality. In Baden during twelve years, of infants born alive, 26.13 per cent died in the first year; of these 10.60 in the first, 3.06 in the second month—more than one-half in the first two months of the year.

Manifestly the mother's milk is the salvation of the infant's life. But in those cases where the mother cannot or will not nurse the child, we must rely on a wet-nurse or artificial feeding. There are many cases in which the mother's milk is lacking in the proper nutritive ingredients, due to defective action of the mammary glands, or to lack of vital power on the part of the mother. Also other cases in which the presence of certain hereditary or acquired taints or active poisons in the shape of acute disease renders the mother's nursing undesirable. Where the mother has an especial or unusual development of scrofula, it is questionable if a child should be allowed to nurse. Consumption, insanity, cancer also, and syphilis if acquired subsequently to the birth of the infant, present bars to the mother's nursing her child. An epileptic or rachitic mother should also relegate the child to another nurse. There are exceptional cases in all of these diseases where the reasons for and against will so nearly balance as to often puzzle a physician greatly what course to advise. In acute diseases in which the blood is in a poisoned condition, typhoid fever, small-pox, puerperal fever or kindred diseases, or in case of mammary abscess, the mother must not supply the child with her breast milk, as that fluid is a liquid poison to the infant, though in case of mammary abscess the gland not affected may be used. There are cases in which the milk does not seem to agree with the infant—it is developing badly and does not thrive well—often in these instances medicinal or hygienic attention to the mother will remove the cause. Change of air or change of food, or relief from some nervous irritation or mental strain, may make a speedy improvement in the offspring. Nervous influences have a wonderful effect on the milk secretion; and a fit of anger or chagrin will originate a colic big enough to require an abdomen roomy as the Heidelberg tun for its playground instead of the contracted and tortured intestine of the unfortunate small citizen—not alone colic and indigestion, but more lasting and serious derangements may follow, such as diarrhoea, convulsions or nervous affections of greater or less severity. Should the mother be profoundly shocked with some sudden, terrible affliction, the milk may become a deadly poison to the child, and death be the result if the babe be nursed while under the immediate effects of the emotion. There are numerous cases illustrative of this detailed in the different books, and probably many more cases in which the cause is unnoticed and unrecorded from ignorance of the possibility of its having any bearing upon the subject. In this connection I will speak of the non-medicinal methods of inducing lactation, mechanical operations, such as suction and friction and electricity being the main means used.

The process of suction will, if frequently employed, cause the mammary to secrete lacteal fluid not only in breasts excited by the genitalia to action, but in unmarried and chaste females, even in aged women and quite young girls; nay, more; men by means of suction, gentle and continued friction, pressure, kneading and fomentations,

and other kinds of stimuli applied to the breasts and especially to the nipples, have been enabled to furnish enough milk to nurse infants for months at a time. Dunglison in his physiology gives a number of cases illustrating this. For a number of years I have made my chief reliance, however, for the stimulation of the milk secretion upon electricity, and from the lack of notice it has received in the text books, the method of its application and statement of results obtained may not be uninteresting. Use a Kidder or McIntosh battery, placing the positive pole between the shoulders over the lower cervical vertebrae; the negative pole is passed over the breast, changing from one to the other after a short time. Generally the woman can feel the milk flow into the breast. Take about ten or fifteen minutes to each sitting, and repeat as needed once a day if the case is urgent and once in three or four days to as many weeks if the gland is simply sluggish and needs stimulation. Generally two, or at the most four, applications are all that are needed to furnish a full supply of lacteal fluid. This, of course, if the woman is strong enough to spare the nutrition for the infant. The battery will not make a bloodless, weak woman able to compete with a strong and vigorous one in lactation. All that I claim for this is that it will cause an inactive gland to perform its functions promptly and energetically. Some examples of the use of electricity in this manner may not be uninteresting:

In the year 1872 I attended a lady whose physique was such that no one would suppose that lactation need be defective. Yet her first child had nursed but six weeks when the milk disappeared—the second one only three weeks, the third child somewhat less, and now in this fourth case the milk did not appear at all. Two applications of the battery were made and the milk flowed freely. The battery was used three or four times afterward at irregular intervals, when the milk supply flagged, and the lady nursed her infant for fifteen months and dried up the milk with some difficulty. On a subsequent occasion one application was all that was needed to continue an abundant provision for the whole nursing period. In another instance I attended a lady in confinement some years ago, and making a call on the fourth day found her in tears, crying as though her heart would break because the milk failed to appear, and she feared she would be unable to nurse her child. I assured her it would be all right, as there was no reason why she should not have a sufficient quantity. Circumstances prevented my calling there until the next day, when one application induced a profuse lactation, and after a week or more another one continued ample flow. Another case of an Irish woman who had given birth to seven children and had but two living ones remaining. These two she had nursed, but the breasts failed to secrete milk for the others for more than three or four weeks, and with an ignorance of the proper mode of artificial feeding and lack of care, her children, to her great grief, faded away during the period of dentition. Her milk had disappeared entirely

and she had seen nothing of it for nearly a month, when one of her neighbors, whose milk supply had been increased by this means sent her to me for treatment. In this case I used inunction of the gland with scented castor oil (that is, some odorous essential oil added to the castor oil so as to disguise the unpleasant smell). The breast was well rubbed with this three times daily and the battery applied every other day; within a week there was a fair quantity of milk in the breasts and within two weeks an abundant amount. I met this woman when her child was eighteen months old and she was still nursing it. I told her that the babe was too far advanced for that now and she should wean it. Her reason for not having done so before was this: "Sure I would, sir, but it's Lint, and nursing women kin ate mate in Lint; comin' Easter, I'll wean it."

I could add numerous cases to these if it were necessary, but I have learned to rely very much on the battery, and consider it one of the most satisfactory bits of practice of which I know for this purpose. When the mother is well developed and healthy and no apparent reason why she should not nurse her child, I think you can safely promise by this means a certain resumption of the supply. The observance of the proper hygienic conditions on the part of the nurse will aid very materially in promoting the flow and in improving its quality. Water lilies and roses may draw their beauty in form and color from impure sources, but our human lilies and rosebuds require cleanliness and purity from which to draw their sustenance and to develop into perfect types of humanity. Animals give a marked increase in the quantity and quality of milk when the stables are kept in a cleanly manner and well aired, and the human being is affected to a degree by his surroundings. "Making bricks without straw" was a difficult matter. Had the clay been withheld, too, the task of brick-making had not been accomplished. So if the mother receive an insufficient amount of nutrition the milk supply must be correspondingly deficient. If the food for the mother be watery in character and lacking in solid and nutritious constituents, the milk will be diluted to a point where a child will have to ingest so great a quantity of it to secure enough for its requirements as to keep it working more hours in the day than we are willing to labor ourselves. Food not so rich as to disagree with the mother (and nature gives the woman additional digestive and absorbent powers at this period) food with an ample quantity of nitrogenous material, is best. With this use the leguminous plants and cereals. Soups containing a mixture of the nitrogenous and cereal or starch foods make a compound admirably adapted to increase the quantity and improve the quality of the milk. Fluids, such as oatmeal gruel made with milk, cocoa milk and other nutrient drinks are often very necessary. Stimulants may be used, but only under your direction. Indiscriminate dosing with milk punch, as the product of the *mammæ* may be called after liberal use of alcoholic mixtures, is to be avoided.

## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

The ninety-fifth regular monthly meeting of this society was held on Saturday evening, January 3, at the Grand Pacific Hotel, the chair being occupied by Dr. Corresta T. Canfield, Vice-President. Before a goodly number of the city and suburban physicians and students of the College Class, the report of the evening was made by

### THE BUREAU OF SURGERY.

G. A. HALL, M. D., CHAIRMAN.

FOREIGN BODIES IN THE PHARYNX, LARYNX, AND OTHER AIR PASSAGES. BY DR. G. A. HALL.—I have chosen this subject, first, on account of their frequent occurrence, and second, they are cases coming under the observation of the every-day practitioner as well as the surgeon.

I desire to draw a distinction between the symptoms attending suffocation or asphyxia, occasioned by foreign invasion of the air passages and the symptoms that attend eclampsia, with which they are frequently confounded. I divide the subject into two departments: First, foreign bodies in the pharynx, larynx and trachea; second, bodies of variable size which pass through the upper air passages and become lodged in the larger or smaller bronchi. I shall speak principally of the first division, and my colleague, Dr. Shears, will supplement my report with a paper treating of the second division. Viewing the anatomy of the mouth, throat and air passages, when the human body is in a normal condition and the mental faculties undisturbed, it would seem impossible that any foreign substance could run the gauntlet of so many sentinels, and slip into the air passage. It is probably when the parts have lost their sensibility from partial paralysis or some mental aberration, the attention of the patient for the moment being called in another direction, as, when eating or holding foreign bodies in the mouth, the patient is seized with a violent spell of coughing or laughing, thus taking a sudden inspiration, unmindful of the foreign substance in the mouth, or



when he suffers some sudden injury or convulsion, producing atony of the parts, that foreign substances are precipitated into the larynx. Substances of every conceivable variety, mineral, vegetable, animal and compound may be deposited in the air passages, their place of lodgment depending upon their size, form, consistency and mode of introduction. Burrs, fish-bones and other sharp, irregular substances are more liable to be lodged in the pharynx, near the glottis, producing a violent spasm of the epiglottis, followed by partial or complete asphyxia. Should the foreign body pass down the pharynx to the oesophagus, it will cause more or less spasm of the epiglottis, partially impeding respiration and causing partial dysphasia, but the case is less serious. In either of these locations the patient will be greatly distressed and partially asphyxiated, there being violent spasms of the respiratory muscles, with gasping and clutching at the throat and livid face. He is unable to speak or express his wants except in pantomime. He seldom loses his consciousness, but soon settles down from exhaustion, respiration becoming stridulous, and great distress being depicted upon the countenance. This gives a photograph of the unfortunate victim. When the foreign substance passes through the glottis, and becomes lodged in the larynx or trachea we have a more desperate case to deal with. The patient is unable to breathe; he struggles violently at first, clutches at the throat and gasps; is unable to speak or swallow; the face becomes livid, purple, bloated; froth may issue from the mouth; pulse becomes greatly accelerated, and unless relieved in a few seconds, he falls down in an unconscious condition. This case differs from the ordinary eclampsia in the fact that the spasmodic muscular contractions take place before loss of consciousness, whereas in the latter they always occur after the loss of consciousness. These cases terminate quickly, and usually before the surgeon arrives the patient has either by violent effort expelled the foreign invader, or has succumbed in death.

Surgical treatment may differ according to the age and condition of the patient, the character of the foreign body and its place of lodgment. In children, who are liable to be choked with various articles of food, or by crowding pebbles, buttons and other articles into their mouths, owing to the diminutive aperture of the glottis, these substances are usually found in the upper part of the pharynx. We would recommend inversion of the child. Seize it by the heels

and give it a few violent jerks, passing the finger into the mouth, and cautiously down the throat, over the epiglottis. This will cause a spasmodic condition of the parts below, which will raise the foreign body, and you are enabled to hook it out with the fingers. If it is a fish-bone, pin or other sharp, angular substance, by introducing the finger or a feather down the throat, you cause violent vomiting, the contents of the stomach being poured out with a rush, will carry with it frequently the foreign substance. Should this not succeed, by exposing the face to a strong light, having the head firmly held by an assistant, tickling the fauces and producing gagging, will enable you to see the location of the intruder. Older people who have suffered from chronic inflammation of the throat and pharynx, may become suffocated by the lodgment of a bolus of meat, a dry crust of bread, or other hard substance in the lower part of the pharynx. If all efforts to expel it through the mouth, by coughing, gagging or vomiting, have failed, and efforts to remove it with forceps, blunt-hook, sponge or horse-hair mop, have proved unsuccessful, you may resort to large draughts of water or fill the mouth with bread, and when it has become moistened by the saliva, give the patient a glass of water or milk, letting him take a large swallow, and so pass the bolus down, letting it pass in advance of the fluid.

Foreign bodies may become lodged in the glottis or pass on and become fastened in the ventricles of the larynx, or the rima glottidis. If they succeed in passing the constricted part of the larynx, their will usually be found in the lower part of the trachea or bronchi. When fastened in the glottis or lodged in the larynx or trachea, we have little time to consider what we shall do. If the subject is a child, or person of light weight, suspend him instantly by the heels, and give him one or two sharp jerks. In this posture patting upon the back is admissible, and may dislodge the foreign body. But here let me speak against the pernicious habit of striking on the back when in the erect posture, and already exhausted by vain efforts to dislodge the irritating substance. When the poor sufferer has managed to draw in a little air to support him in his effort, don't knock it out of him. Should the patient be large or too heavy to be suspended, place him on an inclined plane with the head downward. This process is usually successful, if the body is of a metallic nature, or has great solidity. If not, lower tracheotomy should be at once

performed, by such impromptu means and measures as you may have at hand. This will allow the admission of air and support life. You can then open the crico-thyroid membrane, and, with a flexible probe push the substance up, or, if it has become lodged below this aperture, between it and the tracheotomy, you may, by means of the small, long forceps, introduced through the aperture, grasp and remove through this opening. Pins, needles and other small substances, lodged in the larynx, but not producing perfect occlusion of the air passage may, by the aid of the laryngoscope, be removed with the laryngeal forceps. This, however, is not so successful in children or people of an extremely nervous temperament, and we may be obliged to resort to laryngotomy, tracheotomy, or both. A physician might not be provided in such an emergency with all the paraphernalia to attempt a surgical procedure of this kind. He can, with a simple pocket knife open the crico-thyroid membrane for the admission of air, and prolong life until suitable aid is summoned. A small tube should be introduced through the aperture or it should be kept open by means of a bent wire.

*Case 1.*—During a short stop in the little village of Dunkirk, I stepped into a grocery store and made a small purchase. Several children were playing about the floor with beans. Leaving the store, and hurrying toward the depot, I was arrested by a shout from the door of the grocery, "Doctor, doctor, come, quick." On re-entering I found a little one, about three years old, unconscious, gasping for breath and clutching at the throat. Divining the cause of the asphyxia, I caught it by the heels and jerked it quickly up and down. The cause was not removed, and the child had ceased to make an effort to breathe. It had grown limp and lifeless. Seeing the need for immediate action, I laid it upon the counter with its head upon a pile of papers, took a knife from my pocket-case and made an incision into the trachea below the isthmus of the thyroid gland. Looking about for a tube, I saw only a pile of clay pipes. Introducing the stem of one into the orifice of the trachea, I inflated the lungs by blowing into the tube; as the little one showed signs of returning life and made respiratory effort, I introduced my finger into the mouth and plainly felt the bean lodged in the glottis, just beneath the epiglottis. I took a long pair of curved forceps that happened to be with me, passed them along the finger of my left hand, at the same time drawing the base of the tongue forward to raise the epiglottis, seized the bean and extracted it. The child soon regained consciousness.

*Case 2.*—Master C., twelve years of age, while playing about, was suddenly pushed forward by one of his playmates. In endeavor-

oring to regain himself, he threw up his hands, made several ineffectual efforts to breathe, was unable to speak, and violent spasms ensued. His little playfellows, greatly alarmed, rushed into the house for help, but before the mother could reach the yard where the children were playing, her child had become unconscious, prostrate upon the ground, the face livid, and foam issuing from the lips. Supposing him to be in a spasm, she took him up hurriedly and carried him into the house. I was summoned to the case, and arrived about an hour after the accident, finding the child dead. The family were still ignorant of the cause of his death. The history of the case satisfied me that it was not the result of a convulsion. To justify the conclusion I opened the air passage, and found firmly imbedded in the rima glottidis a periwinkle, which he had had in his mouth and swallowed in his effort to recover his position after the push of his comrade.

*Case 3.*—This illustrates forcibly the value of good common sense in the household. Some children were amusing themselves throwing burdock burrs at each other. While in the act of laughing, one of them was unfortunate enough to catch one of the burrs in his mouth, and it passed down into the upper part of the pharynx. A very sensible lady present passed her finger into the child's throat, and removed the burr, affording instant relief.

*Case 4.*—Mr. B. had long suffered from chronic laryngitis. While dining at one of our principal restaurants, a bolus of beef became lodged in the upper part of the pharynx, and he died before any assistance could be rendered. The diseased condition of the parts probably aggravated the spasmodic, and also, by weakening the muscles of the locality, made them less capable of expelling the foreign substance.

*Case 5.*—Is one illustrative of the second division of the subject. Master E., age fourteen years. This lad was assisting his father in shingling barn roof, when he slipped and fell from the scaffolding, striking obliquely upon his hips, spine and head. He was picked up unconscious and carried into the house. I saw him about five hours afterward, and found him suffering from symptoms of slight concussion of the brain. At times he would have severe fits of coughing and vomiting. After his recovery from the immediate effects of the injury, he was invariably attacked by spells of coughing, after running, or any violent effort. He also became subject to periods of illness, during which the lung tissue seemed much involved. The middle and lower lobe of the right lung became hepatized and abscesses formed, accompanied by rapid pulse and respiration; night sweats, high temperature and cough, with expectoration of purulent sputa, were characteristic at these times. About three years after his fall, while bolstered up in bed during one of the attacks, he was seized with an unusually hard coughing fit accompanied by retching

and followed by expectoration. He leaned forward to expectorate, and as he did so, heard a metallic click in the cuspidore. Examination showed a rusty shingle nail, the cause of the long-continued lung disturbance. Upon questioning, I learned that the workmen were in the habit of holding the nails in their mouths while shingling, and the boy probably did the same, swallowing this one at the time of his fall. He recovered his health rapidly, though the right lung still remained crippled.

FOREIGN BODIES IN THE TRACHEA AND BRONCHI. BY G. F. SHEARS, M. D. *Case 1.*—July 16 I was called to see Paulie W., aged twelve years. I found her in bed, with pale face, flushed cheeks, coated tongue, pulse 130, temperature 103°, and a most distressing loose rattling cough. The lower portion of the right lung was dull upon percussion, and the respiratory murmur could not be heard. The following history was given: She had been taken ill some ten days before, after a rather prolonged bath in the little lake near which they were spending the summer. A chill had been followed by fever, and a sharp pain in the upper portion of the right lung and between the shoulders. The pain after remaining in this locality for several days left the upper portion and became seated in the lower. The child received during this time and until I saw her, about one week, the ordinary homœopathic remedies from the family case, but as she did not improve she was brought home for treatment and placed under my charge. I made the diagnosis of pneumonia and prescribed accordingly. The patient remained in nearly the condition I found her for two weeks, the only change being an increasingly disagreeable odor, which was noticeable after every fit of coughing. This odor was very penetrating, a heavy, sweetish smell, unmistakably the odor of gangrene. The breath of the patient was not particularly disagreeable in the interval between the coughing spells, but no sooner did she cough than the room was filled with the sickening odor. I consulted with several of my associates upon this rare and threatening complication, but received little comfort. One day, while examining the sputa, I noticed in one spot where they had dried upon the handkerchief several fine threads or hairs. Looking farther, upon almost every place where the expectoration had dried the little hairs were to be noticed. A portion of the sputa was placed under the microscope, and the little hairs were distinctly seen to be fibers of vegetable origin. The thought flashed upon me that some foreign body must have entered the air passages, and was the cause of the whole difficulty. At my next visit I thoroughly questioned the child, and she then remembered that some two or three days before she was taken ill and while playing with one of her friends, she placed a head of timothy in her mouth. While laughing the head of grass disappeared, she felt a tickling in her throat and began to cough violently. The paroxysm of coughing continued for a few minutes,

when relief was obtained. For half an hour she felt a slight tickling behind the sternum, but as it soon passed away she thought nothing more of it. The sputa was now carefully examined from time to time, and seeds and little hairs similar to those of timothy were found. In about three weeks the odor began to be less noticeable, the temperature was reduced, and the patient gradually recovered. One year later examination disclosed a small dull spot near the nipple, otherwise the patient seemed quite well. So far as I know the stem was never discharged.

*Case 2.*—Frank L. came into my office to be relieved of a coin which he said was in his windpipe. A half hour before, while attempting to emulate some of the tricks which he had witnessed at the circus a day or two previous, he had thrown the coin into the air and caught it in his mouth. During one of the successful catches the coin slipped into the pharynx and then into the trachea. Its entrance was followed by a fit of coughing, but since then it had given him no inconvenience except a sensation of constriction in the right side. The patient was placed over a chair which had been turned over on the floor. While in this position he was lifted up by the heels, his weight resting upon the chest. He exclaimed, "I feel it coming." At that I struck him several times on the back, and told him to cough. Upon the third attempt the coin, a ten cent piece, fell from his mouth.

*Case 3.*—James R., aged forty-nine, had been treated by me for some time on account of a troublesome cough and profuse catarrhal expectoration. On one occasion, after exposure and an increase of the cough, he came to me complaining of a soreness in the right side of the chest and a feeling as if something were moving up and down. On the previous evening he had had a paroxysm of coughing, during which he had distinctly felt something come up into his throat. The irritated feeling had continued during the night, but had gradually subsided. At his request I made an examination of the affected side, but could discover nothing except a slight rattling sound and what seemed to me a slight dullness on percussion. Of this latter, however, I was not sure, for the area was very small. On the following morning he returned with the inquiry: "Do you know what has been the matter with me for five years?" I answered, "Bronchial catarrh," and he replied, "Tooth in my lungs." He then showed me the larger part of the roots and body of a molar tooth, which he had expelled during a severe fit of coughing, the preceding evening. Upon further inquiry, I found that five years previous he had taken chloroform for the removal of some thirteen teeth and roots, intending to wear a plate. After extraction only twelve could be found, but inasmuch as the dentist had thrown them all over the room in his haste, it was concluded one had rolled under the furniture, and no extended search was made for it. Since that time he had been troubled with the cough for which I had treated him, but had always

ascribed it to a severe cold he had taken some time after the removal of the teeth. Although the foreign irritant was removed the cough still remained.

*Case 4.*—Birney, aged four years, while playing, was seized with a severe fit of coughing. As he was playing with a lot of beans at the time it was feared one had gotten into the air passages. His physician was sent for, but on his arrival the urgent symptoms had subsided. Twenty-four hours later he was seized with another violent paroxysm of coughing, respiration became difficult, and was very painful; the features were cyanotic. The physician sent for assistance. Upon my arrival tracheotomy was proposed, but as the child was somewhat relieved, the parents objected. The child was kept under observation several weeks, at the close of which time all irritation had subsided, and all evidence of the presence of a foreign body disappeared. Six weeks later the child took a severe cold, which was followed by an attack of capillary bronchitis. During one of the attacks of coughing a bean was expelled. The child gradually recovered.

The above cases are cited not because they represent all the possibilities of foreign bodies in the air passages, but because besides coming under my observation, they present some of the strange objects that may enter, and the difficulty which may arise in determining accurately the cause of the symptoms present. Accidents of this kind are of great interest, also, because of the gravity of the symptoms which may accompany or follow the introduction of a foreign body, and the doubt which so frequently arises as to the best plan of treatment. Knowing, as we all do, the guards which nature has appointed at the open extremity of these organs, and the decided resistance that is offered whenever an attempt is made at entrance, it seems strange that so large and shaggy a body as a head of timothy or so hard and irregular a one as a molar tooth could ever have passed the portals. A single drop of water will excite a most violent paroxysm of coughing, and yet notwithstanding the most strenuous efforts, bodies of such large size and irregular form have easily effected an entrance. Probably two-thirds of all the foreign bodies which pass through the larynx enter the right bronchus. Of the four cases reported, in three the substance was found in the right bronchus. This is due not only to the larger caliber of the right bronchus, and the greater power of aspiration on the right side, but also probably to the fact that the rostrum which exists at the division of the bronchi, is a little to the left of the median line, and a body falling in the trachea would naturally be directed to the right side.

Having once entered, the foreign substance becomes an unknown quantity for evil. Even if subsidence of the initial paroxysm is

complete, there is no surety that the object may not within a few minutes be hurled against the glottis, and all the possibilities of expulsion or asphyxia take place. If it remains there, the possibilities are increased manifold. Bronchitis or tracheitis presenting symptoms similar to the third case reported, are the most common results. When the bronchitis commences shortly after the introduction of the foreign substance, it is usually localized. If the foreign body remains, the disease often spreads until one or both lungs are involved. Although the trouble is usually mild, it may be severe enough to cause death, and even if the foreign body is expelled, the disease in a chronic form may remain.

Pneumonia is a much more rare complication, and a much more generally fatal one. In most cases it occurs in the chronic, although it may take, as in the first case reported, the acute form. The more rapid cases take on a form of gangrenous pneumonia, accompanied by an exceedingly nauseating odor. They usually run a rapid course, terminating in from one to five days. A case reported by Dr. Blondin, the patient having taken a piece of meat into the bronchi, terminated within twenty-four hours, the entire one-half of the right lung being hepatized, and the bronchi containing a greyish white mass. In another case, from the same authority, death took place in five days from the entrance of a small piece of wood into the left bronchus. This was followed by pneumonia, gangrene and purulent pleurisy. Sometimes the irritation and inflammation are sufficient to produce abscesses which destroy lung tissue, and which may open into the bronchi, pleura, or even the abdominal cavity. A case of this character is reported in the *Lancet*, in which a young farmer swallowed a head of wheat, which entered the left bronchus. On the following day fever began, and continued for twenty-four days, when a swelling was noticed about the tenth rib. This was opened, and a large amount of pus escaped. No doubt about the connection of the abscess with the lung could have been held, for the air entered and passed freely from the opening. The wheat was expectorated in small quantities, and the patient gradually recovered.

In patients predisposed to phthisis, the presence of a foreign body may be sufficient to excite the disease. This has been sufficiently shown by the production of the disease in other portions than the apices of the lungs, the usual place in idiopathic phthisis. It is impossible that real phthisis is produced in a subject not predisposed; but a chronic pneumonia resembling very much phthisis, is frequently the result of this long-continued irritation. The trouble usually develops slowly, taking first the form of a bronchitis, which becomes chronic. The expectorations become purulent; dullness on percussion is noticed; night sweats make their appearance; the patient emaciates; hæmoptysis takes place, and the patient may die with all the symptoms of phthisis. These cases differ from ordinary phthisis in that the lesion is found in the right more frequently than in the left, in the lobe rather than in the apices, and are not accom-



panied by tubercles. Another still more fortunate difference is, that the patients oftentimes recover upon the expulsion of the foreign body, even when to all appearance at death's door. The continued ulceration at almost the last moment frees the foreign body, and it is borne out by the rush of blood.

The cases reported illustrate also another point—the difficulty of diagnosis. Besides bronchitis and pneumonia, in such cases as those reported, in which the patient has forgotten the cause, other affections, as spasms, oedema of the glottis, croup, and stridulous laryngitis may simulate very closely the symptoms produced by the entrance of something from without. Even if a foreign body has disappeared from the mouth and irritation is felt in the chest, it is not always an indication that it has entered the trachea. In a case of this kind reported in the *London Record*, tracheotomy was performed under the supposition that the body was in the trachea. In determining the question the patient or friends can often give the most useful information. The patient was handling some article, which, when placed in the mouth, disappeared. At the same time the patient was seized with a violent paroxysm of coughing. If an adult, he complains of pain or distressed feeling at some point, as the neck or back or side of the chest. Sometimes the patient may be conscious of a movement of the body up and down in the trachea. Upon application of the ear to the chest a change in the vesicular murmur may be noticed, a rattling or stridulous expiration. Upon these a diagnosis may be made of the presence of a foreign body, but still further evidence is necessary to determine the location. Large bodies, and especially large and compressible bodies, as partially masticated meat, bread or potatoes are usually arrested in the larynx. The asphyxia in such cases is rapid, and does not follow paroxysms of coughing, as when the foreign body is loose in the trachea, and is thrown against the larynx by fits of coughing. Pain in the larynx is a valuable symptom, but it cannot be relied upon to the exclusion of others, for pain often remains after the body has been expelled or dropped down into the trachea. Changes in the voice, as aphonia or hoarseness and a valvular sound, are more diagnostic. Foreign bodies in the trachea, if fixed, are very difficult of diagnosis; if movable, their presence is indicated by frequent repetition of the initial paroxysm, with cough, asphyxia and cyanosed face. In most cases also there may be heard upon auscultation a rattling or flapping sound. Foreign bodies in the smaller bronchi can only be absolutely diagnosed when a bronchial tube is completely occluded. In such cases, besides the clinical history of the case, there is severe dyspnoea and persistent oppression. Unless the body is large there is no change upon percussion, but upon auscultation the vesicular murmur is absent in the portion of lung occluded, which is most frequently the median. If the foreign body has remained some time in the lung and the patient or friends have forgotten or doubted its entrance, an error in diagnosis can hardly be helped.

Pneumonia, bronchitis or phthisis are usually pronounced, these diseases so frequently supervening.

Since writing the above, two cases of head of timothy in the lungs have been reported in the *Medical Record*. In one by Dr. H. C. Coe, the patient, a young man, was supposed to be suffering from phthisis. One year later he coughed up the foreign substance, and then rapidly recovered. In the other, reported by Dr. Leaming, the patient died from destruction of the lung, although the offending substance was expectorated.

**THE CLINICAL USES OF THE SPHYGMOGRAPH.** BY R. E. DUDGEON, M. D., LONDON, ENGLAND.—Most medical men admit the utility of the sphygmograph as a useful adjunct to the physician's armamentarium, but few go farther than this verbal assent to its value. Several things deter them from its use as a common aid to diagnosis. They imagine that it is difficult to use, that its indications are uncertain, that it will give various tracings of the same pulse, according to the dexterity or awkwardness of the operator. In short, they believe in their hearts that it is not adapted for common use, and is only fit for employment in a hospital or by one specially trained. The prejudice against it, or at least the indifference toward it felt by the general body of the profession, is, I think, chiefly owing to the cumbrous and complicated character of the instruments known to the profession up to the last two or three years, and the uncertainty, not to say incorrectness, of their work.

The instrument I had the pleasure to introduce a few years ago is free from the objections that attach to previous sphygmographs. It is small, can be readily carried in the pocket, it can be easily applied, so that a tracing of the pulse can be taken in much less time than is usually devoted to feeling the pulse with the finger (which leaves no trace behind it). It is regulated in such a manner that the figure drawn by the needle is just fifty times the size of the movements communicated to the spring by the pulse, and the pressure of the spring can be adjusted whilst the instrument is in situ from one up to five ounces. The greatest trouble is the preparation of the smoked papers, but if the physician is too occupied to do this for himself, any intelligent child can easily make them. The absolute correctness of the tracing made can be secured by attending to a few precautions. The first of these is so to regulate the pressure upon the spring and the tightness of the strap around the wrist that the needle shall make the longest up-stroke the pulse can communi

cate to it, and that the tracing shall occupy as nearly as possible the center of the paper. Very little practice enables this to be done almost automatically. Varnishing the smoked paper, so as to make the tracings indelible, is done at home. Any rapidly drying varnish suffices; that I generally use is made by mixing about two drachms of mastic with four ounces of methylated ether. I have a narrow jar or wide-mouthed bottle filled with this varnish. Into this the smoked paper is dipped and immediately withdrawn. It is dry and ready for sticking in the case-book in less than a minute. I have tried several modes of dispensing with the smoked papers, but none have proved satisfactory, though I am not without hopes of finding a substitute for them.

The advantages of the sphygmograph over ordinary pulse-feeling with the finger are numerous. It gives you a permanent record of the state of the pulse at the time it was used. It tells you the exact strength of the pulse, and hence gives you a tolerable idea of the strength of the heart, which can only be imperfectly guessed at by the digital examination. It tells you the exact number of beats per minute without the trouble of counting them for a half or quarter minute, as must be done by the old method. It shows you the exact condition of the several parts which go to make up one beat of the pulse, of which the finger does not give the slightest information. It gives you a very fair idea of the rhythm of the heart's action. It shows whether the systole is performed quickly or slowly, strongly or weakly, evenly or unevenly. It shows the condition of tenseness or laxity of the arterial coat, and it may indicate free or impeded circulation in the capillaries. It gives a tolerable indication of the condition of the aortic valve. It shows if the successive beats are regular or irregular; it records every intermission and analyzes each irregular beat. It unravels the mysteries of abnormal pulses, and shows how they are caused, which the finger, assisted even by the ear to the heart, is often unable to tell us.

I have heard the instrument blamed because it does not reveal the precise condition of the heart, its cavities, valves and large vessels. It is forgotten that the sphygmograph is not put forward as a substitute for, but as an aid to, other methods of diagnosis. Those who are accustomed to its use find it a very valuable aid, and in many cases its revelations may be relied on exclusively, but as a rule it would be unsafe to trust entirely to it in forming our diagnosis.

It has not been sufficiently long in use to enable us to interpret with certainty all the peculiarities of its tracings, but we know enough to assist us greatly in practice, and we feel assured that further experience will enable us to derive still more profit from it. In fact, the longer I use it the more I am convinced that ere long it will be acknowledged to be as indispensable for the practitioner as are the stethoscope and thermometer. It will probably not come into general use until all the subtleties and variations its tracings present shall have been satisfactorily interpreted. There is still much to be done in this direction, and I believe that young physicians would render a greater service to practical medicine by devoting themselves to the study and explanation of the obscure points of sphygmography than by torturing frogs and rabbits in the vain endeavor to gain thereby a knowledge of the action of drugs.

But no doubt the reader will say that I am unduly prepossessed in favor of the sphygmograph, or rather of my pocket sphygmograph, just as every one thinks his own geese swans, as every parent is or ought to be prejudiced in favor of his own brats. At all events, I am not led to sing its praises by any hope of profit or loss by its more or less extensive use, for I have no pecuniary interest in it whatever.

Before entering upon the details of the cases I propose giving, illustrating the use of the sphygmograph, I may say a few words by way of introduction to the use of the instrument. There is no such thing as an absolutely normal sphygmogram. Persons in health present differences in the character of their sphygmograms as great as they do in the character of their features. But the tracings of all healthy pulses effected by the sphygmograph show certain common features. The pulse tracing is made up of certain elements which are shown in the tracing by strokes and curves. Fig. 1 shows a very

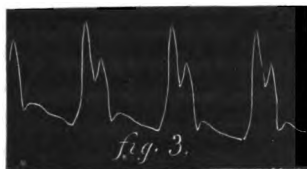


common form of this tracing which may, indeed, almost stand for the normal form.

The vertical up-stroke is followed by a sloping descent of the needle interrupted by two larger and one very small curve, until it attains the lowest point. These curves are formed by the movement of the paper from right to left through the machine. The actual motion communicated to the needle by the pulse is perpendicularly up and down, the curves and slopes being produced by the more or less rapid up and down-strokes of the

needle making their mark in a moving ground. The various elements of a complete pulse are these: *a*, a vertical up-stroke caused by the dilatation of the artery by the blood forced into it by the systole of the left ventricle of the heart; *b*, is the highest point attained by the up-stroke; it is usually a very acute angle, owing to the sudden descent of the needle, *c*, caused by the contraction of the elastic coat of the artery; *d*, indicates an upward movement of the needle, caused according to some, by a centripetal wave produced by the obstruction to the onward flow of the blood offered by the capillary circulation; various experiments have satisfied me that the wave is centrifugal and therefore not explicable in this way; my own idea is that it is caused by a relaxation and subsequent secondary contraction of the artery; *e* is the angle formed by the next rise of the needle: it is called the "aortic notch" by some writers; *f* is the curve caused by this rise of the needle; it is generally supposed to be produced by the reflux of the blood from the sudden closure of the aortic valve; that this is its cause I have, I think, proved by showing that the further the artery from which the tracing is made is from the heart the nearer this curve comes to the end of the pulse's beat; *g* is a small curve caused by a slight rise and fall of the needle produced probably by a little wave in the declining blood-stream which overcomes for an instant the contraction of the artery; it is scarcely noticeable in the figure; *h* is the lowest point to which the needle descends and indicates the degree of emptiness of the artery.

All these points in the tracing are liable to great variations both in health and disease. The up-stroke *a*, in place of being vertical, or nearly so, may be more or less sloping, indicating a slower systole of the left ventricle. Or it may be broken as in Fig. 2, which may be produced either by a hesitancy in the systole or a slight contraction of this artery before it attains its full dilatation by the blood propelled into it. Or it may be curved as in Fig. 3, like Hogarth's line of beauty, indicating that the

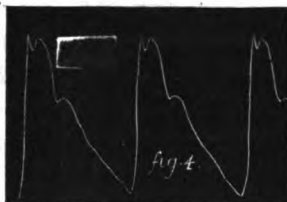


systole was somewhat slower in the beginning and end than in the middle of its act. That this peculiar curve is not an effect of the length of the up-stroke, is shown by the circum-

stance that we may have a very long and yet perfectly straight up-stroke as in Fig. 4. Another variety of the up-stroke is shown in Fig. 5. I

have met this remarkable form of the up-stroke in four

cases, two of which pathologically resembled one another, in that both were subject to epileptic fits, but otherwise they had nothing in common; one, the subject of this illustration, being a young man with a perfectly sound heart, the other an elderly gentleman with mitral insufficiency. The third case was one of acute catarrh of the bladder, with no history of epilepsy or heart disease; the fourth a young lady much reduced by chronic diarrhoea. The apex or highest point of the up-stroke *b* forms with the descending stroke *c* an angle usually very acute owing to the instantaneous contraction of the artery when it has attained its maximum dilatation. But when the contraction of the artery follows more slowly the angle becomes less acute as in Fig. 6. This obtuseness of the apical angle shows a loss of elasticity or con-



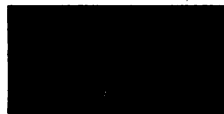
tractile power of the arterial coats. The angle may be so obtuse as to give the apex of the tracing a dome-like form as in Fig. 7.

The next event, *c*, is the descent of the needle caused by the contraction of the artery and the diminution of the blood stream.

The distance to which the needle descends varies greatly from a scarcely perceptible depression (Fig. 8) to a considerable depth below the point from which the needle rises in the systole (Fig. 9).

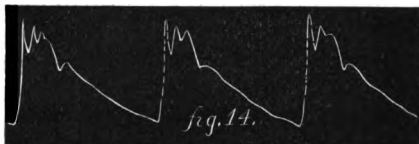
The next event, *d*, is the curve caused by the re-ascent of the needle and its descent to the point *e*. The shape of this curve varies greatly. It may be altogether absent, as in Fig. 9, or it may be just faintly indicated, as in Fig. 10, or it may be strongly marked, as in Fig. 11. It may rise to and even overtop the apex *b*, as in Fig. 12.





Sometimes it may rise much higher than the apex, as in Fig. 13. This curve is usually simple, but sometimes it is double, as seen in the last figure, and still better in Fig. 14. The depth to which the needle will

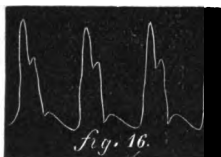
descend in this event varies from a mere trifle, as in Fig. 15, to a very low point, as in Fig. 16, also in Fig. 3.



The angle formed by the re-ascent of the needle, *e*, called by some the *aortic notch*, varies very considerably. It may be scarcely distinguishable, as in Fig. 8, or very well marked, as in Fig. 11.



The next curve, *f*, called the *dicrotic*, or sometimes the *aortic curve*, varies. It may be scarcely or not at all perceptible, as in Figs. 6, 7, 8 and 12, or it may be a very conspicuous feature in the sphygmogram, as in Fig. 17.



The last curve, *g*, called sometimes *second tidal wave* is very often imperceptible, but sometimes it is quite as large as the two preceding curves, as in Fig. 18; sometimes it is double, as in Fig. 19.

The lowest point attained by the needle, *h*, is the same for each beat in a regular or uniform pulse. But when the pulse is unequal in point of strength the lowest point of a series of pulsations may vary considerably. In the case of an intermitting pulse the needle during the intermission generally descends lower, and at the following systolic impulse rises higher than in the other pulsations as in Fig. 20.



In very slow pulses additional curves are perceived. These



show that the artery is not quite quiescent, but, when the finger is sensible of no movement, and conveys the impression of a pause in the

arterial action, the sphygmograph shows that undulating movements are still going on as in Fig. 21, which is merely a slow pulse without any morbid character.

On the other hand, a real pause or suspension of all action whatever, except the gradual emptying of the artery, and consequent uniform descent of the needle, is sometimes observed in intermitting pulses as in Fig. 22.



In this pulse the intermission was indicative of a real pause in the circulation, and in the following systole the heart had not quite woken up to its normal activity, as shown by the feeble character and low height of the next beat.



Occasionally all the minor curves are extinguished, and only two considerable curves are seen in the tracing. This constitutes the dicrotic tracing seen in Fig. 23, the pulse of



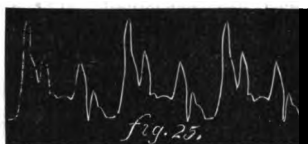
a young man in the last stage of amyloid kidney.

The sphygmograph is very valuable for analyzing, as it were, irregular pulses. This pulse (Fig. 24) was that of a little girl, which



I could not make out by finger or ear. The sphygmograph resolved it immediately; it is seen to be a pulse with an imperfect intermission every other beat. Intermissions, I may observe in passing, are very frequently imperfect. A sort of abortive attempt at a beat is shown at the middle of the intermission. More perfect intermissions are observed in Figs. 20 and 22. The next pulse (Fig. 25), that





of a man in the last stage of Bright's disease, was to finger and ear quite incomprehensible. The sphygmograph resolved it into a bigeminous pulse of tolerable regularity. There

are, however, some pulses of such extreme irregularity that the sphygmograph cannot assist us in unraveling them. I have given some examples in my little work on the *Sphygmograph*, p. 56.

In the above I have only given a fraction of the varieties of sphygmograms met with in practice. But the examples I have adduced fairly represent the extremes of variation of each event recorded in the tracings of pulses. But there are all kinds of intermediate variations, and, moreover, there are combinations of all the diversities I have above described. Again, while almost every pulse presents peculiarities of its own, which peculiarities are reproduced in whatever circumstances the pulse may be taken, there is no doubt that some pulses give very different sphygmograms at different times. Not to speak of the great alterations caused by disease, the sphygmograms of the same person may vary according as he is hungry or full, nervous or calm, during exercise and when at rest, even when seated or standing as in this extreme case. These two sphygmograms were taken from the same person. Fig. 26 was taken when standing.

Fig. 27 when sitting, five minutes afterward. The tracing gen-

erally varies considerably under different pressures of the spring. A little practice will enable the operator to find quickly the pressure, required to obtain the largest tracing from any pulse. I never now use the tourniquet to fix the band around the wrist, but do this with the thumb and forefinger of the right hand, adjusting the spring over the artery with the left hand.

(To be Continued).

## Hospital Notes.

### THE WOMEN'S CLINIC.

#### SERVICE OF PROF. LUDLAM.

✓ **PURPURA HÆMORRHAGICA AT THE CLIMACTERIC.**—*Case 17,333.*—Mrs. B., aged forty-eight years, has been married thirty-one years. She has had five children and three miscarriages, the last being a miscarriage at four months, which occurred about seven years ago. The menses appeared soon after her twelfth birthday, at which time she contracted a severe cold by washing her underclothing and putting it on again while it was still wet. Her menstrual history from that time is one of great irregularity, the menses usually being too frequent, too profuse and lasting for a long time. Sometimes, however, six weeks would pass without their appearance, but the flow was always profuse and long-lasting. The menses were usually preceded by an intense headache, with a flushed face and intolerance of light or sound. Epistaxis was frequent, and it often occurred several times a day.

Four years since she was treated for some displacement of the uterus, and wore pessaries of various sizes, shapes and material. These manipulations and instruments produced intense pain and inflammation, which finally resulted in a pelvic abscess. For the last two years her menses have been absent at times for three months; then again there would be an interval of two to six weeks. They were always profuse, continuing from ten to fourteen days. In the latter part of October, 1884, she observed numerous dark purple spots on the lower extremities. Their appearance was preceded by aching and weariness of the limbs, with profuse menorrhagia and frequent hæmorrhage from the nose.

The night of November 4 she was attacked with vomiting and diarrhoea, the stools and ejecta consisting mostly of blood. The physician who was called prescribed the inevitable *Ergot*, gave a guarded prognosis, and was altogether so indifferent that they for the first time concluded to try homœopathy, and November 8 I was called to attend her. I found her frightened, anxious, with a weak, almost imperceptible pulse, the lower extremities cold and œdematous, and covered with a purplish eruption to the hips, the spots varying in size from that of a pin head to a ten-cent piece, and they would not disappear from pressure. There was constant nausea and occasional vomiting. The conjunctiva was injected, but no hæmorrhage had appeared from the eyelids, the ears or the mouth. There was no fever present, and the general health seemed unaffected, with the exception of the extreme weakness and a tendency to faint.

These symptoms were relieved by appropriate remedies. The eruption still at times makes its appearance, and is at first of a bluish purple, changing successively to greenish, blue-brown and yellow. The hæmorrhages have not been repeated since she came under my care, although the menses appeared after being delayed two weeks. Previous to the petechia making its fresh appearance there will be fugitive rheumatic pains in the limbs, then in the back and chest or head. When the head was affected the pain was agonizing, compelling screams from the patient, and was accompanied with a cold perspiration upon face and hands, and a sensation of coldness in head. For this condition *Veratrum alb.* did good service. The next morning the petechial spots covered the scalp.

When first called *Ipecac.* was indicated and given; but *Lachesis* 6 and 30, *Phos.* 3, *Ledum* 3, *Arnica* 3, and *Arsenicum* have been the remedies prescribed as the symptoms called for them.

Mental and physical rest was strictly enjoined. Tea, coffee, and stimulating food or drinks were rigidly prohibited, and all food and drink was taken cold, and as little of the latter as was practicable. Lemonade was allowed in moderate quantities. She had always been accustomed to a stimulating diet, with an occasional glass of wine or beer, which was of course denied her.

This case, which I am privileged to show you through the kindness of our friend, Dr. C. T. Canfield, is a rare and a very interesting one. Its whole clinical history, the epistaxis, the irregular and copious menstruation, the cerebral congestion in advance of the monthly cycle, and the appearance of the peculiar spots which you have seen upon the legs of this patient, are so many points for study. The derangement of the menses through chill from wearing wet clothing at their first appearance was a mischievous factor of subsequent ill-health; and the approach of the climacteric undoubtedly has to do with the development of purpura at this time of life.

The treatment that she has received from Dr. C. was skillful and appropriate. Under it her last two periods have been only six weeks apart, and the flow has continued but four days instead of ten. Her general condition and spirits are greatly improved. The case has been well managed, and the only suggestion that I have to offer is to put her upon a medium attenuation of *Hydrocyanic acid*, which I have found to be a very useful remedy in other forms of purpura hæmorrhagica.

✓ [NOTE.—This patient was given *Hydro. acid* 6 and 30 in alternation, and is recovering rapidly].

**FIBRINOUS CASTS OF THE UTERINE CAVITY.**—*Case.*—Mrs. H., aged thirty-nine, the mother of five children, had enjoyed good health until six months ago, when she was supposed to have aborted. A month later she was seized with labor-like pains and a profuse hæmorrhage which continued for several days, but nothing was expelled from the uterus. On local examination her former physician decided that she had cancer of the cervix. October 2 the hæmorrhage was repeated, and she suffered from burning pains in the uterine region, with occasional pains in the back. At that time she passed three or four large clots, as she termed them, after which the hæmorrhage ceased; twice since that she has expelled four of these bodies. The hæmorrhage is always profuse before, during and just after their expulsion, when it assumes a passive form. When placed in water they assume the pyriform shape of the womb. She has taken *Sabina*, *Trillin*, and *China*, which have acted very well.

The notes of this case including the specimens were sent to the clinic by Dr. F. J. Magee, of Texas, who also stated that the condition of the uterine cervix was almost certainly that of cancer. The points of interest in the case were the recurring hæmorrhage and the formation and expulsion of these bodies, which are pear-shaped, about two and a half inches long and one and a half in width. A careful examination of the latter shows an entire absence of anything like an organized tissue either within them or about them. The tuft-like exterior of the *decidua menstrualis* is lacking, and the diaphanous character of the membrane which is moulted in exfoliative endometritis is not present. These are not moles, nor hydatids, nor polypi. When we examine them carefully, we find that they have been formed like the post-mortem heart-clot, and are due to the contractions of the uterus upon the fibrine that was retained in its cavity during the hæmorrhage.

It is not merely from curiosity that we should desire to be able to recognize these peculiar casts of the uterine cavity when they occur. They are always connected with sudden and alarming hæmorrhages, metrorrhagia, and usually signify that the case is malignant. Given such casts as these, we could hardly go wrong in saying that the womb from which they came is in a cancerous condition.

**TRAUMATIC OVARITIS, EXFOLIATIVE ENDOMETRITIS AND RECTAL ULCERATION.**—This case was brought to the clinic January 11, by Dr. R. L. Patton, by whom the following history was given:

*Case 17,327.*—R. R., thirty years old, unmarried, and of a nervous temperament, has been in poor health all her life. She had

premonitions of menstruation at eleven years of age; these symptoms recurred monthly, but there was no flow until her thirteenth year. The first time it was very profuse and continued for seven days, leaving her completely prostrated. She did not menstruate again for three months, when the discharge was rather copious, but did not continue so long as at the former period. Six months elapsed before menstruating again, but the period was quite normal. She then menstruated every three and five weeks alternately until seventeen years of age, at which time the mammary glands began to develop. After this time the menstrual flow was regular every month. She has had a profuse leucorrhœal flow every month since she was twelve years old. Since the menses have been regularly established, the leucorrhœa precedes the menstrual flow and comes in gushes producing excoriation of the vulva and the surrounding parts. At the approach of the catamenia she has forebodings of evil and is very nervous. Nine years ago she lifted a heavy lounge, and felt "that something had torn loose" in the left ovarian region, causing a severe intra-pelvic pain, with prostration, and leaving a sore place in the left inguinal region which has remained until the present time, and is very painful during menstruation. She, however, always feels remarkably well just before the flow commences. She was once treated for four years for an alleged "curvature of the spine." After failing to find relief, she abandoned all treatment for the next three years.

In March, 1884, when she came under Dr. Patton's care, she had a severe pain in the left ovarian region. Subjective and objective symptoms showed that she had ovaritis with endometritis. Hot fomentations were applied locally and the indicated remedies were given internally. The improvement was steady until she was able to be upon her feet again. About the middle of July she overdid in entertaining some country friends, and then a relapse followed. This experience was repeated until November 10, when she had missed her period and went six weeks without the flow. November 22 she had a severe nervous chill followed by severe uterine pains. These gradually subsided, but December 3 they had returned very forcibly and brought on the flow. After continuing through all of one night, like a genuine labor, an entire membranous cast of the uterus was expelled. The hæmorrhage was soon controlled by *Secale* and *China*.

After the relief of the subsequent symptoms she directed attention to the condition of her rectum, which had annoyed her for a long time. She had pain and burning, with an excruciating dread of having a movement of the bowels. The stools were somewhat tinged with blood at times, but she never passed any matter with them, nor did she have external hæmorrhoids. A local examination revealed two distinct linear ulcers within the anus, which accounted for the burning at and after stool.

In his remarks upon this case Prof. Ludlam said that falls, blows and strains, as from lifting heavy articles, was a more frequent source of uterine and ovarian disease than was generally supposed. At his last clinic he had shown the class a remarkable illustration of this fact, in which, six years ago, a woman had been thrown from a swing against a tree, striking the crest of the left ilium, and the corresponding side of the pubes, since which time she had suffered constantly from ovarian symptoms and a total inability to void the urine. A month ago they had seen a remarkable old lady, aged seventy-six, with an enormous abdominal tumor, which was large enough to extend beyond her knees when she sat down before them. Five years ago that woman fell in a street-car, flat upon her face and abdomen, in the city of New York, after which the tumor first made its appearance. Two days previous to this lecture he had removed a tumor as large as an orange from the posterior lip of the uterine cervix that was caused by a fall in a skating rink three months ago, and of which there was no sign before that accident.

Traumatic ovaritis may result in membranous dysmenorrhœa, endometritis, ovarian dropsy, or ovarian cancer; but its most frequent effect is to induce dysmenorrhœa, hysteria, hystero-epilepsy and sterility, with or without a serious lesion of the Fallopian tube. No single class of cases is more difficult of radical cure.

With regard to the rectal ulcer and its detection he had little confidence in the use of any kind of anal speculum. The practical objection to them is that the instrument is very apt to obstruct the view, and especially to hide such a linear lesion as was found in this case. These hair-like ulcers are located near the margin of the anus, and are the source of a deal of suffering and discomfort. The way to find them is to put the patient under an anæsthetic, and then apply Storer's method of everting the bowel so as to expose these or any other kind of ulcers that may exist in that locality. The remedies suited to the cure of the linear ulcers of the rectum are *Nitric acid* ✓ 2 internally, and the same acid with glycerine locally; with, if the bowels are badly constipated, *Collinsonia can.* 2 three times a day; ✓ and absolute cleanliness.

## Miscellaneous Items.

The engravers have not yet finished the portrait of Prof. Cooke. —Prof. Hawkes will deliver the valedictory at the next Commencement of the Hahnemann Medical College and Hospital. —Prof. Hoyne's "Directory of Homœopathic Physicians" appears as a monthly under the title of the *Medical Visitor*. It is newsy and notice-able at \$1.00 for the year. —The Practitioners' Term opens March 3. —Dr. J. H. S. Johnson, class of 1884, was recently married to Miss Margaret Boosing, of Buffalo, N. Y. —The Secretary of the Alumni Association of the "Old Hahnemann" has already received acknowledgments of the circular issued by the Executive Committee from members scattered from New York to California, and there is a grand prospect of a full meeting. The date of the meeting is February 25. Come all who can. —Our thanks are due Dr. S. E. Nixon for a copy of the Transactions of the Fourteenth and Fifteenth Sessions of the Hahnemann Medical Association of Iowa; to Dr. John Moore, of Liverpool, for his excellent *Reminiscences of the Cholera of 1849*; and to Dr. J. C. Burnett, of London, for his pamphlet, *The Law of Similars the Scientific Principle of Vaccination; Homœoprophylaxis*. —If Dr. J. D. W. H. — knows where he lives and will kindly give us his address his letter will be answered. —For the month of December, beside the contributions to the treasury of the Hahnemann Hospital of \$1,000 from Mr. E. H. Sheldon, \$100 from Mr. Armour, \$10 from Mrs. Dr. Sarah A. Andrews, the Woman's Department acknowledges donations from Mrs. C. S. Dole, Mrs. Tappan Halsey; Joseph Twyman and "A Friend." —Dr. H. C. Jessen, who is making a brief visit in this city, will locate in Los Angeles, Cal. —Mr. Tait, a benevolent citizen of Liverpool, England, has donated the building and grounds for a free Homœopathic Hospital in that city. It will be very large and complete. —Notes from the Women's clinic in the Hahnemann Hospital will be furnished to each number of this journal throughout the year. —The second part of Prof. Laning's lecture on Nerve Inhibition will bring the subject up to date. —Dr. Wyckoff, *alias* "Peter," is here from Dakota, taking a partial course at the Hospital.







# THE CLINIQUE.

---

VOL. VII.] CHICAGO, FEBRUARY 15, 1885. [No. 2.

---

## Original Lectures.

### *HARELIP.*

A LECTURE DELIVERED BY G. F. SHEARS, M. D., PROFESSOR OF THE PRINCIPLES AND PRACTICE OF SURGERY IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

One of the most common plastic operations which the surgeon is called upon to perform, is necessitated by the congenital malformation known as harelip, so called because of a fancied resemblance to the divided upper lip of the hare. While there is a likeness there is also a difference consisting mainly in this, that in the animal the division of the lip is always in the median line, while in the child it is always to one side of this line.

The varieties of harelip, their anatomical peculiarities and the best methods of treatment can be most intelligently considered when the developments of the parts involved are thoroughly understood. Previous to the second month of foetal life there are no such compartments as the nasal, oral and pharyngeal cavities, these three compartments forming one general cavity. About this time, however, there are indications of a division of this cavity into the three found after birth. From each side of the common cavity, shelf-like processes consisting of membranous folds extend out into the space and approach each other, thus indicating the future division into a nasal and oral cavity. From the centre and anterior of the upper wall is another reduplication of the lining membrane forming a longitudinal elevation, which runs forward and terminates anteriorly

in a triangular lobe. The face viewed from before shows a large, irregular opening, the cavity of which is divided above into two lateral cavities by this ridge and lobe-like process in front, and divided into an upper and lower cavity by these reduplications from the sides. In these irregular openings are the future nasal orifices and the mouth. The shelves on each side are the horizontal plates of the superior maxillary and palate bones, the bar is the septum nasi and the lobe at its extremity is the intermaxillary bone. Under normal conditions as growth proceeds the superior maxillary bones, with the attached lip, the palate bones and the intermaxillary, approach each other, unite and form the distinct cavities of the mouth and nose.

If the palate be examined a short time before birth there will be seen to be a ridge or line extending in the median line from the extremity of the soft palate anteriorly. A short distance from the alveolar ridge this line divides and from this point two oblique lines pass to the space between the lateral incisors and canines. These oblique lines represent the union of the little lobe-like process or intermaxillary bone previously described. This little triangle, which is really a part of the superior maxillary, contains the incisor teeth. The upper jaw with its appendages the lips is therefore in foetal life separated into three divisions, the larger lateral portions and this smaller middle piece. Under normal conditions these unite and a perfect upper lip and palate are formed. If, however, through some as yet unknown agency, development be arrested, there may be a fissure in the soft palate, the hard palate, or the lips, in each instance this cleft being at some point at which these clefts naturally exist in foetal life. From this description it may be understood that if union of the superior and intermaxillary bones took place on one side and failed to take place on the other there would be a single cleft of the lip and this cleft would be to one side of the median line. If union failed to take place at all there would be two clefts, one on each side of the median line. There are then two varieties of harelip, single and double, according as there is partial or complete non-union.

Single harelip presents usually the following appearance: A cleft extends from the border of the lip to the nares of the corresponding side. The sides of the cleft are covered by the mucous membrane of the jaw. The lower edges of the cleft are rounded and the outer lip seems shorter and on a higher plane than the

inner, due to the more pronounced action of the orbicularis oris. The ala of the nose of the affected side droops, appearing flattened, the nostrils being elongated laterally, the lips quite closely adherent to the jaw.

Double harelip may present either a simple double cleft of the lip, that is, two clefts running in the line of the antenatal sutures from the border of the lip into each nostril, there being a large intermediate triangle, no prominence of the intermaxillary bone or deviation of the septum nares, and a more complicated form in which none of the antenatal clefts have united, leaving a cleft of the palate, a wide gap in the superior maxillary and a prominent intermaxillary. These latter cases present a most distressing appearance. There is a larger irregular space representing the nostrils and mouth, the outer portions of the lip are widely separated, the nose is depressed and flattened, and the intermaxillary bone stands out horizontally from the face, surmounted by a little tuft of integument and apparently forming a mere extension of the septum of the nose.

This deformity is frequently associated with deformities due to arrested development in other portions of the body. Thus it may coexist with talipes, hernia, hypospadias, epispadias, extrophy of the bladder or occlusion of the anus. A case of double harelip which came under my observation had a very large anterior fontanel and spina bifida of the three lower lumbar vertebræ, the spinal column being separated about an inch and a half and permitting the existence of a tumor about the size of an egg. Gross relates a case in which besides the harelip there was deformity of the hands, one being deprived of three fingers and the other of one finger and thumb.

Besides the deformity, which is repulsive to every one, and especially to the mother, harelip in its more severe forms interferes greatly in the act of suckling and deglutition. In many instances the child finds it difficult to obtain the requisite amount of food. The palate being cleft suction is very imperfect, and much of the nourishment obtained, upon an attempt being made to swallow, regurgitates through the mouth and nose, the natural barrier in this direction being deficient or absent. In addition to these many annoyances, the child as he grows finds himself unable to speak intelligibly, the labial and palatal sounds being entirely from under his control.

There is no question as to what should be done in these cases. An operation is the only resort, but when shall it be done and how shall it be done, admits of several answers. The age at which the operation should be performed has been variously stated by different authors and operators. The older surgeons were accustomed to recommend that the operation be deferred until the child had attained two years of age, but most modern surgeons are in favor of early operations; Agnew says any time after the second week, if physical indications do not contra-indicate; Gross, a few days after birth, if the child is plump and well nourished, while Sayre and several English surgeons advise and have made the operation a few hours after birth. In this as in all similar operations it is useless to lay down any more specific rule than that the operation should be made as soon after birth as the physical condition of the child will permit. In most cases the operation may be made safely in a few days after birth. If, however, the child is puny, jaundiced, or in any way departs from the usual standard of health, the operation should be deferred until the condition has been overcome. The existence of a cleft in the palate is an inducement rather than an objection to the performance of the operation, for the pressure exerted by the tightened lip favors materially the closure of the bony aperture.

The evil effects of disregarding the injunction to place your patient in the best physical condition possible before operating, is shown in a case which came under my observation a short time ago. The child, then a few days old, had a double harelip, a cleft palate, and a very prominent intermaxillary lobe, the latter looking more like an excrescence on the tip of the nose than a portion of the superior maxillary. The parents were desirous of an immediate operation, because of the peculiarly depressing effect which the sight of the child had upon the mother, who could neither let it out of her sight nor remain quiet in its presence. I should have acceded to their demands were it not for the unfavorable physical condition of the patient, who was quite thin and noticeably jaundiced. The operation was shortly afterward performed by another surgeon, and as I am informed, in a very satisfactory manner, as far as the work itself was concerned. The flaps, however, never united, and eventually sloughed away, leaving a much worse deformity than previously existed. It is quite probable in my mind that the unfavorable result was due to the anæmic, jaundiced condition of the patient.

The operation may be performed with or without an anæsthetic. In the latter case the child's arms are held to the side by means of a towel pinned firmly around the body. It may be then held in the arms of the nurse or laid upon a table. In most cases I prefer to use an anæsthetic. Chloroform is easily and safely borne by the youngest child if administered carefully, a few drops upon a handkerchief or napkin being sufficient. The operation consists essentially of three steps or stages, the freeing of the lip from the gums and superior maxillary, the excising of the edges and the closing of the fissure.

The child having been anæsthetized or firmly secured, the operator grasps the lip with the thumb and finger, lifts it up and with a small scalpel or bistoury detaches it from the gums on both sides of the fissure. This must be thoroughly done in order that the lip may be free and the edges brought together without tension. It may be necessary in some cases to go as high up as the nose to attain this object. The next step, the excising of the lip, requires some consideration. It would seem to be simply sufficient to freshen the edges of the cleft, and bring the parts together in order to reproduce the lip, but if you examine a case of harelip you will notice that the free borders of the lip instead of being rectangular have become rounded; if then the edges are simply freshened, after the union of the two sides there will be left at the bottom of lip an unsightly little notch. Several plans are advocated to dispose of this prolabial notch, all of which possess some merit. Erichsen advocates semi-elliptical instead of straight incisions; Clemot and Malgaigne triangular incisions or reversed triangles, and Colles two straight incisions to the border of the lip and the saving of the parings. The last two are the plans most frequently followed, and the ones with which the best success may be attained. In the triangular plan the surgeon pushes his narrow bistoury through the lip at the apex of the fissure, and cuts downward with a sawing motion, passing away from the fissure as he passes down, making the angle of the triangle near the lower border of the lip, and the lower line wholly at the expense of the mucous membrane. The opposite side is now treated in the same manner, leaving, after the removal of the parings, a diamond-shaped aperture. Hemorrhage may be controlled in the meantime by the thumbs and fingers of the assistant at the external angles of the mouth. Usually it is unnecessary to use any ligatures as the

firm pressure which is made when the lips are brought together prevents all hemorrhage. The edges are now ready to be approximated and held in place. This may be done by the interrupted silver suture or the harelip pin and twisted suture. The former does away with the scar that so often follows the use of pins, but union is not so uniformly attained as by the latter plan. The pin should be fine, sharp, and either galvanized or made of silver or gold. An ordinary steel pin or needle should never be employed on account of the tendency to oxidation, and the resulting difficulty of removal. I remember a case of this kind in which an ordinary steel needle had been used to take the place of the proper pin. The healing progressed favorably until time came for the removal of the sutures. These were easily removed with the exception of the needle. As great a pressure as was permissible without destroying union was exerted without avail, and the needle remained until it absolutely ulcerated its way out.

The first pin is inserted at the muco-cutaneous border, entering about a quarter of an inch from the edge, and passing through the whole thickness of the lip almost down to its mucous surface, thus bringing together not only the deep portions of the wound, but controlling by acupressure the orifices of the coronary arteries. A strong silk thread is now wrapped around the pins elliptically, not so tight as to create undue tension, but sufficient to maintain perfect apposition. A second pin is placed through the middle of the wound, and a third near its upper angle. The thread from the first pin is carried across the interval to the second pin, and after this is secured to the third. The sharp points of the pins are removed by the pliers and small pieces of adhesive plaster placed under the extremities to protect the skin. If perfect coaptation is not attained at the vermilion border of the lip, a superficial suture of silk or cat-gut should be employed. If the tension is great, and with safety in all cases, strips of adhesive plaster may be placed across the lip from one cheek to the other to give additional support, and lessen the tension on the sutures. Over the whole may be placed a thin dressing of dry absorbent or borated cotton.

The child should not be put to the breast or the bottle for at least seventy-four hours, but should be fed with a spoon. On the third day the two upper pins may be removed. The lower pin should be left from twenty-four to thirty-six hours longer. In

removing the pins care should be taken that no tension is made upon the wound. For this purpose the thumb and finger may press the cheeks together, while the surgeon seizes the head of the pin with a pair of forceps, rotates it a few times to loosen it, and then quietly withdraws it. Having removed one pin, a piece of adhesive plaster is placed over the lip, and a second pin removed with the same caution. The loops of thread may be allowed to remain if thoroughly dry, as they still are of some service in holding the lip together. If, however, they are moist, it is best to remove them and apply a dry dressing.

Although the plan described is usually sufficient to perfectly restore the lip, in some instances, this may be best obtained by Colles' plan. In this operation incisions are made on each side parallel with the fissure, down to the vermilion border of the lip, and then ceasing, leaving two little fleshy tongues, one on each side. When the raw surfaces are brought together there is a little prominence instead of a notch at the border of the lip. In time this atrophies, or is cut away if necessary. In very severe cases where there seems to be a deficiency, too great a space intervening to make the adjustment of the two surfaces of the cleft possible by the ordinary operation, the cheeks may be separated from the molar bone and the incision extended from the cleft along the naso labial furrows under the alæ of the nose. The lip may then be elongated by sliding the detached piece downward.

In double harelip the operation may be simple or quite complicated, depending upon the condition in which the different parts of the lip and superior maxilla are found. In the more simple cases, in which there are two clefts corresponding to the prenatal clefts, but no prominence of the intermaxillary bone or displacement of the septum, the operation is not a difficult one. The first step consists in the severing of the labio-maxillary fold and freeing entirely not only the outer lip but the intermaxillary triangle. The edges of the lateral pieces are excised in the triangular method previously described while the edges of the intermaxillary piece are simply pared. This latter piece never equals in length the lateral pieces, and cannot therefore be brought down to the lower border of the lip, which must be formed of the lateral pieces of the lip entirely. If the middle piece is long, the septum not displaced, and the nose not materially flattened the intermaxillary piece may be stretched almost to the border



of the lip; if, however, the nose is flattened, and the lateral pieces of the lip are not too short, it is better to close the lateral pieces as high as possible, and by pressing the middle piece into the upper part of the aperture, use it as a column to hold up and support the flattened nose. The pins are inserted in the usual manner, penetrating the entire breadth of the intermaxillary piece. In the more severe cases, in which the intermaxillary piece is horizontal or nearly so, it is necessary to carefully dissect it from the nose and then press it firmly back with the fingers. Before this can be done, it is necessary in many cases to remove a V-shaped piece from the septum. Having done this, the parts are pressed into place and held by strips of adhesive plaster placed over the lip until the healing process takes place, when the edges are pared and brought together as in the simpler forms. If the intermaxillary piece is very irregular and the other methods fail, it may be removed after having been dissected from the little tuft of integument. The septum should not be excised too far back. It is better to leave a slight prominence. By this means the sunken appearance of the upper lip is overcome. Even if the intermaxillary bone is pressed back into place and unites too much must not be expected, for in many cases the teeth are defective or viciously placed. The cleft of the palate which accompanies the severe form of the disease must be left for treatment until the child has become older.

---

ITEMS.—The final examinations in the Hahnemann College are now in progress.—Dr. Waggoner's cases of trichinosis will appear in our next issue.—A correspondent wishes to "blow up" the author of a re-print from the *N. E. Med. Gazette* entitled "A Layman's View of the Potency Question;" but we have no space for that sort of thing, you know.—Quite a full meeting of the Homœopathic profession was held February 2, at the Grand Pacific Hotel, Dr. D. S. Smith in the chair, to take action concerning the death of Prof. Cooke.—"The Eye as an Agent in Causing Headaches and other Nervous Disturbances," is the title of a neat and useful monograph by Dr. George S. Norton.—Ditto, "The Progress of Homœopathy," a paper read before the Canadian Institute of Homœopathy in June last, by George Logan, M. D.—The *Monthly Hom. Review* of London for February is freighted, as usual, with good things.—Our indefatigable friend Arndt is working like a beaver on Boericke's Encyclopedia.—The Practitioner's Course in the Hahnemann College and Hospital opens March 3.

## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

The Clinical Society held its ninety-sixth regular monthly session in Club Room 4, at the Grand Pacific Hotel, on Saturday evening, February 7. On account of the unavoidable absence of the President, Dr. R. Ludlam was elected to fill the chair, and in due course he called for the report of

### THE BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

C. H. VILAS, M. D., CHAIRMAN.

OF THE ALKALOIDS COMMONLY USED IN EYE AFFECTIONS. C. H. VILAS, M. D., CHICAGO.—In the treatment of eye diseases the practitioner may require the aid of various alkaloids, as hypodermic and internal remedies, but more especially for collyria. I therefore abridge those commonly used into the space of this short paper, in the hope that the condensation may be found useful.

First among such alkaloids, and without which the treatment of eye diseases would at times be extremely hazardous, is atropia sulphate, more commonly called atropine. But atropine is insoluble in water, and hence, if ordered, must be cut with an acid. To overcome this objection there is commonly used the sulphate of atropia, or atropine treated with sulphuric acid, which is freely soluble in water. That it be well prepared is important, or there may be attributed to the atropia unfavorable results due to other causes. When rightly prepared, atropia sulphate is wholly devoid of any acid effect on the eye, causing no smarting or tingling sensation.

As a mydriatic, atropia sulphate is commonly used in strengths of from two to four grains to the ounce of distilled water, a drop in the conjunctival sac every few hours, *pro re nata*. Its use in iritic affections and diseases of the uveal tract is often imperatively demanded, and yields speedy and important results.

Homatropine is another alkaloid artificially obtained from atropine in a pure white, crystalline form. It has been recommended,

and is used in the treatment of the several diseases of the eye as a substitute for atropia. As a collyrium it may be employed of the strengths customary with atropia; hypodermically the dose is from 1-50 to 1-30 of a grain.

Duboisine, the alkaloid of *duboisia myoporoides*, is similar in its effects to atropine, but more powerful, and often causes rather alarming symptoms; care should be used in its use. Preferably used in the form of the sulphate, its strength should not be quite equal to that of atropia, one-half the quantity being usually sufficient. Hypodermically from 1-100 to 1-60 of a grain is the dose.

Hyoscyamine, the alkaloid obtained from *hyoscyamus*, may be used when atropine is not well borne, and fully considering the various statements, it would seem that under its use the pupil will dilate more rapidly, remain longer dilated, and of not less maximum degree than when atropine is used. Unlike duboisine, its effects are not distressing at times, but it does not keep as well and is more difficult to procure, though this latter objection is rapidly passing away.

Pilocarpine, and usually the hydrochlorate, is the alkaloid obtained from *jaborandi*. It causes profuse salivation and sweating and has been used to quite an extent in optic nerve troubles, but not with such a sweepingly favorable result as was at first predicted. Usually it has been given hypodermically;  $\frac{1}{4}$  of a grain being used.

Eserine, the alkaloid of calabar bean, has been justly greatly praised for its effects on the eye, especially in corneal troubles. It may be used of about the same strengths as atropine. The salicylate of physostigmine, now official in the new U. S. Pharmacopœia, is another preparation of value from the bean. The great value of eserine, aside from its use in corneal troubles, is found in that it is the only myositic on which dependence can be placed. While antagonistic to atropine mydriasis, and displacing it and substituting its myositic effect, eserine cannot long hold the ascendancy, but gives way after a short time, and the mydriasis reappears. A solution of the alcoholic extract of the bean (four grains to the ounce of distilled water) or a little of the extract itself may sometimes, with advantage, be substituted for the alkaloid.

Daturine, the alkaloid of *datura stramonium*, is also useful, especially when atropine cannot be borne. A solution of four grains to the ounce of distilled water is usually the strength required.

Cocaine has been made the subject of a special paper, and hence is not treated of in this.

THE HYDROCHLORATE OF COCAINE.—C. H. VILAS, M. D. The oculist, if one can be found, who has not written on the new eye-anæsthetic, must be a very eccentric and lonesome man. Our literature has been crowded with reports and the remedy has been extolled regardless of its merits. To one who really has used it, many of these so-called experiences smack of the closet rather than the bed-side. In response to some inquiries from members of this society, I shall endeavor to give the result of such experience as my hospital and private practice has afforded me, free from preconceived or unwarranted ideas or prejudices. Necessarily the first person is used; you will pardon its frequency as unavoidable.

I think we may dispense with carefully copied encyclopædia articles as to the origin and preparation of the drug, and proceed to its effects.\* I have in all cases used a 2 per cent. solution of what I believe to be Merck's preparation of cocaine hydrochlorate.

When I first obtained a supply of the drug, necessarily small, owing to the sudden exhaustion of the stock on hand by the immediate demand, I applied it first on some acquaintances privately, and then on members of my class at the Hahnemann Medical College, of this city. Those who submitted to its use, kindly wrote out their experiences and gave them to me. They corresponded so closely to those given in Dr. Koller's paper that I omit them here.

I have used it successfully in iridectomy for glaucoma, and in iridectomy for artificial pupil, in the extraction of hard and the needling of soft cataract; for slitting up the canaliculus and probing the duct; for strabismus, for pterygium, and, in short, for all the usual eye operations except enucleation. Foreign bodies in the cornea, very painful affairs, should not be omitted.

I believe I have tried it in all the ways I have seen suggested. My usual plan after a little experience at first has been to instill a drop or two in the conjunctival sac, and after a minute or two touch the conjunctiva, and as soon as all sensibility has vanished proceed to operate. Some persons are very susceptible to its effects, and the eye is at once ready for operation. Others come under its effects very

\*Should any desire to examine the origin, pharmacology, etc., fully, for the best article recourse should be had to the *Pharmazeutische Rundschau*, New York, December, 1884, p. 260. Dr. E. R. Squibbs has an entertaining article on "Cocaine" in his *Ephemeris* of November, 1884, p. 685.

slowly, and some scarcely at all without oft-repeated applications. Where the second statement was the case, after waiting from five to ten minutes with no satisfactory result, I have put in a drop or two more, and if unsuccessful then added still more after a like interval. In case of probing, by catching the right moment, a little has generally sufficed.

Some twenty minutes after instillation dilatation of the pupil begins, but never progresses to the maximum degree. I have always operated in the early afternoon, and the mydriasis has passed away during the succeeding evening, or night at the farthest, after I have gone away, so that I have been unable to note its exact duration. This dilatation may be readily overcome by instilling a drop of eserine, and will not appear again, even though more cocaine be used afterward. A slight paresis of the accommodation has been apparent in some cases. A staring appearance of the eye has been very noticeable a few minutes after instillation; its cause is explained in Dr. Koller's paper farther on.

In one or two cases I have seen rather distressing symptoms ensue, but have had no eventual bad result. The patient has become exceedingly anxious in expression, has complained of "a sinking sensation at the pit of the stomach," with fluttering in the præcordial region. Beads of cold sweat have stood on the face, and great restlessness has ensued. It has been difficult, however, to dissociate these symptoms from other causes, though I believe them attributable to the drug. Further experience is necessary to confirm them. I have since noticed that other experimenters have noted these symptoms. The temporary anæmia produced by the drug is of great value in operating, as it renders the operation bloodless, or nearly so, when done on the conjunctiva. The value of this alone in strabismus operations will be evident to all operators.

In extracting foreign bodies from the cornea, and other external portions of the eyeball, its value can hardly be overstated. When the tissue is fully under its influence, deep indentations can be made on the cornea, spuds and finger readily used, and any foreign body removed. Thus these painful little operations, often not to be done without chloroform heretofore, become a matter of a few moments painless procedure.

To an operator who is easily sickened by the usual anæsthetics, chloroform and ether, it is indeed a boon. The nervous headaches

from breathing these odors have cost many operators a restless night and much discomfort; neither has a resort to bi-chloride of methylene, or a mixture of them, removed these objections.

In operating for hard cataract the corneal incision has been entirely painless. But in seizing hold of the iris a spasmodic movement of the ball has been incited of a violent nature. The escape of the aqueous humor even has seemingly provoked this. It was so entirely unexpected in my first experience that although I was intensely watchful, I narrowly escaped tearing out a portion of the iris. At that time I had not seen Dr. Koller's paper, but since then have noticed that he mentions this peculiarity. Yet in operating for glaucoma, and in one case where the iris seemed in an approximately healthy condition, there was no such movement.

To the patient who has undergone the often necessary retching, vomiting and even purging, and sometimes suppression of urine, resulting from general anæsthesia, the instillation of a few drops on the eye, and the performance of the operation with no physical pain and entire freedom from the mental distress consequent on loss of consciousness and fear of resultant death, the remedy seems like a gift from a divine power, and calls forth most enthusiastic praise. Were this alone the result of the discovery, the patient's expressions would serve as a full compensating reward for the discoverer.

In enucleation, I have not found it sufficient, but take note that other oculists have. Further experience with a stronger solution may render it entirely sufficient for this purpose. But the difficulty of getting even enough for what has already been done has warned against the slightest waste or unnecessary use. Provided it have no injurious effect on the general system, a 15 per cent solution might be all-sufficient. But as cocaine dissolves only up to 5 per cent without the addition of an acid, and as the addition of an acid causes intense burning, I am fearful it cannot be advantageously used. I shall know of this soon, however, as I shall try it. In a few cases I have been unable to use it because the patient was too nervous to permit of an operation, even when painless, because he could see it. This, however, it should be noted, was not the fault of the drug, and only happened in that middle age of youth when the patient had outgrown the trustfulness of infancy and not reached the sense of adolescence. While I have not yet met with such a case, I could readily understand that a very nervous person could not tolerate the witnessing of an enucleation of the fellow eye.

That a large field of usefulness is open for its use as a mitigator or allayer of pain in eye diseases is apparent. In such diseases as phlyctenular keratitis, where photophobia is so painful, and diseases of that class, and in ulcers of the cornea, its use must tend to comfort. I have not used it sufficiently yet to have an experienced opinion in such cases, but it seems indicated. *En passant*, a furunculous rash of the external auditory canal must yield some of its pain at least, I think, to an oleate of the same substance. Being a dermoid rather than a mucous surface, I am not certain of the efficacy of cocaine, however.

Contrary to my original intention, I shall not give a detail of cases, because they would add nothing to the paper and only encumber the valuable space of our organ, THE CLINIQUE.

I cannot do better than conclude by quoting quite extensively from an original paper of Dr. Carl Koller, of Vienna, the discoverer of the effects of cocaine on the eye and appendages:

"A few drops of a watery solution of muriate of cocaine dropped on the cornea of a Guinea pig, rabbit or dog, or instilled into the conjunctival sac in the ordinary way, causes for a short time winking of the eyelids, evidently in consequence of a slight irritation. After one-half to one minute the animal again opens its eyes, which gradually assume a staring look. If now the cornea is touched with a pin-head (in which experiment we have carefully to avoid touching the eye-lashes), the lids are not closed by reflex, the eye-ball does not move, the head is not drawn back as usual, the animal remains perfectly quiet, and on application of stronger irritation, we can convince ourselves of the complete anæsthesia of the cornea and conjunctiva. In this way I have scratched and tranfixed the corneæ of my animals of experimentation with needles, and have excited them with electric currents so strong as to cause pain in my fingers and become quite intolerable in the tongue; I have cauterized the cornea with the nitrate-of-silver stick until it became milky-white. During all this the animals did not move. The last experiment convinced me that the anæsthesia involved the whole thickness of the cornea, and did not affect the surface only. But if I incised the cornea, the animals manifested intense pain when the aqueous humor escaped and the iris prolapsed. I have been unable, hitherto, to decide by experiments on animals whether or not the iris could be anæsthetized by dropping the solution into the corneal wound, or by prolonged instil-

lation into the conjunctival sac; for experiments to test the sensibility of non-narcotized animals are very complicated and difficult, and do not yield unambiguous results. The last question which I subjected to experimentation in animals, viz.: whether or not the inflamed cornea could be anæsthetized by cocaine, was answered in the affirmative. The cornea in which I had incited a foreign body keratitis became as insensible as a healthy one.

"Complete anæsthesia of the cornea from the use of a two-per cent solution lasts ten minutes on an average. After such successful experiments on animals, I did not hesitate to apply cocaine also to the human eye, trying it first on myself and some of my friends, then on a great number of other persons, obtaining unexceptionally the result of a perfect anæsthesia of the cornea and conjunctiva. The course of the phenomena is as follows: If some drops of a two-per cent solution are instilled into the conjunctival sac, or better still, let run over the cornea, first a slight burning (accompanied by some lachrymation) is felt, which in one-half to one minute disappears, being followed by a dull sensation of dryness. The eye, like that of animals mentioned above, assumes a staring look, owing to a considerable dilatation of the palpebral fissure, a phenomenon to the explanation of which I shall return later on. If now the cornea is touched with the head of a pin no sensation of pain or of contact is experienced, and all reflexes are absent. The same holds of the conjunctiva, in which the sensation of temperature is likewise abolished. The scleral conjunctiva can be grasped with a pair of toothed forceps, or a dimple can be made into the cornea by pressure without any unpleasant sensation or the least reflex on the part of the person thus treated; the only thing he perceives is an indistinctness of objects, owing, of course, to the change in the curvature of the cornea. This complete anæsthesia lasts from seven to ten minutes, then passes through a longer state of reduced sensibility into the normal condition. About fifteen to twenty minutes after the instillation the pupil begins to dilate. The dilatation reaches its highest degree within the first hour, decreases considerably in the second hour, and disappears without a trace in a few hours more. The pupil is never *ad maximum* dilated, responds promptly to light and convergence during the whole time, and for that reason the sensation of dazzling, connected with atropine mydriasis, is either totally absent or only slightly pronounced.



"A very insignificant paresis of accommodation appears and disappears with the mydriasis; the near point receded a little in myself and another person whom I examined on this point.

"Furthermore, I have observed a marked ischæmia in the normal, especially the palpebral conjunctiva, on the duration of which I am unable to make any definite statement. Other not perfectly ascertained observations, such, for instance, as the ophthalmoscopic conditions, I will pass by for the present, yet I want to say that I have never noticed any symptoms of irritation from the use of cocaine.

"As for the dilatation of the palpebral fissure, this phenomenon at all events precedes the action of cocaine on the muscles of the iris and the ciliary ligament. On account of its almost simultaneous occurrence with the anæsthesia of the cornea and conjunctiva, I have thought it to be in connection with this anæsthesia, accounting for it by the omission of the excitations which in the normal state act upon cornea and conjunctiva, and upon which the ordinary width of the palpebral fissure depends.

"In regard to the anæsthesia, \* \* \* as it can be demonstrated that cocaine is absorbed, and that from each instillation a certain, though small, quantity penetrates into the interior of the eye, first of all into the anterior chamber, it could *a priori* be expected that the deeper structures of the eye might be anæsthetized if they could be reached by sufficient quantities of the remedy. But as the absorption requires a certain time, and the anæsthesia of the cornea is of short duration, the anæsthesia of the cornea will have disappeared before the iris and ciliary body are acted on. We must, therefore, anæsthetize the cornea again. Both demands can be satisfied by successive applications."

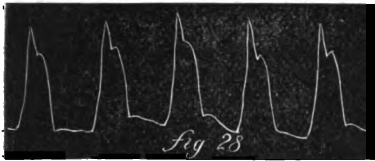
THE CLINICAL USES OF THE SPHYGMOGRAPH. BY R. E. DUDGEON, M. D., LONDON, ENGLAND.\*

I shall here proceed to illustrate the use of the sphygmograph by a few cases.

*Case 1.*—A lady aged fifty-four, and otherwise apparently quite healthy, consulted me about a lachrymal fistula that had formed on the left side of her jaw. The opening was very small, but through it there exuded on pressure a small quantity of pus. I endeavored

\* Continued from page 30.

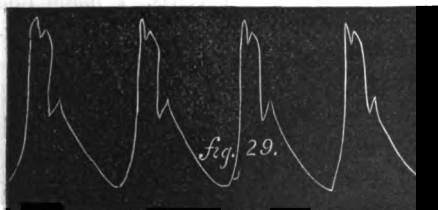
for some time to cure it by means of internal remedies, but finding these without result, I advised an operation. She expressed a great dread of anæsthetics, and said she was sure she should die if they were administered. On asking her reason, she said she felt sure there was something wrong with her heart. On taking a tracing of her pulse, which presented no peculiarity to the finger, I found that the so-called aortic curve was almost absent. This led



me to suspect something wrong, and on applying the stethoscope I found the normal diastolic sound replaced by a rough murmur indicating insufficiency

of the aortic valve and regurgitation. Under these circumstances I could not advise the employment of anæsthetics, and as the patient had a great dread of pain she requested me to go on some time longer with internal treatment. Of course we would naturally examine the heart carefully before consenting to the use of chloroform, but when the patient is otherwise healthy, and the pulse gives a good impression to the finger, we might think all was serene. A tracing like the above would at once convince us that there was probably something materially wrong with the heart.

*Case 2.*—Sir W. S., aged sixty, an engineer of a remarkably energetic character and of astonishing powers of endurance, whose life has been spent in constant intellectual and physical activity, and whose health for the past twenty years, during which I was the medical attendant in his family, was undisturbed except by occasional occipital headaches and sleeplessness, the consequence of excessive mental work, and slight attacks of dyspepsia, generally traceable to dietetic errors. I had frequently noticed that his heart's action was

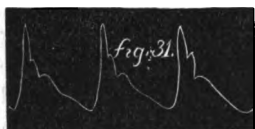


unusually strong. Fig. 29 is a tracing taken when standing with a 3-oz. pressure of spring in October, 1882, he being then in perfect health and vigor. Heart's

sounds were perfectly normal and all the organs of the body were healthy, so this unusually strong pulse excited no uneasiness in my

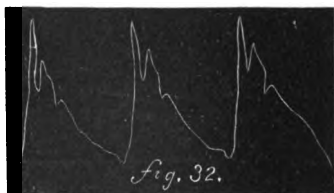
mind as to the condition of his heart. On November 5, 1883, when walking with a friend, his foot struck upon the curbstone and he fell forward on his hands. He took no notice of this, but went to his business as usual. On the morning of the 8th, when walking across Hyde Park to his office, he found that he had to stop frequently and sit down on one of the park seats to recover his breath, and on each occasion he perspired profusely. He drove home from his office and I saw him about 6 P. M. He made light of the matter, complaining only of a little uneasiness in the chest, but making no allusion to the attacks of dyspnoea and perspiration which had occurred when walking that morning. The stethoscopic signs of heart and lungs were normal. Pulse, sixty-three, but the sphygmogram was quite unusually weak for him. I prescribed *Arnica* 1, and urged him to take a few days' rest.

The next day, November 9, however, he drove to his office, and when I saw him in the evening he said he felt nearly quite well, and proposed to go to the theatre after dinner. This I persuaded him not to do. His pulse was seventy-seven, the sphygmogram more like its usual form but showing with more strength than that of the previous day. The next morning, November



10, he awoke at 4 A. M. with violent pain in the cardiac region. When I saw him about an hour later, he was sitting up in bed complaining of violent indescribable pain referred to the left of the sternum above its middle, with numb pain extending down the left arm. He was very cold and bathed in cold sweat. The respiration was not affected, the pulse under 70 and the heart's and lung's sounds normal.

The morbid picture was that of angina pectoris. I made him inhale a few drops of amyl nitrite, and gave internally *Digitalis*. Under this treatment the pain and distressing symptoms soon subsided, and by the morning they had quite disappeared. He never had any recurrence of the angina. It was his first and last attack. I took a tracing of his pulse at 10 A. M., when the attack was subsiding. Except in a slight shaking it does



not materially differ from his sphygmogram when in health. It was

only 63 per minute all day, which again is its usual rate in health. The sphygmogram of the evening is still

more satisfactory. He hardly slept that night, and on the 11th he complained of weariness, but felt easy. The pulse in the morning was found the same as on the previous evening, except that it was 70 in place of 63. As the day advanced he complained of some embarrassment of respiration, and I found crepitating râles at the base of the left lung. The sphygmogram showed slight



jerkiness. I again used *Phosphorus*, 2. Next morning (12th) the crepitation seemed to be diminished in extent. The pulse

was 90, weaker; temperature 99°; no cough, no pain; tongue white, no appetite; bowels acting regu-

larly; had slept but little. On the 13th the improvement continued; the pulse had regained its strength, and was down to 84.

The tracing shows a remarkable roundness of the apex which I had not observed before. On the 14th he felt so much better that he insisted on going down-stairs, transacting business with his Secretary and dictating letters

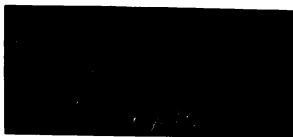


of an agitating character. He also went up-stairs into a cold room with the windows open to search for a letter. He now began to

cough up small quantities of bloody mucus, without any effort, nor did he complain of pain. The crepitating râles in left lung continued and

there was marked dulness at its base; pulse seventy. Sphygmogram shows a marked diminution of jerkiness. At 5 A. M., of the 15th,

he had a violent attack of dyspnoea. I found him sitting up in bed, breathing very quickly and improperly. The dyspnoea was out of all proportion to the amount of pneumonia in the left



lung. Pulse 90. The apical angle very acute. The acuteness of this angle increased towards evening. He had had small attacks of dyspnoea during the day, during which the respiration was as high as forty per minute, very superficial, attended by great anxiety and



profuse perspiration. The paroxysms were relieved by making him sit upright, with his legs in hot water. From this time he had repeated attacks of dyspnoea, the intervals between them

varying greatly. No medicine seemed to be able to relieve these attacks, though many were tried. The pneumonic signs continued to the end, but without increasing in extent or causing much cough or any pain. The expectora-

tion, which was very scanty, came up without much coughing, varied in appearance from light red to dark, black-currant jelly color. The temperature never arose above 99.5°. The sphygmograms varied considerably. At 5 A. M. on the 16th, during a paroxysm of the dyspnoea, the tracing was extremely feeble. In

the course of the day, when breathing tolerably well, it improved. The next day (17th) it had precisely similar fluctuations. The night between 17th and 18th, was very restless; the fits of dyspnoea very frequent. On the 18th I had the advantage of a consultation with Dr. Dyce Brown, who formed a very



bad opinion of the case, believing that the heart was the chief cause of the attacks of dyspnoea, and was probably far gone in fatty degeneration. This diagnosis seemed to be

borne out by the character of the peculiar tracing taken in Dr. Brown's presence, which shows greater weakness of the heart's action than was observable either before or afterward. At 7 o'clock next morning, after a restless night following a severe attack of dyspnoea, the sphygmogram was quite changed. The very uneven upstrokes, though of moderate strength, shows a very irregular contraction of the ventricle. At 10 A. M. the sphygmogram was again nearly normal, showing neither the weakness of the

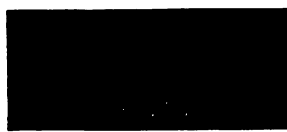
previous day, nor the irregular systolic action of the early morning. The last tracing I took was at 4:30 P. M. This shows a somewhat feebler heart's action than the previous tracing, but not so feeble as  on the previous day. After this he had another paroxysm of dyspnoea which passed off in the usual way. He sat up in his chair and spoke cheerfully, though somewhat incoherently. About 9 P. M. he coughed, spit a little bloody mucus into a basin at his side, and immediately afterward fell back in his chair, dead.

With the assistance of Drs. Clark and Moir I made a *post mortem* examination, eighteen hours after death. On opening the chest a considerable amount of serous effusion was found in both pleuræ and also in the pericardium. Both lungs were adherent at their apices with old pleuritic exudation. The lower lobe of the left lung was dark red, hepatized in about one third of its extent, and exuded bloody serum when cut into. The heart was large, weighing twenty ounces. Much of its muscular structure, especially of the left ventricle was in a condition of fatty degeneration. The left coronary artery was ossified and a fissure extended through its walls not far from its origin. Its lumen was occluded by a semi-organized clot. The right ventricle was occupied by a large white clot. All the valves of the heart were sound and efficient. The abdominal viscera were healthy. On the left kidney there was a depression that looked like the cicatrix left by a boil in the skin, but the parenchyma of both kidneys was normal. The brain was not examined.

The immediate cause of the sudden death was probably owing to the degeneration of the muscular structure of the left ventricle, caused by the occlusion of the left coronary artery. Perhaps a sudden muscular spasm of the powerful heart caused by the fall on the 5th of November injured and cracked the brittle coronary artery, thereby giving rise to the formation of the clot that filled it in its whole length. The unusual size of the heart, unaccompanied as it was by vascular disease, was the cause of the uncommon force of its beats, which I had observed before the patient's accident. The contusion of the coronary artery by depriving the left ventricle of its nourishment was no doubt the cause of the fatty degeneration. The pneumonia was not croupous, but probably embolic. The presence of a large white irregularly-shaped semi-organized clot in the right ventricle seems to show this.

In this case the sphygmograph would never have sufficed alone to establish the diagnosis of the disease, as its tracings varied remarkably from day to day and did not show any regular decline of power in the heart; still they showed enough to give rise to strong suspicion that the heart was undergoing some remarkable pathological changes, and though it seemed to right itself occasionally it never quite regained its normal character. The very variety of the sphygmograms points to the great share the heart had in the symptoms observed. The tracings I have given are embarrassing by reason of their diversity, and I cannot point to any one of these as pathognomonic of the morbid condition of the heart. Those taken at the last day of life seem more normal than many of those taken at an earlier period of the disease. The most unusual forms are Figs. 36, 38 and 39. Fig. 43 also is a very exaggerated specimen of a not unusual form, which was seen at an earlier period of the disease in Fig. 34.

*Case 3.*—J. B., aged seventy-three, stout in the body but rather thin in the limbs, pale complexion; has lived a very active life as a statesman, and an orator of very unusual powers. Some years ago had to give up his public life in consequence of brain-fag. He was then recommended by his medical attendants to eat very sparingly. After recovering from this state and returning again to public life with unabated energy, he still continued to practice the abstemious regimen that had been recommended to him when ill, and for the last four years his diet had been chiefly vegetable, and not too much of that. On the last day of March of the past year I was sent for in the evening. He had been feeling ill for a few days, and had a slight cough and oppression of chest. The cough was frequent, in single impulses, and accompanied occasionally by expectoration, the character of which he could not tell me, as he always spat into the fire. Examining his chest, I found crepitating rales at the lower part of the left lung, and as he coughed I begged him to spit the sputum into his handkerchief. I found that it was streaked with blood. Temperature normal, pulse 77; the sphygmogram was good.



I could not compare it with his normal tracing, as, though I had attended some of his family in past years, I had never before taken a tracing of his pulse. I advised him to go to bed, and gave him *Aconite* 1. The following morning (April 1), I ascertained that he had slept tolerably well,

coughing occasionally, and expectorating a small quantity of rusty colored sputa. The crepitation as before, and slight dullness at the lower part of left lung; pulse 70, sphygmogram feeble. Appetite good temperature normal. I now put him on *Tartar emetic* 3, every two hours, [redacted] and light diet. The next morning

(April 2), his symptoms were much the same. He felt no pain, the cough was not very troublesome, but the expectoration and physical signs were as before; pulse 63, sphygmogram like that of yesterday; no pain; tongue rather white. On visiting him in the evening at 9:30, I found him cheerful and comfortable, but the pulse down to 56, and the sphygmogram indicative of increased fullness of

[redacted] circulation. The following morning he said he had had a restless night, and he felt rather low. The cough and expectoration and physical signs were as before; the pulse still 56, but evidently much feebler; the sphygmogram extremely weak. Continuing the same medicine, I now ordered a more generous diet, fish and [redacted] fowl and milk, and Valentine's

fluid beef in between. In the evening I found him much revived, and the pulse, though still only 56, showed much more vigor. After

[redacted] this the case went on quite favorably, and by the 11th he was sufficiently well to go out for a drive

The crepitation and dullness cleared off, and the cough, with expectoration of a little ordinary mucus, was quite insignificant. The improvement of the sphygmographic tracings was gradual but steady. I give the tracing taken on the 8th of April, and that on the 10th of April; this last taken when he was up.



This case was remarkable for the complete absence of the ordinary accompaniments of pneumonia. The physical signs, such as crepitation, dullness, rusty-colored expectoration were well marked, but there was no pain, no fever and no rise of temperature. The



pulse fell steadily from 77 to 56 and even after putting the patient on generous diet, it never rose above 63 as long as he remained in bed. The sphygmographic tracings indicated increasing fullness of the heart's action until the liberal diet was adopted. As the patient was a total abstainer I did not order any stimulants and he did very well without them. I persuaded him to adopt a more liberal dietary after his recovery, as I felt sure that his long-continued abstinence had much to do with the rapid failure of his circulation during the first days of his pneumonia. Since his recovery he has resumed his active habits, and after his Parliamentary duties last summer he enjoyed a customary recreation of salmon fishing in Scotland.

I will not at present give any more cases illustrating the use of the sphygmograph, though I am well aware that those I have given are not by any means the best I might have given for this purpose, but they possess other qualities which may recommend them to the attention of the physician besides their bearing on sphygmography. On some future occasion I may perhaps give another series of issues possessing a greater sphygmographic interest and displaying the peculiarities of the pulse tracings in cerebral, renal and heart diseases. In the meantime I hope this paper may lead physicians who have hitherto neglected this important means of diagnosis to think more favorably of it, and may convince them that there are no great difficulties in the way of its general use in practice.

Before concluding I may direct attention to the importance of using the sphygmograph when proving drugs. Some sphygmographic tracings are given in Allen's *Encyclopædia* but they are not my instructors. Either the instruments with which they were taken were bad or the operator was unskilled. Of course Dr. Allen is not responsible for their accuracy, as he only copied them from the works of others.

CHLOASMA. BY H. G. GLOVER, M. D., CADILLAC, MICH.—M. T., æt. twenty-seven, barber. Consulted me December 11, 1884, in regard to a skin disease which for five years had been the "plague of his life." He first noticed a yellowish spot on the right breast, which enlarged, spreading over the entire breast, neck, abdomen, back, arms, and on to the thighs slightly. For a period of six months he received no treatment. Then he consulted a "regular" physician, who told him the affection was syphilitic, and treated him

for more than a year without success. Afterward he tried various baths, soaps, blood-purifiers, etc., etc. He was troubled at times with an intolerable itching. Careful examination revealed extensive tawny-yellow, scurfy patches, slightly raised above the spots of healthy cuticle. On detaching some of the diseased epidermis, the skin beneath appeared reddened and slightly swollen, but *dry*.

What was the disease? A typical case of *chloasma*, ( *pityriasis versicolor*) a disease caused by the vegetable parasite, *microsporon furfur*.

As the trouble was purely a local one, I prepared this recipe:

Acid Pyro-gallic, gr. xxx., Cosmoline oz. j, and gave it to the patient with instructions to bathe thoroughly and apply the ointment every night. Improvement was perceptible from the start, and in less than three weeks no trace of the disease remained. The patient was highly pleased, and—so was the doctor. Moral: Be sure of your diagnosis, "and then go ahead."

Internal treatment would have amounted to nothing at all in such a case. There has not been the slightest recurrence of the trouble up to date.

**AUTOPSY OF DR. NICHOLAS FRANCIS COOKE.**—Before the reading of the minutes taken at the post-mortem examination of Prof. Cooke, and the exhibition of the specimens obtained thereat, Dr. W. E. Reid being called upon said: The diagnosis made by a physician of note in June, 1883, of the case of the late Dr. N. F. Cooke, was to the effect that there was a cardiac murmur of old standing—as was the hypertrophy resulting from the regurgitation at the mitral orifice which gave rise to the murmur.

The action of the heart was good, the pulse strong, blanching of skin slight, and no cyanosis. It was considered that there was not sufficient venous engorgement of the kidneys, from the cardiac obstruction, to account for the albumen in the urine.

The small accumulation of fluid in the abdominal cavity was thought not to be caused by the cardiac trouble. The symptoms of weakness, difficulty of breathing, oedema of the lower extremities and ascites, the catarrhal condition of the stomach and intestinal canal and albuminuria, the portal obstruction and hepatic engorgement were said to be mainly due to the developing of cirrhosis of the liver resulting from the action of alcohol on the liver and kidneys.

The autopsy was conducted by a committee appointed by the Faculty of the Hahnemann Medical College. It took place at 369 Chicago Avenue, at 4 P. M. Monday, February 2, 1885, thirty-four hours after death. There were present Drs. D. S. Smith, W. E. Reid, C. E. Laning and A. K. Crawford.

Rigor mortis well marked. The countenance and color of the skin both natural and normal. Some post-mortem discoloration noted at the back.

The incision along the median line reveals immense fatty deposit. The ascitic fluid drained from the abdominal cavity does not exceed twelve ounces.

. The great omentum is large, free, and heavily laden with fat.

The left kidney is removed from a deep bed of fat. The capsule strips off easily.

No trace of the supra-renal capsule is to be found.

The usual longitudinal section of the kidney reveals a homogeneous surface throughout the central portion of the organ, which is quite friable, while the extremities present a more normal appearance, the cortical and pyramidal formation being readily seen.

The right kidney *in situ* and after removal answers to the description given of the left, excepting that the changes are less marked. Externally the kidneys present a rugous appearance.

The spleen is slightly enlarged, of a deep, reddish-brown color over its convexity. The capsule parts from the organ over-easily, and the substance of the gland is very friable.

The liver before removal appears normal in size, color and position. On taking it out the right lobe is found to be slightly paler in tint than the left, and on section this lighter color is found to be general throughout its texture.

The gall bladder presents very marked thickening of its walls, and when distended its cavity is only five-eighths of an inch in diameter. It contains a small amount of fluid bile.

The lungs collapse on opening the thorax; crepitation sub-normal. The right has some adhesive bands connecting the costal with the pulmonary pleura at the junction of the upper and middle lobes. Both apices are completely and firmly bound to their respective summits by old pleuritic adhesions. Section shows slight œdema.

The heart is greatly enlarged. Before disturbing even the pericardium the measurement from base to apex is seven and one-half

inches, and transversely across the base it is six and one-half inches.

The pericardium contains only a small amount of fluid, not more than ordinarily found.

The heart had ceased action in diastole, and consequently the cavities are distended with blood, coagulated. There were no ante-mortem clots.

On section the left ventricular cavity is found greatly dilated. Portions of the wall exhibit evidence of hypertrophy, while other parts had become as thinned as the wall of the auricle. Both segments of the mitral valve are rough-edged and thickened, and appear shrunken. The cords and fleshy bodies, and the endocardium apparently normal.

The aortic orifice and valve are perfect.

The right ventricle is specially abnormal in the hypertrophied state of its columnæ carnæ. The tendonous cords and endocardial surface are in good condition. The tricuspid valve lacks the roughness of its neighbor the mitral, but it presents marked attenuation of its leaflets.

Both auricles are dilated, the right auricle much the greater of the two.

The weight of the heart without fluid or appendages is twenty-two and one-half ounces.

HOLDEN'S ANATOMY.\*—So much of the history of medicine is to be found intimately connected with the study of the structure of the human body, that this fact is apparent, that every advance made in the science of medicine is the legitimate result of some discovery in anatomy. It is one of the requirements of the times, more so than ever before, that the student and practitioner of medicine shall be proficient in understanding the structure, function and harmony of the various parts of the body. The work before us is one calculated to instruct. It is a valuable book for any library, large or small, not simply to occupy shelf-room, but for constant use. The descriptive text is in simple English, free from ambiguity or unnecessary technicalities concerning minute and variable details.

The arrangement is such as to treat of the several regions of the body in the order considered most suitable for their thorough descrip-

---

\*HOLDEN'S ANATOMY.—P. Blakiston, Son & Co., Philadelphia. Fifth edition, pp. 800, and over 200 illustrations; 1885.

tion; and to the "rusty" practitioner who has always designed to "brush up" in anatomy sometime, but never has since his graduation, the book offers special instruction, as the following brief extract will show. After giving a description of the manner of dissection, the coverings and relation of the adjacent parts—the author adds, as one of the sub-heads to the subject of femoral hernia: "The practical application of the subject.—From what has been said, the student ought now to understand 1, At what aperture a femoral hernia escapes from the abdomen; 2, The course which it takes and its relations to the surrounding parts; 3, The proper mode of attempting reduction; 4, The structure and arrangement of its coverings; and 5, The probable seat of stricture."

The practical *resume* of descriptive text throughout the entire work is a feature of special merit. The illustrations are true to structure, and real as well as artistic.

C. E. L.

**HEART STARVATION** \*—This little pamphlet of twenty pages refers to a class of individuals who are possessed of asthenic hearts, accompanied by impaired digestion, and sometimes following continued deficiency of sleep. The peculiarity is that in the prime of life such evidence is furnished of cardiac weakness that many of the symptoms and physical signs point to fatty degeneration of the heart, which essentially pertains to old age, and atheroma. The practical point of the essay is to help differentiate between a malady of the heart which is functional in its nature, and within the bounds of curative medicine, and one which is structural in character, and almost unvaryingly incurable. Even though seemingly so similar, that they differ materially is judged first of all from the condition of the arteries, next from the grouping of the concomitant conditions, and lastly, from the response to treatment. The "starved" heart is found in one in active life who has over-taxed his energies; whose digestion is imperfect; whose liver is sluggish and possibly enlarged, with pale stools and a deposit in the urine. In consequence of this, the constantly worked heart and diaphragm lack the proper "tissue nutrition" and asthenia results.

As might be expected, Dr. Fothergill dwells mostly on the dietary aspect of the treatment of these cases. He summarizes it thus:—"The rational treatment is (1) to reduce the work of the liver by a dietary containing albumenoids in sparing quantities, and in easily digestible form; and (2) to sweep away the nitrogenized waste, and so cleanse the blood." The remedial drugs are placed in the dim perspective. In fact, he shows why digitalis, iron, and strychnia will do no good to such patients, while their administration will often do harm.

A. K. C.

\* **HEART STARVATION**—By J. Milner Fothergill, M. D. London: H. K. Lewis, 186 Gower St.

## Hospital Notes.

### THE SURGICAL CLINIC.

#### SERVICE OF PROF. HALL.

*Case 1.*—CYSTO-SARCOMA.—Mr. W—, aged fifty-four years, entered the Chicago Surgical Institute with a cysto-sarcoma involving the right femoral and inguinal regions. The history of this was as follows: Prof. Andrews, two years before, had removed a large cysto-sarcoma arising from the fascia of the vastus internus. This tumor was ten inches in its long diameter and five and a half in its transverse. It was supposed that the tumor was entirely removed. Considering the extent of the dissection, the wound healed with rapidity. About six months after the operation several small nodules appeared along the cicatricial line and one just below Poupart's ligament. The size of these nodules increased until the date of the patient's admission into the Institute. The entire femoral region was found to be involved, the thigh measuring twenty-eight inches in circumference. The growths were evidently attached to the periosteum at different points, the largest nodule being situated near the femoral fold, surrounding the femoral vessels and the anterior crural nerve, and having an attachment near the trochanter minor. The inguinal glands were enlarged, the adipose tissue in the gluteal and femoral regions, infiltrated and boggy. The limb below the knee was slightly swollen. The general health of the patient was very much impaired. His face bore unmistakable signs of cachexia, the bowels were inclined to be constipated, and appetite poor. We gave a grave prognosis. The true nature of the case was explained to him, and he was given the choice of these alternatives; he might allow the limb to remain, let the disease take a natural course, live and enjoy what he could of life, before the inevitable fatal termination, which must ensue within a few months; or, he might choose amputation at the hip-joint with removal of the inguinal glands. If we were successful in our attempt to remove all tissue involved, and he survived the shock of the operation, there were possibilities of the prolongation of his life. Recognizing the dangers of the operation, and the probable impossibility of extirpating all the glands involved, we operated, May 16. An anterior integumental flap was made. This was necessarily short, because of the skin being adherent to the upper portion of the growth. The posterior flap was also integumental, but of sufficient length to easily meet the anterior flap. The greatest difficulty lay in separating the femoral vessels from the growth surrounding them. The anterior flap was reflected to Poupart's lig-

ament, when the inguinal glands were removed and the femoral vessels and nerve carefully dissected out. The artery and vein were ligated at the inferior border of Poupart's ligament, the flaps carefully united over a large drainage tube, and an antiseptic dressing applied. The patient made a rapid recovery from the operation, but about the 1st of July an ugly nodule made its appearance above Poupart's ligament, directly over the iliac vessels. Two months from date of the operation, he returned to his home, refusing further surgical interference. Shortly after hemorrhage from the iliac vein terminated his life.

*Case 2.*—CHRONIC ABSCESS OF THE PROSTATE GLAND AND ULCERATION OF THE NECK OF THE BLADDER.—Mr. J., aged thirty-eight, entered the Surgical Institute, August 2. For many years the patient had suffered with rectal trouble and vesical irritation. In the beginning, the urinary difficulty was paroxysmal, becoming more continuous and for three years he had been a constant sufferer. He was thin, pale and exceedingly nervous. There was marked digestive disturbance—irritability of the stomach, nausea and want of appetite. There was a constant desire to void the urine, which was only passed in small quantities and with the most violent straining. When an attempt to urinate was made, he was compelled to get upon the floor upon his hands and knees; then, by leaning forward and making a protracted effort, about half an ounce of urine might be passed. Exhausted by this he would retire to his bed, but the pain would not subside before the next demand for urination. The interval between these attempts varied from twenty to thirty minutes throughout the night and day. The bladder was enormously distended and the pressure so great that there was slight leakage, necessitating the wearing of sponges and compresses for the purpose of absorbing the fluid. Analysis of the urine showed mucus, epithelial cells, pus and an excess of ammonia. Putting the patient under the influence of chloroform, a digital examination was made through the rectum and the prostate gland was found to be much enlarged, filling one-half the rectum, and very sensitive, so as to preclude the possibility of the examination without the aid of an anæsthetic. Passing the sound we found a stricture involving the whole prostatic portion of the urethra and it was only by prolonged and careful effort that we were able to pass the smallest size, No. 1, metallic sound. This was followed by the passage of Nos. 2, 3, 4, 5 and 6. As the last entered the bladder, and was withdrawn, quite an amount of pus and blood followed its removal. The catheter was then introduced and a large quantity of offensive urine drawn off. The bladder was then filled with a one per cent solution of glyco-phenic acid and the patient allowed to come from under the influence of the anæsthetic. Upon returning to consciousness, his desire to empty the bladder became irresistible and this was accomplished with little or no straining.

Glyco-phenic acid in solution was used once daily, and once a day an injection of two ounces of the following solution was given:

|                      |    |      |
|----------------------|----|------|
| Gum Arabic.....      | 1  | 3    |
| Hydrastia Sulph..... | 1  | 3    |
| Morphia Acet.....    | 10 | grs. |
| Aqua Font.....       | 1  | qt.  |

Internally nascent phenic-acid was administered, one tablespoonful every four hours, and a hypodermic injection of the same was given daily. At the end of four weeks the patient was convalescent.

*Case 3.—FIBROUS NASAL POLYPUS.*—Mr. H., aged forty years, entered the Surgical Institute May 20. Several unsuccessful attempts had been made to remove a fibrous polypus of the nose, from which he had suffered for a great many years. There was laryngeal irritation, the lungs and bronchi were involved, and he was considered far gone in consumption. The growth perfectly occluded the nasal passages, and there was constant drainage from the posterior nares into the throat, constituting, as we believed, the exciting cause of the throat and lung difficulty. Upon exploration of the nares, we found that the growth was so impacted in the nasal cavities, that it precluded the possibility of determining the exact seat of attachment. From its nature, we had reason to believe its origin to be in the upper pharyngeal and nasal cavity. With the long, serrated, curved forceps, we extracted the mass by installments, scraping the base with the curette and afterward applying a twenty per cent solution of persulphite of iron. This was followed by a daily application of glyco-phenic acid and hydrastia. This treatment was continued for four weeks, when the patient was discharged.

*Case 4.—HEMORRHOIDS AND HYPERTROPHIED MUCOUS MEMBRANE OF THE RECTUM.*—Mrs. H., aged thirty, was admitted to the Institute July 23. For many years she had suffered with hemorrhoids and thickening of the mucous membrane of the rectum. At every act of defecation, there was abundant hemorrhage with severe pains, and the rectum and hemorrhoidal tumors became prolapsed. We injected the hemorrhoids with glyco-phenic acid daily, for three days. Suppositories manufactured by C. E. & G. S. Halsey and containing fluid extract of ratanhia or fluid extract of hamamelis were used. The hamamelis was introduced every morning after a warm water injection, and at bedtime the bowels were evacuated with enemas and the suppositories of rhatania introduced and allowed to remain during the night. As remedies, she was given *Aloes* and *Rhatania* in dilution with small doses of *Podophyllin* once a day. In four weeks the patient was convalescent and has had no return of the trouble.

*Case 5.—RECTOCELE.*—Mrs. E. entered the Institute, July 28, suffering with rectocele caused by an irritable sphincter and retro-



version of the uterus. For her relief, the sphincter ani was paralyzed, the uterus restored to its normal position, its flexure removed by dilatation, and the parts supported by pledgets of cotton saturated with the following solution:

|                   |          |
|-------------------|----------|
| Fl. Ext. Ratanhia | 1 part,  |
| Pond's Extract    | 2 parts. |

Complicating this case was an irritable bladder, which yielded to *Chimaphylla* followed by *Clematis*. The patient was discharged August 28.

**Case 6.—ADENOMA OF THE CERVICAL GLAND.**—C. G., aged twenty years, came to the Hahnemann Hospital Clinic in November, 1883, for the removal of an indurated cervical lymphatic gland. This growth involved the cervical plexus and impinged upon the carotid artery and jugular vein. It exerted pressure upon the pneumogastric and phrenic nerves, causing great distress and pain. The patient remained only a short time in the hospital after the operation, when he returned to his home under charge of his family physician. Being of a restless, active habit, he was not willing to wait until the parts had become solid. By his imprudent exercise, he caused a residual abscess to form, which was opened in the upper angle of the posterior triangle. The pus burrowed deep down into the triangle, forming a pocket, the base of which lay below the clavicle. Various attempts were made to remove this abscess, but without success. The patient entered the Chicago Surgical Institute for a second operation, September 2. We found a fistulous opening about the point at which the sterno-cleido-mastoid and the levator anguli scapuli cross each other. A probe introduced into this passed downward and inward a distance of five inches. September 5 a careful dissection was made, and the fistulous track and sac with their lining of pyogenic membrane were removed, together with adjacent tissues and membranes. Antiseptic dressing was applied and quiet enforced until the wound healed by granulation.

**Case 7.—OVARIOTOMY.**—Mrs. W., aged fifty-seven years. During the absence in Europe of my colleague, Prof. Ludlam, this lady came to the Institute for surgical relief. An abdominal tumor had been discovered by her about a year previous to this time, and had since grown with great rapidity, accompanied by marked impairment of the health and nervous prostration. September 16, the patient having been placed under the influence of chloroform, the usual exploratory incision was made, when it became evident that there was fibro-cystic degeneration of the right ovary. The incision was then lengthened at its upper end, and the mass removed, after the partial withdrawal of the fluid through the cyst wall. The entire tumor weighed eighteen pounds. Adhesions were extensive in the right iliac fossa, and the pedicle, consisting of the right broad ligament, containing

the Fallopian tube, was bound firmly down to the brim of the pelvis. As the pedicle was very short and broad, a needle armed with a double ligature was passed through the middle of the broad ligament, and the two threads tied about the two portions of the ligament thus made. Owing to the adhesions, the hemorrhage was quite troublesome. Great care was exercised in controlling the oozing before closing the cavity. Lister's dressing was applied, and the patient placed in bed. This case was remarkably free from back ache and colic usually following such operations. She had no drawback, and made a rapid recovery, enjoying now exceptionally good health.

*Case 8.*—SARCOMA OF BOTH MAMMÆ.—September 25 I was called in consultation with our late esteemed colleague, Prof. N. F. Cooke, to see Mrs. K, aged fifty-six years, who had come from Missouri to place herself under his charge and receive the benefits of phenic acid treatment. The case was an extreme one. In the right breast, involving the entire gland, was a tumor about six inches lengthwise, and about four and a half inches transversely. In the left breast was a growth of similar appearance of about half the size. The patient being extremely anxious to try the phenic acid, because of the cure of what was called cancer of the lip in the case of a friend of hers by Dr. Cooke, she continued its use for more than forty days, taking nascent phenique by the mouth and hypodermically. She was removed to the Institute, September 30. October 16, there seeming to be no improvement in her case, but a rapid enlargement of the tumor, and her health becoming greatly impaired, she consented to allow surgical interference. Both mammary glands and the axillary glands of the right side were removed. The entire right breast being involved, a clean sweep was made, and the whole gland tissue removed, leaving an open surface with a length of ten and a half inches, and a breadth of eight inches. This was left to heal by granulation, under the influence of a tar plaster dressing. In the left mamma the tumor was small and the surrounding tissue less involved, so that two oval lateral integumental flaps were made, and the gland structure removed. The flaps were brought together, partially covering the denuded surface, reducing the open space to a length of about five inches and a breadth of two. The same dressing was used as was applied to the other breast. In about two months she returned to her home, resuming the phenic acid treatment. February 8, she writes that her general health is good, and there is no sign of a return of the trouble.

## THE WOMEN'S CLINIC.

SERVICE OF PROF. LUDLAM.

**COLLOID CANCER OF THE UTERUS AND BOTH OVARIES.**—At the women's clinic a very remarkable specimen of colloid tumor was shown and thoroughly explained to the class. It was removed at post-mortem and sent to the hospital by Dr. R. F. Baker, of Davenport, Iowa. The following is the clinical history furnished with the specimen:

*Case.*—Mrs. X, aged forty-two, married, the mother of two children, the youngest being twelve years old, consulted Dr. B. three years ago for menorrhagia, and metrorrhagia, to which she had then been subject for about a year. On local examination he discovered a growth as large as a small orange attached apparently to the right side of the body of the womb. Within a year from this consultation the left ovary had developed which, in all, was tapped three times, averaging ten quarts of fluid at each tapping. After the last tapping she seemed to improve, and although the sac refilled, it could be tolerated. The uterus had become anchored, and was quite immovable, and in the right inguinal region the tumor was very hard. A month ago he was consulted concerning the advisability of another tapping, but it was not thought best. Ten days ago, after the use of electricity over the back and abdomen, she felt "something give way," and suffered a sudden collapse from which it seemed impossible for her to rally. In two hours after the rupture of the sac there was a very copious fluid discharge, amounting to several quarts, per rectum. This discharge continued at intervals until she died from exhaustion.

The autopsy revealed a rupture of the parent cyst, and extravasation of the gruel-like contents into the peritoneal cavity. From the fracture of smaller cysts, some pus and other kinds of fluid had also escaped. The tumor was everywhere so adherent that it was next to impossible to get it away. The uterus and portions of the intestine were lost in the mass, and both ovaries had undergone a very complete cystic degeneration. The weight of the solid portion was fifteen pounds, and of the mass and the fluid together, thirty-five pounds.

**OVARIAN DYSPEPSIA.**—*Case 17,264* having been several times before the class we have gathered the following clinical remarks upon it. This is one of the forms of reflex dyspepsia which is likely to be overlooked, especially by the busy practitioner, and that in any event is difficult of cure. For, while utero-gastric disturbances are common enough, and are prescribed for very often, ovario-gastric difficulties are obscure and unknown to many. \* \* \* \*

In the majority of cases of ovarian dyspepsia the patient is thin and meagre, physically weak and anæmic. She is indisposed to exertion, and although usually hysterical, is more inclined to be hypochondriacal. She is of middle life, past thirty, and approaching the climacteric; but may be married or single. She may or may not have been addicted to habits that induce dyspepsia in others; in most cases she will not have had any other form of indigestion. The bowels are always constipated. \* \* \* \* \*

A marked peculiarity of this affection is an increase of the gastric trouble and distress with the monthly return. In some cases the added discomfort anticipates the beginning of the monthly flow; in others it comes with, and continues during the discharge; and in others still, it follows the period quite regularly. But it is not always possible to link the functional disorder of the stomach so closely with either of the three periods usually considered as belonging to the monthly menses; and hence we are not always able to recognize the periodical aggravation of the dyspeptic symptoms in any but a general way, just as we do in menstrual headache. \* \*

\* \* \* \* \*

Scanty menstruation is the rule in these cases; and the accompanying conditions are very different from those which we find in stout women whose flow diminishes as they approach the menopause. In ovarian dyspepsia the flow decreases in about the same proportion that the anemia and the general and nervous dilapidation are developed. There is not the same tendency to amenorrhœa that we have in incipient phthisis, and yet these patients sometimes skip a month. As a rule the flow is regular as to time, but deficient in quantity. Any and all pain is usually referred to the region of the ovaries, which are either in a state of irritation, or of sub-acute inflammation. Relapsing dyspepsia of this sort, in which the attacks recur at the month, and subside or disappear in the interval, almost always depend upon sub-acute ovaritis. I have seen several marked cases of this kind, some of which have been in my clinic.

In hysterical subjects an ovarian irritation which may be induced by emotional causes will often suffice to bring on an acute paroxysm of dyspepsia. Occasionally we find that such a fit of indigestion is accompanied by a strange and uncontrollable vomiting; while at other times there is extreme suffering from taking the slightest particle of food, no matter how simple it is, into the stomach; and it is

not very rare to see such women with caprices of appetite that correspond with those from which others suffer in the early months of gestation.

This same class of patients sometimes suffer from ovarian gastralgia with an incidental dyspepsia. You will remember such a case in our clinic, and the prompt and permanent relief obtained by the use of *Argentum nit.* 30, a dose three times a day. In that case when the stomach was relieved the pain settled for a little in the left iliac region, and finally disappeared altogether. The hysterical factor in it was shown you by my examination of the throat and fauces. \*

\* \* \* \* \*

Two remedies are suggested in the case now before us, viz.: *Alumina* and *Platina*. We shall not shock anybody present by giving them in alternation (although we are sometimes guilty in this regard), but will choose the most appropriate of the two on clinical grounds. The cardinal indications for *Platina* are the hypochondria with cramp-like pains in the stomach, bearing down in the lower abdominal and uterine region, and a scanty flow of the menses. For, strange to say, in this class of subjects especially, this remedy is almost the only one that acts promptly to increase the catamenial discharge. My preference is for the sixth decimal attenuation.

*Alumina* is suited to such cases with scanty menstruation, the flow being pale and followed by great exhaustion, and more or less palpitation of the heart. There is no remedy to compare with it under these circumstances, especially if there is constipation with a torpid, paralyzed condition of the rectum. A strong symptomatic indication, which has been confirmed clinically now and then (when the uterus is displaced backward), is an inability to pass the urine except when at stool. *Alumina*, like *Aloes*, is a remedy that is not so often prescribed in uterine and ovarian affections involving the rectum as it should be. I prefer it also in the sixth attenuation.

## Miscellaneous Items.

**THE LATE PROF. N. F. COOKE.**—The profession and the public were shocked with the news of the sudden death of Dr. Cooke, at 6 o'clock A. M. of Sunday, February 1. The cause of this sad result as shown in the autopsy (of which a report is printed in this issue), was a chronic hypertrophy with dilatation of the heart, a double lesion from which he had suffered for several years.

Prof. Cooke was born in Providence, R. I., August 25, 1829. His literary education was obtained in Brown University. From 1849 to 1852 he traveled very extensively, and returned after having made a complete circuit of the globe. His medical preceptor was Dr. Usher Parsons, of Providence, R. I. He took his professional degree from the Homœopathic Medical College of Pennsylvania in the spring of 1854; entered into partnership with the celebrated Dr. A. Howard Okie, of Providence; removed to Chicago in 1855; was married October, 1856; was elected Professor of Chemistry in the Hahnemann Medical College in 1859; held the chair of Theory and Practice in the same institution for three years ending with 1870, and of Special Pathology and Diagnosis for two years more; gave one brief course on the latter branch in the Pulte Medical College in 1872; and published his book on Antiseptic Medication in 1882. In 1876, at the re-organization of the Faculty of the "old Hahnemann," he was made an Emeritus Professor, a position which he held and honored until the time of his death, and in which capacity he gave occasional short and very acceptable courses of lectures to the students. Dr. Cooke was a genial and scholarly gentleman, of varied and extensive attainments, and a most cheerful disposition, a good writer and an excellent diagnostician. He was a Senior in the American Institute, and an ex-President of our State Medical Association. Of the esteem in which he was held by his colleagues in the Faculty of the Hahnemann Medical College and Hospital, the following resolutions, passed February 11 will bear witness:

**WHEREAS;** It has pleased the Great Father of us all in his inscrutable providence to remove our brother, Prof. N. F. Cooke, from his family, his friends and his professional Fellows; and

**WHEREAS;** The deceased was for so long a time a co-worker with this Faculty in building up and defending the interests of this institution; therefore, be it

*Resolved*, That while this body bows in humble submission and reverence to the decree that will deprive its Members of his fellowship and of his aid in the future, it hastens to express its sense of loss and its affliction in his sudden death.

*Resolved*, That, although this is but the second removal by death of any member of its Faculty during an existence of a quarter of a century, yet the loss is most keenly felt by those of us who survive, and who must continue our labors for the professional and the public welfare.

*Resolved*, That the Faculty hereby extends its heartfelt sympathy to the devoted widow and family of our friend, with the hope that the son, who is now in our college-class, may succeed to his father's good name and reputation.

*Resolved*, That a copy of these resolutions be entered on the records of this body, and furnished for publication to each of the different medical journals.

Dr. S. J. Quinby, of Cheyenne, was married to Mrs. S. R. Johnson, of Greenbush, Ohio, January 22.—Our good friend, Thomas T. Howard, M. D., of Hinsdale, is much afflicted in the recent death of his son, Dr. T. T. Howard, Jr., of South Amboy, N. J.—Dr. Horace E. James has located at 719 S. 9th Street, Philadelphia.—Attention is called to the advertisement of Drs. Farnsworth's Pharmacy at East Saginaw, Mich.—A cordial invitation is extended to physicians to participate in the forthcoming convention of homœopathic physicians in New Orleans, April 9.—Concerning the work of the Illinois State Board of Health, the *Boston Med. and Surg. Journal* says: "The State of Illinois is naturally looked upon as the leading State of the Union in the regulation by law of the practice of medicine, and the official reports of the Board of Health, to which is entrusted the execution of the laws, must be of interest to all who have at heart the good of the profession and the protection of the community from those who would make man's necessity the prey of their selfishness."——Bound volumes of the CLINIQUE for 1884 can be had of our publisher for \$1.50, if sent for early.—The Home for the Friendless, a flourishing charity of this city, which cares for more than 2,000 homeless ones yearly, has been placed under homœopathic management with Mrs. Dr. B. L. Reynolds, Physician-in-chief, Dr. J. P. Cobb, Alternate, and Drs. G. A. Hall, Consulting Surgeon, and R. Ludlam, Consulting Physician.—The Twenty-fifth Annual Commencement of the "old Hahnemann," occurs at 2 P. M. of February 26, with the banquet in the evening. Come along (!)

**THE ALUMNI ASSOCIATION.**—The time appointed for the yearly gathering of the veteran graduates of the Hahnemann Medical College is now at hand, and it behooves them to have their valises packed so that when an opportunity presents they may get off, and turning their faces Chicago-ward be on time for the meeting, Wednesday evening, February 25. The Constitution reads that there shall be no annual dues, neither is there any stipulation that the hat shall be passed around, all of which shows a due regard for the pocket-books of the members. But the Constitution also avers that the Officers of the Association shall be elected from among the members in attendance; hence all those Alumni not looking for a Post-mastership or a seat in the Cabinet this year, will be expected to attend this meeting in the hope of obtaining an office.

**THE PUERPERAL COURSE FOR 1884-85 IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.**—The following is a list of those members of the general College Class, who, during the present winter, have taken Prof. Ludlam's special course on the Puerperal Diseases, and received the certificate therefor:

|                         |              |                         |              |
|-------------------------|--------------|-------------------------|--------------|
| Abbott, Edward S.,      | Maine.       | Carley, James O. R.,    | Illinois.    |
| Anderson, G. H.,        | Kansas.      | Churchill, Mrs. A. E.,  | Wisconsin.   |
| Ashby, Sherman F.,      | Illinois.    | Clark, Edwin J.,        | New York.    |
| Austin, Edson C.,       | New York.    | Colwell, Charles E.,    | Illinois.    |
| Bacon, Earl Z.,         | New York.    | Congdon, Mrs. C. A.,    | Illinois.    |
| Baldwin, Olivia A.,     | Texas.       | Cranson, Cassius S.,    | Minnesota.   |
| Ballard, E. A., M. D.,  | Illinois.    | Cushing, Charlotte W.,  | Illinois.    |
| Barnes, Francis G.,     | New York.    | Cutler, J. W.,          | Illinois.    |
| Boardman, E. W., M. D., | Wisconsin.   | Day, Charles H.,        | Wash. Ter.   |
| Bollen, Christopher,    | Australia.   | Dickey, F. J., M. D.,   | Louisiana.   |
| Bossard, Clement,       | Wisconsin.   | Douglas, Chas. Irvin,   | Illinois.    |
| Bouldin, I. W.,         | Illinois.    | Eddy, V. C., M. D.,     | New York.    |
| Bowers, J. H.,          | Indiana.     | Ertl, Mrs. Mary,        | Wisconsin.   |
| Boyd, Mrs. M. A.,       | Illinois.    | Farrington, C.,         | Kansas.      |
| Bozarth, Charles A.,    | Wisconsin.   | Fellows, Charles Gur-   |              |
| Brien, Daniel H.,       | Wash. Ter.   | nee, A. B.,             | Wisconsin.   |
| Brown, Herbert Wm.,     | Michigan.    | Fink, Mrs. C. E.,       | New York.    |
| Brown, S. Francis,      | Minnesota.   | Finley, David M.,       | Michigan.    |
| Bruce, Augustus H.,     | N. Hampshire | Focht, Adam E.,         | Kansas.      |
| Buckley, S. Byron,      | Illinois.    | Gallagher, Miss,        | Connecticut. |
| Buckner, E. D.,         | Nebraska.    | Graves, Kate I., M. D., | Illinois.    |
| Bushnell, George E.,    | Illinois.    | Green, O. W.,           | New York.    |
| Campbell, Mrs. A. T.,   | Illinois.    | Gruber Charles,         | Wisconsin.   |



---

|                         |               |                          |               |
|-------------------------|---------------|--------------------------|---------------|
| Harris, Mrs. N. R.,     | Iowa.         | Paul, Irvin N.,          | Iowa.         |
| Hassler, Frank,         | Dakota.       | Peaslee, Clara Winsor,   | Michigan.     |
| Hinn, Louis,            | Wisconsin.    | Penny, L. E.,            | Minnesota.    |
| Holden, Nettie J.,      | Kansas.       | Perkins, Ernest D.,      | Illinois.     |
| Hottelman, O.,          | Wisconsin.    | Perrigo, Stella H.,      | Wisconsin.    |
| Howard F., Henry,       | Iowa.         | Peery, Bettie E., M. D., | Missouri.     |
| Howland, Frank A.,      | Kansas.       | Peters, Wesley,          | Ohio.         |
| Hubbard, Wm. A.,        | Iowa.         | Putney, Emma L.,         | Illinois.     |
| Jones, A. C.,           | Missouri.     | Rudorf, Paul,            | Illinois.     |
| Kimberling, I., M. D.,  | Michigan.     | Shattuck, J. F., A. M.,  | Vermont.      |
| Kinley, J. B.,          | Colorado.     | Shults, J. W., D. D. S., | California.   |
| Lager, Mrs. Benedicta,  | Sweden.       | Shultz, C. L.,           | Wisconsin.    |
| Landon, Charles C.,     | Michigan.     | Smith, Mrs. Jennie,      | Iowa.         |
| Landreth, Mrs. M. H.,   | Illinois.     | Spatz, J. Ellis,         | Illinois.     |
| Langstaff, Henry W.,    | Illinois.     | Stanard, O. B.,          | Illinois.     |
| Lee, William H.,        | Pennsylvania. | Stevens, H. F.,          | Vermont.      |
| Lillard, Z. F.,         | Missouri.     | Strader, Alice Hunting-  |               |
| Lockwood, Benjamin F.,  | New York.     | ton,                     | New York.     |
| Lowe, Thomas,           | Iowa.         | Sweet, Emily F.,         | New York.     |
| Ludlam, R., Jr.,        | Illinois.     | Sylvester, William O.,   | Illinois.     |
| Lyman, Mrs. Della,      | Wisconsin.    | Thompson, James H.,      | Pennsylvania. |
| McMachen, Wm. H.,       | New York.     | Thorpe, Mrs. E. L.,      | Iowa.         |
| MacKay, Jennie I.,      | Illinois.     | Tracy, Polly S.,         | Pennsylvania. |
| Mason, Albert E.,       | Illinois.     | Tracy, S. P.,            | Michigan.     |
| Mayer, Charles Raphael, | Louisiana.    | Veenschoten, T., A. B.,  | Iowa.         |
| Menzel, L. Wm.,         | Wisconsin.    | Vincent, Clark H.,       | Michigan.     |
| Morrison, James N.,     | Iowa.         | Walker, Catherine,       | New York.     |
| Morse, J. M., M. D.,    | Illinois.     | Waterhouse, Miss M. F.,  | Pennsylvania. |
| Mueller, Gustave A.,    | Pennsylvania. | Webster, Bernard N.,     | Wisconsin.    |
| Mumaw, Henry A.,        | Indiana.      | Webster, Edwin,          | Illinois.     |
| Murray, Elmore War-     |               | Whittier, G. N.,         | Colorado.     |
| ner,                    | Michigan.     | Wilcox, Sarah C.,        | Iowa.         |
| Myers, Priscilla G.,    | Illinois.     | Willer, M. Albert,       | New York.     |
| Patton, R. L.,          | California.   | Total,                   | 110.          |

---

# THE CLINIQUE.

---

VOL. VI.]

CHICAGO, MARCH 15, 1885.

[No. 3.]

---

## Original Lectures.

---

### *CYSTO-SARCOMA OF THE OVARY.*

---

A CLINICAL LECTURE DELIVERED IN THE HAHNEMANN HOSPITAL OF CHICAGO, FEBRUARY 19, 1885, BY R. LUDLAM, M. D., PROFESSOR OF THE MEDICAL AND SURGICAL DISEASES OF WOMEN.

During the session which is now closing I have shown you more than a dozen abdominal tumors of various kinds, but the case now before you is, in some respects at least, the most interesting of them all. The patient was sent to the hospital yesterday by Drs. E. D. Kanouse & Son, of Appleton, Wis.

*Case.*—Mrs.——, married, aged forty-six, has conceived only once, which occurred twenty years ago. The child was still-born. She enjoyed comparatively good health until fourteen years ago, when an enlargement was observed in the left ovarian region. This enlargement grew slowly for a period of five years, giving rise to no special inconvenience. The abdomen had attained a circumference of between thirty-six and thirty-nine inches, when she received a fall, soon after which the abdominal enlargement diminished. From this sudden disappearing of the tumor it was supposed that it must have been ruptured by the fall. No perceptible discharge occurred, neither did the patient suffer any special shock or inconvenience, saving a slight weakness for a few days.

Following this accident an enlargement appeared in the right ovarian region, developing quite rapidly for eighteen months, when it also was ruptured spontaneously. At this time a very small quantity of a thin, inoffensive fluid escaped per vaginam.

This sac apparently refilled, and in one year more ruptured again ;

the abdomen decreasing in measurement within about twenty-four hours, from a circumference of forty-one to twenty-two inches. At this time there was a clear, inoffensive, syrupy exhalation from the skin, necessitating a constant sponging of the patient for three days and nights, and then it gradually disappeared. No serious illness followed, and the patient was about as usual, after a lapse of ten or twelve days.

But this did not end her trouble, for soon after it was noticed that the tumor was again developing. The progress of this growth has been very much slower than that of the preceding two, having covered a space of six years in attaining its present size.

During the last five years the menstrual periods have been very irregular. The flow is copious, dark-colored and clotted, lasting as a rule for ten days, and being accompanied with, and preceded by intra-pelvic pain, notalgia and cephalalgia; and during the past two years the flow has been of an extremely offensive odor. She occasionally has a slight intra-pelvic pain during the inter-menstrual period. The urine is normal; the bowels are constipated; the œdema of the lower limbs is quite marked.

Her mother died at the age of fifty-six of cancer of the womb, and an aunt, her mother's sister, died of some morbid growth of the stomach; but with these exceptions the health of the family seems to have been good.

I will not repeat what has already been said and shown you, concerning the different methods of physical diagnosis in abdominal tumors, but will proceed at once to discuss the peculiar clinical features of this case. Observe, then, that percussion gives a singular outline to this contained growth. I will mark it with a pen, so that you can all see it. While its margin on the left side, and transversely below the thorax, is rounded, it gives us a triangular patch of resonance on the right side, the apex of which points across the abdomen, and nearly reaches the mesian line, about half way between the umbilicus and the pubes. (See Fig. 1). Such irregularities of outline, and there is a variety of them, almost always signify that the tumor is composite, or partly solid and partly cystic. That this tumor is partly cystic is shown in the history of its having been ruptured, as well as by a perceptible fluctuation, especially at its left and superior portion.

Although you are aware that the womb is usually drawn upward and forward in ovarian tumors, it may surprise some of you to learn that it can not be felt or found, per vaginum, in this case. When the uterus is lost in this way it may be a good or a bad sign. It is always

an obstacle to diagnosis. It may have adhered to the wall of an ovarian cyst, and been retracted as the sac has developed, and no harm come of it; but if it is included and imbedded in a solid growth that lies above the superior strait, the case is very different. We shall see.

But what of the repeated rupture and the disappearance, as well as the refilling of this tumor? Briefly there are three kinds of rupture which may either temporarily or permanently dispose of the fluid contents of an ovarian cystoma: (1) there may be a leak through which the fluid is discharged very gradually; or (2) there may be a breaking down of the partition walls of a multilocular cyst, so that its compartments may communicate, and the shape and size of the tumor be changed; or (3) it is possible to have a large-sized rent through which the fluid may be poured into the peritoneal cavity. The causes for either of these kinds of fracture is atrophy or distension, or both, and not ulceration of the cyst-wall, as is generally supposed.

A considerable share of these cases of spontaneous rupture recover, and the cyst does not refill; but others are fatal. You should remember that, when the first rupture is not accompanied by shock, or followed by illness, and especially if there is no reaccumulation of its fluid contents, the tumor is a cyst of the broad ligament, or something else, and not a proper ovarian cyst.

Not only does the true ovarian cyst fail to disappear by a spontaneous evacuation, or even by a single tapping, but it is peculiar in another respect, which is that every time it refills its contained fluid becomes more depraved in quality, so that, although such a cyst might possibly break for the first time and pour its innocuous contents into the peritoneal cavity without harm, this thing could not be repeated very often with impunity. We do not know, and nobody knows what kind of fluid escaped from this sac when it collapsed the first, or even the second time that it yielded; but if this last accumulation is ovarian, it is next to impossible that it should not be vitiated.

The irritating and poisonous qualities of the ovarian fluid, especially if it comes from an old sac, are known to you. When such a tumor has been tapped a very few times it becomes septic in a high degree, and this is why repeated tapping increases the risks of a subsequent ovariectomy. Providing death does not follow from shock, or

peritonitis, or hemorrhage, or from all these, an early or a repeated rupture of the cyst-wall will have the same effect.

From this point of view, therefore, you perceive that, since this growth has so nearly attained its maximum size, or the point of distension at which it burst on two former occasions, our patient is really in a perilous condition. On the theory that the fluid which fluctuates beneath my hand is very poisonous, it should not be permitted to escape into the abdomen; for the greedy lymphatics, of which the peritoneum is almost entirely composed, would absorb it and develop a speedy and fatal infection.

There is another reason why I have brought this woman before you, *id est*, to illustrate the impossibility of making a satisfactory diagnosis in some of these cases without a resort to tapping, or to the exploratory incision. The former of these final methods of diagnosis has been very much abused—abused by those who have practiced it without the proper discrimination, and whose carelessness has greatly increased the mortality from ovariectomy, and more recently abused by a few leading specialists who go to the other extreme, and who insist that it should no longer be practiced under any circumstances whatever.

Now there are several good reasons why, in my judgment, tapping is advisable in this case, which is certainly an exceptional one. They are (1) to avoid the imminent risk of another rupture, for the circumference of the abdomen is thirty-nine and a half instead of forty-one inches; (2), to remove the fluid in order that it may be examined; (3) to get it out of the way of a further physical exploration; (4) to decide whether the tumor is wholly cystic, or if it is composite, and, if possible, to find the whereabouts of the womb; and (5) to enable us to decide intelligently whether, and if so, what further operative treatment is expedient and necessary.

Tapping is usually a very simple operation, but in such a case as this, we must proceed cautiously. With the peculiar form and outline of this tumor, and this acute angle of resonance coming so near to the mesian line, we might puncture a coil of intestine; or, if the cyst-wall happens to be very weak and attenuated, it may leak around the needle, or the canula, or possibly fail to close the orifice when the instrument is withdrawn. It will be safer, therefore, to use the aspirator than to take the ordinary trocar, although it may happen that the fluid is too thick to flow through its slender needle.

The patient is sensible and intelligent, and is quite willing for us to do whatever is best. We will, therefore, try the tapping as a means of relief to her and of information and help for ourselves, but not as a curative measure. Having selected a point on the linea alba one-third the distance below the umbilicus, the skin is touched with a strong solution of carbolic acid to anesthetize it, and as an antiseptic precaution. In passing the needle I feel that it enters a cavity and is fairly within the compartment containing a fluid. My assistant exhausts the air-chamber of the instrument, and you will see in a moment what kind of fluid fills the sac, and whether my prediction that it is bad enough is verified. I turn this little stop-cock, it flows freely, and you can all see that it is of a *dark, chocolate color*. It is morally certain that, if this fluid had escaped into the peritoneal cavity, the risk of malignant infection would have been very great. I do not see how she could possibly have survived it.

The aspirator empties these large collections very slowly, but it is a safer instrument than the old trocar, not only because there is no possible admission of atmospheric air into the sac, or the tissues, but because the discharge is so slow that it prevents shock, and permits the abdominal organs gradually to accommodate themselves to their change of position. \* \* \* \*

We have now emptied the tumor of its fluid contents, *eleven and a half pints* in all of this chocolate-looking mixture, and I am going to withdraw the needle. This fluid is all of one kind, which is evidence that we have had to do with a single sac, and we may learn something by the careful removal of the needle. Observe that I hold it in a peculiar position so that I may know if the sac has collapsed, and may be able to indicate its place of attachment when it drops from the point of the needle. She will now be carried to one of my private rooms in the hospital, where she will have every care to prevent any ill-effects from this operation; and, if everything goes on well, I will complete the examination and the diagnosis in this amphitheater in a few days, or as soon as it can be done with safety.

*Monday, February 23.*—Our excellent house physician, Dr. Eddy, has had such a care of our patient that she has escaped all harm, and I have had her brought before you again. You will observe the difference in the contour of the abdomen. The enlargement at its upper part has disappeared, the belly is hollowed out, and the

line of dulness is horizontal, passing transversely about one-third of the distance below the umbilicus (see Fig. 2). Above this line the abdomen is resonant, below it the sound is flat; above it the distended sac has collapsed and disappeared, below it the tumor that remains is solid and immovable. The uterus can not be identified, either internally or externally. The mass is irregular, not rounded like a benign fibroid, and not sensitive as it was at the close of the tapping.

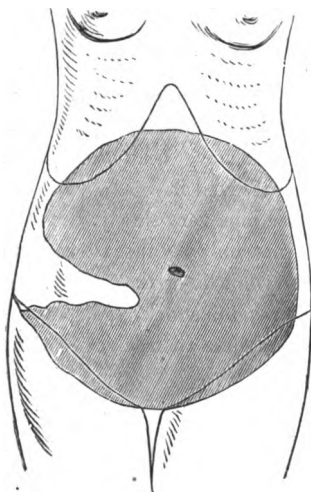


FIG. 1.

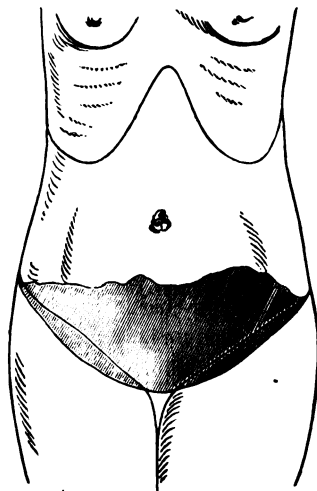


FIG. 2.

The patient has stated one fact not contained in the record of her case, which is that, directly after the rupture of the sac six years ago, the abdomen "was as flat as that of a young girl," and that there was no sign of any remaining tumor in it. If this is true, and I see no reason to doubt it; if the uterus was retracted then as it is now; and if the menorrhagia began soon after, it is fair to infer that the development of the solid portion of this tumor followed the development of its cystic portion. This order of sequence is the reverse of what takes place in fibro-cystic tumors of the uterus. But in cysto-sarcoma, and also in cysto-carcinoma of the ovary the solid part may be first and the cystic secondary, or *vice versa*.

But, what is this solid growth? Is it benign, or malignant, carcinomatous or not? It is manifestly ovarian, although the uterus is

certainly involved and included in the mass. I believe it to be a cysto-sarcoma of the ovaries, although in some respects it resembles a cysto-carcinoma of the same organs. Here is a parallel between the symptoms of each :

*Ovarian cysto-sarcoma.*

The rounded outline of the tumor.

The tumor is not especially sensitive.

There is almost always a history of menorrhagia.

Almost never a pronounced ascites, or any dropsy of the feet.

The pulse is not habitually rapid.

There is no peculiar cachexia.

The solid portion of the tumor develops slowly.

*Ovarian cysto-carcinoma.*

The surface of the tumor is irregular and nodulated..

It is almost always tender and sensitive.

Menorrhagia is exceptional.

Ascites and anasarca are the rule and not the exception.

The pulse is like that of phthisis.

In a confirmed case the cachexia is always present.

The more malignant the solid growth the more rapid its development.

Is this a suitable case for ovariectomy? I think not. The tumor, if not really malignant, is of the recurrent variety; the pelvic adhesions are very formidable, and the uterus is lost in the tumor and must come out with it. The case is very like the one in which you saw me remove both ovaries and a portion of the womb in October last, and which terminated fatally. I have now operated upon five cases in which the uterus could not be identified before the incision was made. Of these three have indeed recovered, but in each of the three that organ was adhered to the ovarian cyst, and had been retracted beyond reach. In the other two it was lost in a solid mass like this. I saw a case like this when in Liverpool, two years ago last September, at the request of my friend, Dr. John Moore. Within a month afterward it was operated upon by the celebrated ovariectomist, Dr. Keith, of Edinburgh, but, despite his acknowledged skill, resulted fatally. So that, with the history that has been given you, and the points that have been made concerning this patient's case, I think it most prudent and advisable to send her home without an operation, for, in all human probability, she would not survive the removal of this mass.



## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

### MARCH MEETING, 1885.

The Clinical Society met in regular session on Saturday evening, March 7, at 8:30 o'clock, in Club Room 4, of the Grand Pacific Hotel, Dr. J. E. Gilman, President, in the chair. The physicians in attendance at the Practitioners' Term of the Hahnemann Medical College added their quota to the number present. After some proposals for membership the President called for the

### REPORT OF THE BUREAU OF SKIN DISEASES,

T. S. HOYNE, M. D., CHAIRMAN.

**RINGWORM.**—BY DR. T. S. HOYNE—As the profession frequently wrongly apply this term to a variety of affections, which present a similar appearance to ringworm, that is, to any eruption which exhibits a more or less circular patchy form, very much as they apply the name salt rheum to all cutaneous affections of the hands, it has been thought advisable by this Bureau to make ringworm the subject for discussion. The dermatologist recognizes several varieties of ringworm under the following names: *Tinea tonsurans* (or ringworm of the scalp), *tinea circinata*, or, to use the old name, *herpes circinatus* (of the body), *tinea kerion* (of the scalp), *tinea barbæ* or *sycosis* (of the beard), *eczema marginatum* (of the thighs), Chinese itch, Malabar itch, etc., all due to the presence of the same parasite.

Briefly ringworm is a contagious parasitic disease, occurring especially during the nutritive period of life, but not entirely confined to the young. It affects different parts of the cutaneous surface, frequently spreading from one portion to another. When confined to the scalp it is called *tinea tonsurans*. This variety occurs mainly in children, and is characterized by the short, broken off hairs; when it extends to the non-hairy portions of the body, or occurs here in the first instance, it is known as *tinea circinata*. This latter variety is met with at all ages, and in both sexes. *Tinea kerion* is simply an exaggerated form of *tonsurans*, with more or less swelling of the parts, and

a boggy feel. When ringworm is located about the fork of the legs, or in locations which are hot and moist, it receives the name of *eczema marginatum*. Burnese ringworm affects the fork of the legs, buttocks, chest, and in some instances is limited to the face. The disease is an aggravated form, owing to the excessive temperature of the place. Malabar itch is very similar.

The same general characters are present in every form of ringworm. The disease begins as a small circular slightly elevated patch or patches of a pale red color, increasing gradually in size by centrifugal growth. There is slight furfuraceous desquamation, and in the scales and hairs is found the vegetable fungus *trichophyton tonsurans*. Itching and burning is present to a greater or less extent, but is never as severe as in *eczema*. The diseased patch, which is seldom larger than a split pea at first, enlarges by degrees, but throughout its course retains its ring form, unless two patches should coalesce. After a time the center of the patch may become healthy and nearly white, while the outer edge or ring, which is sharply defined, may consist of minute vesicles or papules. Ringworm attacks all classes—those in prosperous circumstances as well as the poor, but it is usually only in those whose general health is somewhat impaired that the parasite finds a suitable soil for its nourishment and growth. Eczematous subjects seem to be more liable than others to furnish a rich ground for its speedy development. It is quite rare, however, in very young babies. The disease may be transmitted from the human race to certain dumb animals, and vice versa.

The diagnosis of ringworm is not particularly difficult, when it is remembered that on the scalp the patches are covered with numerous stumps of broken-off hairs, and upon the non-hairy portions of the body the patches are circular, red and slightly elevated, or perhaps a whitish center surrounded by a ring of vesicles or papules, this outer edge being sharply defined.

The diseases which resemble ringworm to a greater or less extent are squamous *eczema*, *pityriasis*, *seborrhœa*, *psoriasis circinata* or *nummularis*, *lupus erythematosus* and *syphilis*, which resembles almost every skin disease in its progress. It is important to make a correct diagnosis, as the treatment varies considerably, especially as regards local treatment.

Squamous *eczema*, occurring in separate patches, is sometimes mistaken for ringworm. The main diagnostic points are, in *eczema*

there is no tendency to clear up in the center, the itching is very annoying, especially at night, the patches are not perfect circles, but are very irregular in form, and the edges of the patch are not sharply defined. In very chronic cases the microscope must be relied upon.

Pityriasis has been mistaken for ringworm on account of the small branny scales and the reddened surface. In pityriasis, however, we do not observe the circular patches clearing in the center and extending at the outer edge by means of vesicles or papules.

Seborrhœa of the scalp has been called ringworm, but in this affection the scales are a dull dirty white, adhering closely to the scalp.

A very common error is to mistake psoriasis circinata or nummularis for ringworm. In psoriasis the patches are covered by white silver-like scales, on the removal of which the skin shows minute red bleeding points; there is no clearing up of the center of the patch, and there is after a time no itching of consequence. There are no vesicles at any period of the disease.

Occasionally ringworm is mistaken for syphilis. The history of the case, the absence of itching and other signs of syphilis render the diagnosis easy. And lastly, it may be confounded with lupus erythematosus. In the latter affection the diseased patch is covered with grayish-brown scales, firmly adherent, and on being removed disclose the gaping mouths of the ducts of the sebaceous glands.

The treatment consists first in improving the general health of the patient and in absolute cleanliness, for a parasite cannot thrive unless the soil is suitable; second, in the use of mild non-irritating parasitocides; and thirdly, in the selection of the proper homœopathic remedy. It should be remembered, however, that ringworm on the non-hairy portions of the body is sometimes self-cured by the desquamative process. Our allopathic friends use for local applications the acids mainly, viz.: Acetic, carbolic, boracic, chromic, chrysophanic, nitric, sulphurous, etc.; also mercurial, sulphur, and other ointments. Diluted acetic acid is one of the best. Internally one of the following remedies may be required:

*Arsen.*—When the scalp is dry and rough; hair falling out in patches here and there.

*Brom.*—For offensive smell of the head, with tenderness of the scalp.

*Phos.*—When the bare scalp looks clear; white and smooth; small bald spots over the ear; hemorrhagic tendency.

*Calc.-carb.*—When the cervical glands are swollen.

*Carbo.-animal*—Where the beard is affected.

*Graph.*—In children with obstinate constipation.

*Sepia.* produces an eruption very like ringworm, and has, perhaps, cured more cases than any other one remedy. Women with thin, delicate skin.

*Tell.* is a very valuable remedy according to Dr. Hughes.

*Rhus.*, *Caust.*, *Sil.*, *Sulph.*, *Vinca*, etc., have proved curative in many cases.

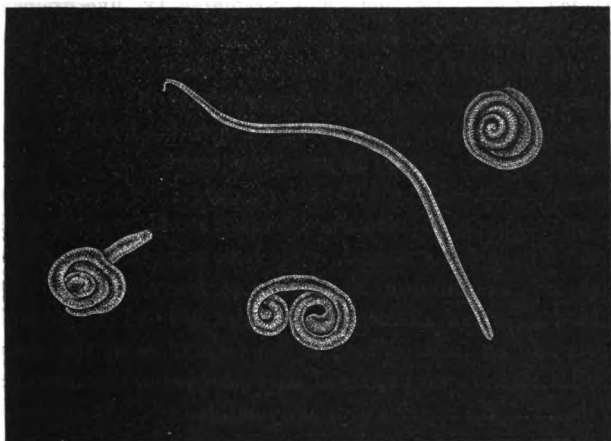
Many cases yield to treatment in a very brief time, and others again hang on for months, or recur just as one imagines that they are cured. The parasite should be looked for with the microscope before ceasing treatment entirely. The diseased child should not be allowed to go to school or to associate with other children, for the spores are carried from one to another by the use of brushes, towels, etc., and even by the air of the room.

TRICHINOSIS.—BY M. R. WAGGONER, M. D., DEWITT, IOWA.  
—December 21 I was called to the neighboring city of Grand Mound, to visit Perry T. Miller, age twelve years, whose health previous to this attack had been good. On December 1 he had a severe attack of diarrhoea; the evacuations were yellow, slimy, and attended with a moderate amount of pain; he was worse at night, during which time the discharges were involuntary; this continued an entire week, resisting ordinary domestic remedies. Then the diarrhoea ceased, and he began complaining of soreness of all his muscles, which would soon cease after he had moved about. December 11, he walked nearly a mile to see after stock; while out a storm came on, and he got drenched in the rain. The next day he was not able to get out of bed, complaining of soreness of all his muscles. The abdomen was tender, and he had a constant fever. At this time an old-school physician was called, who diagnosed typhoid fever complicated with muscular rheumatism. The treatment consisted of cathartics, quinine and acetate of potash. No improvement following, he was discharged, and I was called as above stated. I found the symptoms as follows: Œdema of the entire body; pulse, 110, temperature, 101; tongue coated white, very red at the tip

and sides, and the breath offensive. He lay on his back, and had not been able to turn, nor could he be turned on either side, since he took his bed. The flexor muscles all seemed too short. The fore-arms were flexed at right angles with the arms, and could not be extended; legs semi-flexed. Movements of any kind were painful, and while at rest (?) the pain was so intense in the muscles that he had not slept longer than five minutes at a time since he took his bed. The pains changed rapidly from place to place. When asked to describe the pain, he said "it hurts." His jaws could not be separated more than three-eighths of an inch, nor could he protrude his tongue beyond his teeth. He was very irritable and restless; wanted to be moved a little in bed every few minutes, although his pains were all aggravated by every motion. The skin was hot and dry; yet, during the evening, when his fever was the highest, he perspired like rain. The perspiration was extremely offensive. No disturbance of the bowels since the diarrhoea ceased. Urine, one pint in twenty-four hours, acid reaction, specific gravity (at 60° F.) 1035. On cooling there was a heavy deposit of a bright pink color, which cleared up by moderate heat. There being no further change from boiling or the addition of nitric acid, I pronounced this urates. The respiration was hurried and shallow, thirty-five per minute. There was great tenderness of the abdomen on light palpation, and still greater tenderness of all the inter-costal spaces, in fact, all the muscles were tender. The fingers were semi-flexed and fixed. They could neither be flexed further nor extended. There was moderate delirium at night, and the patient constantly grew weaker. The appetite was irregular; one day ravenous, next day wanting nothing. He was very thirsty all the time, drinking large amounts and often. The parents were anxious to know "what was the matter with Perry." They said the doctor who preceded me had remarked "there was something in this case which he did not understand." I inquired if he had eaten raw meat recently. They said no. Reserving my opinion until my next visit, I gave *Aconite*, 1x, and *Rhus Tox* 2x, in hourly alternation. Locally I had the entire body sponged with a strong and hot solution of salt and water every twelve hours, and directed that milk should be used to satisfy the constant thirst.

December 23. On entering the room the mother remarked, "Murder will out." "They had been talking about the question I had asked, and Perry now remembered of taking up a handful of

pork sausage, all he could hold in his hand, while at the meat market getting meat for the family, and ate it while coming home." This was a few days before the diarrhoea came on. The sausage had all long since been disposed of at the meat market, so that no specimen could be obtained for examination, and Perry refused to become a martyr to science. Nevertheless, I diagnosed trichinosis or traumatic fever from the presence of the *trichinæ spiralis*. It was not rheumatism, as there was no articular swelling, redness, heat or pain. It was not muscular rheumatism, for every muscle in his body was affected, while in the latter only a few muscles are affected at a time,



TRICHINÆ SPIRALIS UNDER THE MICROSCOPE.

and then not attended with fever. There was a marked prostration which does not attend muscular rheumatism. The temperature was too low for typhoid fever, and the diarrhoea preceded the fever nearly a week, while in typhoid fever the diarrhoea occurs during the second week. It is difficult to conceive how trichinosis, with its profuse drenching perspiration during the fever, oedema of the whole body (the joints excepted), and the characteristic rigid contraction of all the flexor muscles, can be mistaken. At this visit the pulse was 95; temperature,  $100\frac{1}{2}$ ; respiration, 30; urine passed, one pint, sp. grav., 1035. No change in the muscular condition. He had slept fifteen to twenty minutes several times, but wanted to be moved often, and complained that his bed was too hard.

*Arnica mont.* 2x every two hours, and local treatment same as ordered at my last visit.

December 24.—Pulse 95; temperature  $99\frac{1}{4}$ ; respiration 30. The lad slept half an hour several times and did not want to be moved so often.

Continued the *Arnica* 2x every two hours.

December 25.—Pulse 98; temperature  $100\frac{1}{4}$ ; respiration 32. Craving appetite. He had a restless night, and complained constantly of the bed being too hard, and wanted to be moved often; the pains were aggravated by moving. He perspired like rain during the night when the fever was at its height, and he constantly bored his finger in his nose or kept picking at it.

*Arnica* 2x every two hours and *Santonine* 1x, five grains night and morning. The local sponging as before stated was repeated as long as the fever and offensive perspiration continued.

December 27.—Pulse 108; temperature 100; respiration 30. He rested better, otherwise no change except that he did not bore at his nose as before. *Arnica* 2x every two hours.

December 29.—Pulse 110; temperature  $100\frac{1}{4}$ ; respiration 28. He reports having rested better, and does not complain of the bed being so hard. The appetite is good. We have to restrict the amount of food taken. He can move his arms more freely, and can now protrude his tongue half an inch beyond his teeth and can separate his jaws over half an inch. There is less tenderness of the abdomen, but the intercostal spaces are still very sensitive to pressure over the entire thorax. He remains constantly on his back. There is oedema of the lower extremities, the ankles pitting easily. He passed one and a half pints of urine in twenty-four hours. Spec. grav. 1033; no albumen. *Arnica* 2x every three hours.

December 31.—Pulse 125; temperature  $102\frac{1}{4}$ ; urine two and a half pints in twenty-four hours; spec. grav. 1032. A miliary rash has come out over the thorax, abdomen and upper extremities, attended with intense itching. His appetite is less, but he still takes more than two quarts of milk each twenty-four hours. *Arnica* 2x and *Ars.* 4x in hourly alternation. The anasarca condition has increased, extending to the lower part of the abdomen; the scrotum is enormously distended with the effusion, but at no time could I detect hydroperitoneum.

January 2.—Pulse 110; temperature  $100\frac{1}{4}$ ; respiration 27; urine two and a half pints; spec. grav. 1030; very little perspiration on the upper part of the body. The abdomen and lower

extremities perspired in large drops like rain, and most profuse during sleep. He hawks and expectorates bloody mucus, and has a similar discharge from the nose. He now sleeps an hour at a time, and last night he slept ten minutes on his side, the first time he has done so since he took his bed. He has had one or two natural evacuations from the bowels each day. There was a steady improvement noted from this date on.

January 7.—He has slept an hour at a time on either side. The anasarca is diminishing. The *Arnica* and *Arsenicum* were continued until the 18th of January, when he could turn on either side without assistance. This was the first time he had been able to accomplish this act since he was taken ill, thirty-eight days ago. The muscles are now relaxing and the dropsy is all gone. His urine has increased to three pints in twenty-four hours; spec. grav. 1020. *Arnica* 2x, four doses a day. Three days later all medicine was discontinued. He now shows great emaciation. The knuckles are prominent, the inter-metacarpal spaces sunken, and the whole body wasted like that of a person in the third stage of phthisis pulmonum. I saw the patient last on February 4. His pulse was 95; temperature 99. He sleeps well; his appetite is good; he has no unnatural thirst, and is gaining in flesh. He tried to stand up to-day, but could not get his heels to the floor on account of there still remaining some rigidity of the gastrocnemius muscles.

Alimentation I consider played an important part in the treatment. Milk furnished the elements of nutrition in a readily assimilable form for the repair of the injured tissues and the maintenance of the vital forces until the process of encapsulation of the trichinæ could be completed. The pathology of trichinosis is essentially a mechanical injury. "The cause of the oedema of the face and extremities occurring almost constantly in extensive infection with trichinæ lies, according to Colberg, in the destruction of the capillaries of the muscles in the part affected by the wandering trichinæ and the tissue surrounding them; the oedema disappears with the establishment of the new capillary net-work."\*

*Arnica* was the remedy not only from a pathological stand-point, but was well indicated by the totality of the symptoms.

[The cut represents the microscopical appearance of trichinæ spiralis obtained from a specimen of trichinous pork forwarded us by Dr. Kreider of Springfield, Ill.—ED.]

---

\* Wagner's Pathology, page 235.



HEPATIC ABSCESS.—BY JAMES C. WOOD, M. D., MONROE, MICH.—Herewith I send you a report of the case from which the specimen of liver sent you last December was taken. I never saw the case, but the urine was submitted to me for examination, and as several of my *confreres* were equally puzzled and interested, it appears to me to be worthy of record. A peculiar fact about the urine was that although it was loaded with leucine, the most careful examination failed to detect any tyrosin. The *post-mortem* was made by physicians residing in another section of the county, and it was my misfortune not to be able to attend it. The decision I had arrived at that the liver was in an atrophied condition, because of the discovery of leucine in the urine, was completely dissipated by the word sent me after the autopsy to the effect that the liver filled a large "milk-pan." The urinalysis made by me November 13, 1884, reads as follows :

For A. S., at the request of Drs. Sawyer, Jones and Gunrolus.

*Physical and chemical characters.*—Total quantity for twenty-four hours, unknown, but not so very much suppressed; color, dark brown; re-action, strongly acid; sp. gr., 1030; deposit, abundant and dark; urea, decreased; urates, heavy deposit; phosphates, almost entirely absent; sugar, none; albumen, none.

*Microscopical examination.*—Crystals of leucine in great abundance, and epithelium from the kidney tubes.

The history of the case as obtained from the wife of the patient in answer to my letter of inquiry, I transcribe in full. Her letter is dated Dundee, December 15, 1884.

For the respect I bear to you, I will take time to answer your questions in regard to my husband's sickness.

When did the diarrhoea begin? It commenced when he was in the army. He lay at Chattanooga three weeks. There had been a heavy battle fought on the piece of ground where they camped. The water was not fit to drink, and it caused him to have a diarrhoea, which he continued to have all the time he was in the war. Some times it was quite bad, at others not so severe. When it was very bad he chewed white-oak bark to check it. He was in the army nine months, and then came home sick with this trouble. After coming home he would take white-oak bark tea, or allspice boiled in sweet milk to check it, but he never got it stopped. The diarrhoea ceased last May; then he had to commence taking physic to have a passage from his bowels. He took one pill every night, or two every other night, until you commenced to treat him; then I gave him in-

jections. When he first returned home he complained of pains in the front part of his head and in the small of his back. When he was very tired he complained of a pain in his right side, or breast as he called it. After being home about three years (that would be in the summer of 1868), he began suffering with bleeding piles, and he has had them very bad ever since.

How long has he complained about his liver? He has had a pain in his right side for as much as fifteen years. The first year that he owned his clover-huller, fifteen years ago, he said that he could not stand it to thresh, for it gave him a pain in his right side. He has complained of it more or less ever since. He has also suffered a good deal from a pain in his stomach as well as in his side, and the odor of his breath has been bad for a number of years, especially for the last five or six years.

When was he taken down in bed? He has been confined to his bed since about the 1st of October. He could do nothing more than walk out as far as the granary or barn since the 1st of August last.

How was he first taken, chills or fever? He was taken with a fever on the first day of August, and it continued returning every afternoon and night for about two weeks. He did not sweat when the fever would go off, but he gradually grew weaker each day. He had also a severe pain in his head and back, which was so bad that I kept a cloth wet in cold water on his head, and applied a plaster to his back. The plaster eased his back, but his head did not stop aching until you came to see him. He had spells of nausea and vomiting when it would almost kill him to vomit. All during his sickness he raised a great deal of mucus streaked with blood. After you commenced to treat him he did not raise so much. He has been troubled with cold feet as long as ten or twelve years. After being confined to his bed they became much worse. I then had to keep warm bricks about his feet and the calves of his legs. He had a great deal of pain in the lower part of his stomach and in the lower part of his bowels. The pain in his bowels was so bad that I kept cloths wet in hot saline water and put them across him, or instead I would apply a ginger or a mustard poultice. His suffering at times was beyond description. He would kick and thrash and throw himself about so with pain that it took two to keep the bed-clothes over him. About forty-eight hours before he died he had a sinking spell, and we thought that he would not breathe more than a few times more, but he revived to experience again the awful pain and suffering until he died. He was conscious by spells till within a short time of his death.

His urine was of a dark coffee color, and had a very bad odor. The last three days of his illness he was unable to rise even to respond to the calls of nature, and the urine tinged the linen an orange color, and the stain was very hard to wash out. He was unconscious only a small part of the time. The greater portion of

the time he knew his family, and if asked a question he would answer us.

When did he commence to bloat? His stomach and bowels bloated a good deal the last four or five weeks of his life. His feet bloated slightly a day or two before you came to see him, but after taking your medicine it was scarcely noticeable.

In regard to his heart, there has been a long time that after running a few steps or lifting something heavy he would tremble and have great difficulty in breathing, and complain that it hurt him in his breast. He has not been able to do a hard day's work for a number of years, in fact, not since he came home from the war. His appetite has been very poor for about three years."

Additional information is furnished me by the attending physician, Dr. K. Gunrolus, of Dundee, in the following communication :

DEAR DOCTOR.—I attended Mr. S. six or eight weeks before his death. I say attended; made him six or eight visits only during that time. The most prominent symptom that I noticed was the abundant secretion of saliva (he took no mercury). His pulse the most of the time was full and regular. His temperature was normal during my visits, with the exception of once or twice, when there was a little rise. He had some pain over the region of the liver, but it was not constant, nor was it at all severe. For two or three weeks before his death, however, Mrs. S. tells me that he suffered intense pain over the region of the liver, but during this time I did not see him. He had a chronic diarrhoea ever since he came out of the army. While I attended him his bowels were quite regular. I examined his urine two or three times, but kept no notes, and do not remember with what results.

There were present at the *post mortem* Dr. Jones, of Ida, Dr. McDonald, of Petersburg, and myself. The external appearances were extreme jaundice of the skin and conjunctivæ, and the body was considerably emaciated. On opening the thorax, we found the lungs normal, and some old pleuritic adhesions on the left side. The heart was of natural size, but had some appearance of fatty degeneration, particularly along the course of the coronary arteries. The cavities and valves were all natural, with the exception of the parts at the commencement of the aorta. There was a bony ring surrounding this opening, involving somewhat the base of the semilunar valve.

The abdominal cavity.—The liver was found to be about twice its natural size, presenting the same appearances both external and internal, as the portion I sent you, which was taken from the left lobe, so I will leave you to draw your own conclusions as to its pathology, etc. I might add, however, that there were two or three circumscribed abscesses in the substance of the organ, one, the largest, the size of a base-ball.

The gall-bladder was empty, barring one calculus about the size of a marble which we found in it.

The stomach was normal in size and healthy. There were no lesions whatever of any of the remaining abdominal organs.

K. GUNROLUS.

The specimen of the concentrated urine which I have sent you has been standing under a cover glass for the last month. This was obtained by filtering and washing with dilute ammonia, after which it was evaporated to the consistence of syrup, when it was agitated in an equal quantity of ether, and then set aside for some days until evaporated to almost dryness. I think that you will find abundant crystals of leucine in this—possibly not so perfect and large as before the evaporation, nor so highly colored with biliary matter. I tried very faithfully the methods of Thudicum, Harley and Vaughan, to also produce crystals of tyrosine, but failed in every instance. That their non-association in this peculiar pathological condition may be significant and of diagnostic value, I do not know. Simply from the history of the case in conjunction with the abundant deposit of leucine, I suspected "acute yellow atrophy," and consequently was somewhat surprised when the report of the autopsy was handed me. Dr. O. I. Sawyer, my associate, had charge of the patient during the last ten days. The relief which Mrs. S. speaks of was from *Arsenicum* and *Phos*, the last being given upon the supposition of the pathological condition being acute yellow atrophy. A part of the sequela is now in your possession (the liver section), and it corresponds to most recorded cases where an abundant deposit of either leucine or tyrosine has been found in the urine.

HENKE'S ATLAS OF SURGICAL ANATOMY.\*—This work contains eighty-one well executed plates representing different portions of the human body. The assistance which it offers the student of anatomy either in the lecture-room or at his dissections is manifest to one who scrutinizes its pages, and is not over-estimated by the translator in his preface. The plates of the head and neck are exceptionally fine. The illustrations of the various sections of the brain are exceedingly well executed, are numerous, and respond to the demand in the medical profession for more perfect knowledge of the cerebral anatomical relations. The different sections of the face,

\*Translated by W. A. Rothacker, M. D., Pathologist to Cincinnati Hospital; Lecturer on Pathological Anatomy in Miami Medical College.

mouth and throat serve their purpose of giving definite information of these organs and assisting the surgeon in his operations about these parts—operations rendered difficult by the complicated and minute anatomy of the regions. The plates of the thorax would not seem so serviceable or complete. Best of these seems that of a horizontal section through the third inter-costal space. The plates of the abdominal cavity are many and good. The necessity for perfect representation of the pelvic cavity, the hips and the gluteal regions has been observed. In the plates of the extremities, the joints are well given, the muscles obstructing view being cut away so as to give a clear idea of the relations of the vessels and nerves to the ligaments and bones. The relative positions of the muscles, vessels and nerves during flexion of the limb, as well as the relation of the bones of the forearm to each other and the parts about them during pronation and partial pronation are well presented. Throughout the book there is an originality of representation, the sections, except in a few instances which seem to be reprints, being made in directions different from those ordinarily given. This is notably true in regard to the plates of the head.

While there are many things to commend in this book as a guide or assistant to the anatomist, the pathologist, the student or the ordinary practitioner, as an aid to the specialist in surgery, beyond the important part that anatomy must always bear in his work, it falls short; in other words, it does not seem fully to merit its title, "*Surgical Anatomy*," no especial advantage to the surgeon being apparent in the work as a whole.

G. F. S.

## Miscellaneous Items.

PROF. HALL is at home again from a short trip South.—Dr. Chas. G. Fellows, '85, has located at 96 Canal Street, New Orleans.—Dr. H. W. Wells, '84, has been appointed surgeon to the Wisconsin Central Railway.—Both of Dr. Richard Hughes' books have been translated into Spanish.—An Alumni Association has been organized for the Hahnemann Medical College of Philadelphia.—Dudgeon's Sphygmograph is on sale by Halsey Bros., 27 Washington Street, Chicago.—Prof. Frank Wheeler, demonstrator, is off on a visit to Government Park, Montana.—Dr. William H. Sweeting was married to Miss M. E. Van Wickle, of Savannah, N. Y., January 15.—Dr. M. O. Terry, of Utica, is the new President of the New York Homœopathic Medical Society.—The Homœopathic Hospital of Melbourne, Australia, advertises for candidates for the position of a resident medical officer.—The Practitioner's term in the Hahnemann Medical College and hospital was opened March 3 with an introductory by Prof. Vilas, and is now in progress.—During the five months winter session just closed the course afforded a clinic on the Diseases of Women for every alternate working day, twenty-eight of which were given before the large college class, and thirty-one before the 106 senior students in sub-classes. Thirty-five operations were also made in this department meanwhile.—Gross & Delbridge are about to issue a new edition of Dr. Cooke's "Antiseptic Medication."—Dr. J. H. Kimball will remove from Litchfield, Ill., to Pierce City, Mo.—Of the 946 deaths which occurred in Chicago during the month of February, one-half were under five years of age, and 30 per cent of the whole number died of pulmonary diseases.—The very last item of news, received as we are going to press, records the death, on March 3, of our good old friend, Dr. F. R. McManus, of Baltimore, in the seventy-eighth year of his age. For thirty-seven consecutive years he had been Chairman of the Board of Censors in the American Institute, and during all that period had missed but one of its meetings. He was greatly beloved and respected.

## Commencement Exercises

---

### OF THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, SESSION 1884-85.

---

The Twenty-fifth Annual Commencement Exercises of the College were held in the Grand Opera House, Chicago, at 2 P. M., of Thursday, February 26, 1885. The day was auspicious, and the friends of Homœopathy flocked in crowds, so that the house was filled to overflowing. The programme opened with prayer by the Rev. F. M. Bristol, pastor of the Trinity Methodist Episcopal Church. After a selection by the orchestra came the reading of

#### THE ANNUAL REPORT

BY PROF. R. LUDLAM, DEAN OF THE FACULTY.

MR. PRESIDENT: This occasion closes the first quarter of a century in the history of this institution. It is a matter for thankfulness and for congratulation that in many respects the last year has been its best one thus far. As usual, it has afforded two courses of instruction—one for Practitioners in the spring of 1884, and the other for the regular Student-class during the present winter. The former was attended by a class of 81, and the latter by 257 students, making an aggregate of 338 pupils in our College and Hospital for the current year.

In the work that has been done by our teaching corps, more especially in the way of clinical lectures and object-lessons, the facilities afforded have been greatly in advance of those of former years. These increased advantages were largely due to the rebuilding of the Hahnemann Hospital amphitheatre, which was accomplished and paid for at a cost of \$10,000, during the summer of 1884.

The metropolitan character of the school has now been fully established, and its future is assured. Its reputation at home and abroad attests the faithfulness, the zeal, the singleness of purpose and the character and capacity of its united Faculty.

The classes have been composed of new recruits, and by accessions from the preparatory and provincial schools which are so rap-

idly multiplying around us. The latter contribute a large share of their second and third course students, who come hither for the superior advantages and the higher honors that are offered them.

Of the winter class, 197 were men and 60 were women; 237 were from the Western and 30 from the Eastern States; with 10 from Canada, England, Sweden and Australia.

Of the 106 candidates for graduation, 97 have passed a successful and highly satisfactory examination. They have complied with all the requirements of this institution; with the rules of the State Board of Health, and the laws of the commonwealth, and are therefore most heartily and unreservedly recommended by the Faculty for the degree which, Mr. President, it is your pleasure and privilege to bestow.

### ADDRESS OF THE PRESIDENT ON CONFERRING THE DEGREE.

BY PROF. A. E. SMALL, M. D.

GRADUATES IN MEDICINE AND SURGERY.—A crisis in your existence has at length taken place. The first great probationary period has been accomplished. The mark of distinction which you have received to-day introduces you into honorable professional relations, and secures you equal rights and privileges as members of the noble profession of Medicine.

Your industry, hard study and ceaseless toil have culminated pleasantly, in receiving the endorsement of your *alma mater*. Your diplomas attest truly that you are sufficiently learned in the curriculum of medical sciences to advance a step farther, and make your acquirements practical in relieving human suffering; and may an all-wise Providence guide you safely to professional homes, and surround you with choice and sympathizing friends.

Your claims for public recognition must be based not only on your literary and scientific attainments, but on a high-toned moral and religious character. Humility, modesty, honesty and truthfulness are attributes of character that command the respect of mankind. They will surely pave the way to success in life.

But the physician opens the way to prosperity also, when, as soon as he enters upon practice, he absolutely resigns the command of his entire time. No moment of it is his own to use as he pleases; *semper paratus* is the motto of the good physician, who regards himself but a servant of the Divine Master who went about doing good. He is ever at his post, and ready to respond to the cry of suffering, night and day. The cold of winter and heat of summer



are all the same to him. He does not suffer the howling tempest, or blizzards from the north, or even the mountains of snow to interfere with his promptness. No eight-hour law regulates his time of labor.

Whether at the festive board, in the society of friends, on his bed of rest, or in the house of prayer, he is at the command of the sick. He can fix no time for social pleasures or other pursuits. He must become familiar with sleepless nights and days of fasting, as well as with perpetual self-denial.

I pray you not to hesitate in view of this picture. Your happiness will be in the service of Him whose example in healing the sick is before you.

Avoid at all times a reckless haste, especially in the practice of surgery. A fractured finger or sprained wrist, or a contusion or wound carelessly or indifferently treated, may mar the perfection of the human form, and be a greater misfortune than the loss of such surgical skill. Uncertain action or careless manipulation should be studiously avoided, or otherwise it would be well to heed the caution of Quarles:

"Hold thy hand, health's dear maintainer,  
Life perchance may burn the stronger,  
Having substance to maintain her,  
She untouched may last the longer.  
When the artist goes about  
To redress her flame, I doubt,  
Oftentimes he snuffs it out."

### LIST OF GRADUATES.

FOR THE SESSION OF 1884-85.

|                        |               |
|------------------------|---------------|
| ABBOTT, EDWARD SEWALL, | Maine.        |
| ASHBY, SHERMAN,        | Illinois.     |
| AUSTIN, EDSON C.,      | New York.     |
| EVERY, JOHN R.,        | Michigan.     |
| BARNES, F. GRANVILLE,  | New York.     |
| BISHOP, CALVIN H.,     | Iowa.         |
| BLINN, FRANCIS GRAY,   | New York.     |
| BOSSARD, CLEMENS,      | Wisconsin.    |
| BOWERS, JAMES H.,      | Indiana.      |
| BRIEN, DANIEL H.,      | W. Territory. |
| BROWN, H. W.,          | Michigan.     |
| BROWN, S. FRANCIS,     | Minnesota.    |
| BUCKLEY, S. BYRON,     | Illinois.     |
| BUCKNER, E. D.,        | Nebraska.     |

|                                        |               |
|----------------------------------------|---------------|
| BUSHNELL, GEORGE ELMER,                | Illinois.     |
| CAMPBELL, MRS. A. T.,                  | Illinois.     |
| CARLEY, JAMES O. R.,                   | Illinois.     |
| COLE, EDWIN MELVIN,                    | New York.     |
| COLWELL, C. E.,                        | Illinois.     |
| CONGDON, CLARA A.,                     | Illinois.     |
| CRANSON, CASSIUS S.,                   | Minnesota.    |
| CRAWFORD, KATHERINE M.,                | Pennsylvania. |
| CRISSEY, WILLIAM J.,                   | Michigan.     |
| CUSHING, CHARLOTTE W.,                 | Illinois.     |
| DOUGLAS, CHARLES IRVIN,                | Michigan.     |
| FARRINGTON, C.,                        | Kansas.       |
| FELLOWS, CHARLES GURNEE,               | Wisconsin.    |
| FELLOWS, GEORGE,                       | Wisconsin.    |
| FINLEY, DAVID M.,                      | Michigan.     |
| FOCHT, ADAM,                           | Kansas.       |
| GANTZ, BYRON NOBLE,                    | Iowa.         |
| GARRETT, GRACE E.,                     | Illinois.     |
| GRAVES, KATE IRENE, <i>ad eundem</i> , | Illinois.     |
| GREEN, GEORGE DEWITT,                  | Michigan.     |
| HARRIS, NELLIE R. MRS.,                | Iowa.         |
| HASSLER, FRANK,                        | Dakota.       |
| HIGGINS, CURRAN W., <i>ad eundem</i> , | Dakota.       |
| HILL, ANNA SOWLES, <i>ad eundem</i> ,  | Dakota.       |
| HINN, LOUIS,                           | Wisconsin.    |
| HOLDEN, NETTIE J.,                     | Kansas.       |
| HOLTON, CHARLES S.,                    | Kentucky.     |
| HOWARD, F. HENRY,                      | Iowa.         |
| HOWLAND, FRANK A.,                     | Kansas.       |
| HUBBARD, WILLIAM A.,                   | Iowa.         |
| JONES, A. CUVIER,                      | Missouri.     |
| KINLEY, JOSEPH B.,                     | Colorado.     |
| KNEELAND, WILLIS C.,                   | Michigan.     |
| LAGER, BENEDICTA, MRS.,                | Sweden.       |
| LANDON, CHARLES C.,                    | Michigan.     |
| LANDRETH, M. H., MRS.,                 | Illinois.     |
| LANGSTAFF, HENRY W.,                   | Illinois.     |
| LAUGHTON, WILLIAM R.,                  | Wisconsin.    |
| LEIGHTON, JAMES A.,                    | Michigan.     |

---

|                                                |               |
|------------------------------------------------|---------------|
| LILLARD, Z. F., . . . . .                      | Missouri.     |
| LOCKWOOD, BENJAMIN F., . . . . .               | New York.     |
| LOWE, THOMAS, . . . . .                        | Minnesota.    |
| MACY, E. E., . . . . .                         | Indiana.      |
| MASON, ALBERT E., . . . . .                    | Illinois.     |
| MAYER, CHARLES R., . . . . .                   | Louisiana.    |
| MCADAM, ROBERT, . . . . .                      | Iowa.         |
| McFATRICH, J. B., <i>ad eundem</i> , . . . . . | Illinois.     |
| McMACHEN, WILLIAM H., . . . . .                | Ontario.      |
| McPHERSON, ANDREW, . . . . .                   | Pennsylvania. |
| MEINHARDT, EMMA T., . . . . .                  | Illinois.     |
| MENZEL, LUDWIG WILLIAM, . . . . .              | Wisconsin.    |
| MORRISON, JAMES N., . . . . .                  | Iowa.         |
| MUELLER, GUSTAVE A., . . . . .                 | Pennsylvania. |
| MURRAY, ELMORE WARNER, . . . . .               | Michigan.     |
| MYERS, PRISCILLA G., . . . . .                 | Illinois.     |
| OGLESBEE, ELSTHON, . . . . .                   | Ohio.         |
| PARSONS, S. B., <i>ad eundem</i> , . . . . .   | Kansas.       |
| PATTON, R. L., . . . . .                       | California.   |
| PAUL, IRVIN N., . . . . .                      | Iowa.         |
| PEASLEE, CLARA WINSOR, . . . . .               | Michigan.     |
| PENNY, LINCOLN E., . . . . .                   | Minnesota.    |
| PERKINS, ERNST D., . . . . .                   | Illinois.     |
| PETERS, WESLEY, . . . . .                      | Ohio.         |
| ROASBERRY, WILLIAM H., . . . . .               | Ohio.         |
| RUDORF, PAUL, . . . . .                        | Illinois.     |
| SCOTT, JAMES R., . . . . .                     | Iowa.         |
| SHAFFER, JOHN, . . . . .                       | New York.     |
| SHATTUCK, JOHN F., . . . . .                   | Vermont.      |
| SHORT, JAMES L., . . . . .                     | Kansas.       |
| SHULTZ, MARY C., . . . . .                     | Louisiana.    |
| SPAULDING, CHARLES W., . . . . .               | Michigan.     |
| SPATZ, JOSEPH E., . . . . .                    | Illinois.     |
| STANARD, ORA BYRD, . . . . .                   | Illinois.     |
| STEVENS, HARRY FREDERIC, . . . . .             | Illinois.     |
| SWETT, EMILY F., . . . . .                     | New York.     |
| SYLVESTER, WILLIAM OSCAR, . . . . .            | Illinois.     |
| THOMAS, RICHARD A., . . . . .                  | Indiana.      |
| VEENSCHOTEN, TEUNIS, . . . . .                 | Iowa.         |

|                                |           |
|--------------------------------|-----------|
| VINCENT, CLARK H., . . . . .   | Michigan. |
| WALKER, CATHERINE, . . . . .   | New York. |
| WATSON, C. M. E., . . . . .    | Michigan. |
| WELCH, THOMAS RICE, . . . . .  | Kentucky. |
| WILLER, ALBERT M., . . . . .   | New York. |
| Total number of graduates, 97. |           |

### ADDRESS ON PROFESSIONAL HEROISM.

BY REV. F. M. BRISTOL.

"This span of life was lent for lofty duties, not for selfishness,  
Not to be wiled away for aimless dreams,  
But to improve ourselves and serve mankind."

Thus sang the poet in a strain which must ever harmonize with all the holier feelings that stir within us, and all the nobler motives urging us on to deeds. True greatness is humanitarian. Success is service. The greatest hero is the greatest helper. One's most enduring fame is not the people's wonder, but their love and gratitude. The benefactor leaves a name which exhales fragrance as a flower, and seems melodious when spoken as the note of a harp. A Cæsar may feed his high bred horses golden oats in ivory mangers, while a Homer may have to beg for bread. Yet he who sets thirty centuries singing will have at last a name more blessed and a fame more enduring than he who merely astonishes his ignorant neighbors with his vulgar wealth.

There is a progress in ideas, a development in thought, morals and manhood which necessitate the adoption of new standards of excellence and greatness so that the time will come in the history of human advancement when the Macedonian Conqueror will be called "Alexander the Little;" when Pompey the Great will be looked upon as Pompey the Small; when Lorenzo the Magnificent will be considered as Lorenzo the Insignificant, and when the First Napoleon will be recognized as the Worst Napoleon. And why? because these men were cruel, selfish and ambitious, and were destitute of that heroism which toils and sacrifices for the common weal, and without which no man can ever be and forever be truly great. He who fights battles, writes books, explores the seen and unseen world of nature, endures hardships, gains and wields political power, accumulates wealth, or engages in any learned profession for the mere gratification of a proud ambition, unmindful of humanity, blind to the tears of sorrow, deaf to the cry of pain and oppression, unmoved by the miseries and needs of mankind, lives an ignoble life, and when he dies is deservedly forgotten.

The hero thinks of the benefit which he may confer upon others rather than of any personal remuneration for his conduct. He is no more ambitious for fame than he is greedy for gold. Both ideas of honor and fortune are swallowed up in the grander, nobler idea—humanity. The man who succeeds only in getting himself into the ink of his age is a moral and intellectual and professional failure compared to the man who puts himself into the very blood and muscle, nerve and backbone, heart and intellect of his generation, and thus of all generations. The little man is always trying to advance himself, the great man is bent on the world's advancement. One would absorb the world, the other is willing to be absorbed—willing to lose self in a progressive effort and achievement. One would be served, the other would serve. He that would be greatest must be servant of all. In every realm of human enterprise, in war, statesmanship, literature, science, professional life, the most faithful and devoted servants have been and are the greatest men. So that he who renders the most lasting and universal service to humanity will ever rise, in the world's estimation, far above the man who would make humanity his slave.

“Great minds, like Heaven, are pleased in doing good.”

The choice which a person makes of a profession is often the most reliable index to his character. Some professions open the widest fields for the exploits of ambition, and offer the most dazzling rewards of popular applause and fame. Many are lured to the dangers and cruelties of war, or to the excitements of politics because they have a taste for battle or debate wherein honors may be quickly won. Other professions offer a better opportunity for the development and display of the finer qualities of genius, intellect and learning. So art invites the Raphaels, Angelos and Turners to her charming realm, and there crowns their brows with imperishable renown. Again letters invite the Shakespeares, Miltons, Gibbons, Emersons and Carlyles to one of the most enchanting fields open to genius. Invention throws wide her gates to such minds as Galileo, Gutenberg, Stephenson, Watt, Fulton, Morse, Edison, and in this wonder-world men have achieved what earlier generations would have looked upon as miracles, stamping the inventors as gods rather than as human geniuses. While in all these departments of activity and enterprise there are offered opportunities for doing good and for serving humanity, yet there are other professions which give greater advantage to the humanitarian and afford both stronger incentives and wider opportunity to the development and exercise of those higher moral qualities which belong to the benefactor. The educator, minister and physician are called to duties which demand the employment of the highest, noblest faculties, the manliest, divinest attributes and powers of the heart and mind. Here are opportunities for the development and exercise, not only of talent, genius, learning and reason, but also of love, sympathy, benevolence, heroism, of the Christ that is in us.

When one chooses such a profession as medicine there must or ought to be some noble instinct within, some forgetting of self; some regard for humanity; some touch of sympathy; some drops, at least, of the milk of human kindness in him, urging, inspiring and cheering him on. It will not be considered flattery and egotism for me to say there are no professions or callings open to man which offer grander opportunities for the development and display of moral and intellectual powers, or for doing good, and acquiring the lasting gratitude of humanity, than the callings and professions of the minister, the educator and the physician. The perfect man was all these. He was called Master, Rabbi, Prophet, Great Physician. He paid special attention to the sick. His greatest miracles were miracles of healing. While he did not write a line save in the dust; while he left not a single trace of art nor the simplest form of an invention; while he did not effect the shadow of a change in politics; while he did not fight a single battle nor discover a single new star, nor analyze a single flower or mineral; while he did not advance a single new scientific theory or give a single new explanation of the natural universe, yet he healed all who came unto him, and by turning thus toward the blind and lame and sick, he placed the profession of healing upon a plane far above all others, above war, politics, art, invention, letters, finance, worthy to engage the soul and mind of man as it was to call forth the wisdom and power of the Son of God. In this devotion to the suffering the God-man said: "He who conquers disease is greater than he who defeats armies. He who baffles the plague is greater than he who dethrones the despot. He who discovers a remedy is greater than he who finds a planet. He who writes a correct prescription is greater than he who writes an epic. He who restores health is greater than he who restores a kingdom. He who saves life is greater than he who saves fortunes and crowns."

Here, then, is a field for heroism, wherein good may be done by those who are inspired with the god-like ambition to do good. But it was said of the Supreme Man: "He saved others, Himself he could not save." Nor can anyone save himself if he would save others. Is not this forever the test and proof of heroism and true greatness? Self-denial, self-sacrifice, have been the price of the greatest blessings humanity has enjoyed, and these qualities mark the hero. All heroes do not give the life of self for the life of others by a single and instantaneous sacrifice. Socrates in his prison cell at Athens, the brave Knight of Underwalden under the walls of Sempach, glorious Nelson on the deck of his ship and under the Union Jack at Trafalgar, John Brown in Virginia, Lincoln in our nation's capitol, many a patriot on the field of battle, many a fearless martyr at the stake in one grand moment pours out the hero's life and receives the hero's crown of an immortal fame. But is it not as truly heroic and great to give the life-blood drop by drop through years of toil, usefulness, benevolent action and humanitarian deeds?

I put the history of every hero, of every truly great man into the short, immortal legend, "He gave himself for others." He who lives for mankind gives his life to humanity. Men delve in the rich mine of scientific investigation not simply for self-gratification but for the common good, and we count among the heroes Galileo, Roger Bacon, Stephenson, Fulton, Davy, Agassiz, Darwin, Koch. The author toils patiently at his desk and produces a book, an epic, a history, a political economy, an art treatise, into which has been poured his life-blood and his brain, all for the intellectual, ethical, political and esthetic culture of society, and we come to look upon Homer and Shakespeare, Raleigh, Adam Smith, Gibbon and Carlyle, Goldsmith and Burns as heroes; their life went out of them into their great, ever-living thoughts which have become and will ever remain benedictions to the race.

So a Jenner in the very teeth of scientific opposition, a Hahne-mann with the world against him, bravely crying with Athanasius, "If the world be against me, then I am against the world," a Koch braving the dangers incident to his experiments that he may help to relieve the world of the fear and tyranny of the destroying cholera, and many others have studied, toiled, experimented, discovered and revolutionized to give the world more light and more life.

One of the crying needs of this day is a money-forgetting, fame-forgetting, self-forgetting, school-forgetting devotion to truth, to science and to humanity. In the old Greek days the genius of the youth began to decline the moment money prizes were offered to successful competitors in the physical and intellectual contests of the Olympic games. And for the same reason science declines when the scientist toils simply for money.

Statesmanship declines when a pocket is cut into the toga. Literature declines when genius sings for bread and wine and historians toil for a pension. Law declines when the judge or even the attorney is ambitious for a fortune from his occupation; the profession of medicine declines when physicians study and visit and treat the suffering simply for pay, and even the sacred calling of the ministry declines in power and influence when the preacher performs his ministerial functions principally for his salary. God save us from the tyranny of the stomach, from the despotism of bread and butter, from the shackle of gold. Never let genius, learning, skill, influence, experience, power be exchanged for mere pottage. Let the purse, the revenue, the dinner be means but not the end of your toil and study. Be heroic enough to do good if need be without the reward of gold.

The hero must be willing to sacrifice a superficial notoriety in the interests of truth and humanity. He must never be so wedded to a pet theory or method that he will let humanity suffer before he will let his opinion change. Sacrifice brilliancy to safety, genius to common sense, dash to strength, and every pet notion to practical results.

A noted English surgeon visited Paris and called upon the greatest surgeon of the French empire. In conversation the Englishman was asked how many times he had performed a certain very difficult surgical operation. He said he had performed it thirteen times. "Ah," exclaimed the French surgeon with pride, "I have performed it one hundred and sixty times. How many times you save his life?" inquired the boasting Frenchman. "I," said the Englishman, "saved eleven out of the thirteen. How many did you save out of the one hundred and sixty?" "Ah, hem! Ah, Monsieur, I—ah—lose dem all, but ze operation was very brilliant." Be hero enough to choose a good result before a brilliant operation, and though you may lose the applause of the astonished profession you will gain the lasting gratitude, the heart-felt "God bless you," of those you heal and save.

The physician blesses the individual, the family, society, State and church. The happiness of home, the intelligence of society, the strength of the State, the morals and spirituality of the church largely depend upon the physical condition of the people. Study and toil and sacrifice like true scientists, true benefactors, and true heroes to secure health to the people. A well body enshrining a mind that thinks well, and a heart that loves well, makes the best parent for the home, the best citizen for the State, and the best Christian for the church.

---

### THE VALEDICTORY ADDRESS.

BY PROF. W. J. HAWKES.

*Ladies and Gentlemen of the Graduating Class:*

It is my pleasure and privilege, on behalf of the Faculty of your *alma mater*, to say to you on this happy occasion a few friendly farewell words.

Hundreds and thousands of medical students have in the past occupied the same position you do to-day. All have had the same ambitions, the same struggles, the same hopes, the same doubts, anxieties and fears. You are now about midway of this vexed sea of conflicting emotions. The more hopeful and thoughtless imagine, now that the coveted diploma is within their reach, therefore the breakers have all been passed, and the land of success is in full view beyond the horizon. The more thoughtful and wordly-wise are, however, painfully conscious that greater obstacles, graver doubts and responsibilities are yet to be met and assumed or overcome. In the past have come with many of you, first the ambition to become honorable physicians—members of that profession which, more than all others, affords opportunities for doing good to your fellow-men—



then arose the conscientious doubts as to your fitness for so responsible a position; later came the self-denying labor, industry and economy in the effort to earn and hoard the necessary means with which to meet the manifold expenses of your three or more years' course of study in and out of college; then the preliminary examinations, and the confusion and perplexities of the first weeks of college work. After all these had righted themselves or been overcome, the greatest anxiety and doubt of all, "Shall I pass, or shall I be plucked?" stared each individual in the face, disturbing his thoughts by day and his dreams by night.

You will agree with me that this has been the experience of all, even the most confident. It has been the experience of all who have before you earned the title of Doctor of Medicine. It will be the experience of all who shall after you deserve the same honor.

You have doubtless thought, up to the present moment, and may so think until the pleasure and excitement of the present ceremonies and those of the feast to follow shall have passed, that your troubles are at an end, and that only smooth sailing on a calm sea with a fair wind is before you. If so, "I am bound to tell you," you are mistaken. Your real cares and responsibilities are about to begin. And, if I can, by pointing out some of the advantages which you to-day enjoy over students of the past, encourage the timid and doubting; or if, by indicating to the over-confident some of the many obstacles yet in their way to success, prepare such the better to meet and overcome them, I shall hope this valedictory—this last talk—will have been of use.

To the doubting and timid many encouraging truths may be cited. First: Success will surely attend your efforts, if after choosing your field, you *stay*, and be studious, upright and punctual. "A rolling stone gathers no moss," applies to the physician more aptly than to the worker in any other field. If you will have patience you will have patients. Carefully select your location, wait until the people have become acquainted with you, and have gained a measure of confidence in you as men and women, and by and by in an emergency they will test you as physicians. But trial and opportunity are what you desire. They enable you to prove the second encouraging truth, to-wit: Nine-tenths of the sick you will be called upon to treat in general practice will recover under proper care, even though they receive no medicine. Your medicine, even if you do not find

the proper remedy in every instance, can inflict upon the patient no positive harm, and when you do select the right one his recovery will be hastened. In any event, you have at least nine chances in ten for success. This could not have been truthfully said previous to the nineteenth century. Neither could the third truth have been asserted previous to Hahnemann's time, viz.: That the perscribing of medicines for the sick is a *science, under law*. No hap-hazard experimenting upon the sick is necessary or warrantable in our day; no wasting of precious time in blindly trying this and that drug on the dying patient! The test has already been made upon the healthy, so that when you are called to the bedside, you know the effect which the drug you find indicated will produce, you know how and why you know this, and you know also, that such action as it may have will be for the patient's good. Realize these facts fully, and you need have no fears.

But the greatest truth of all, and the one which makes the heart of every true physician who fully realizes its magnitude and import swell with generous pride, is the fact that every portion of medicine properly administered, under the homœopathic law, lessens the disease tendency in the individual to whom it is administered! And this because when so administered, it attacks the subjective constitutional root and chief cause of the morbid phenomena which we call disease. The converse of this proposition is equally true: every drug dose given to suppress these morbid phenomena, being directed to the effect rather than to the cause, tends to increase and complicate the disease susceptibility of the patient to whom it is administered.

As evidence in support of the proposition, two facts, to which my own experience, reinforced by that of many conscientious and successful physicians, abundantly and unreservedly attests, may be cited: First. Treatment of the unhealthy parents of a diseased child decreases the disease tendency in children of the same parents born subsequently. Second. The yearly medical bills of families who are continuously for a period of years under homœopathic treatment, gradually grow smaller, even though sometimes the families grow larger. My own account books show this. So also do letters from representative physicians all over the land. Thus you help gratify two of the strongest desires in the human breast—health and wealth.

Are not these truths cheering and encouraging to the physician? Could they have been truthfully asserted a hundred years ago? Ask

Hahnemann, Cullen, Bichat, Hoffman, Girtanner, Boerhave, Sir Astley Cooper, Farre, Hufeland, Sir John Forbes, and a score of others.

Therapeutics, the *sine qua non* of medical science, has made greater strides during the past eighty years than during all previous time. Great progress had been made, it is true, in the collateral branches through all the years of medical history. But therapeutics was as crude and uncertain and as fatal a hundred as three thousand years ago. And we have the proud consciousness that we hold the key and have developed this great progress. Is it not encouraging to know that our work is to be done in so clear a professional atmosphere, robbed as it is of the uncertainty and remorse of old medicine and old measures?

To the over-confident who will start out in practice with the serene faith that they will cure all who may be so fortunate as to fall into their professional hands, a word of warning may be of use in diminishing the number and mitigating the bitterness of their disappointments.

Death will come to all at last. In nature Time accomplishes this without the aid of Disease. Medicine and medical skill cannot overcome Death alone. Much less can they conquer Death reinforced by Disease. The grim pair did but yesterday make a sad breach in our own immediate professional family. Nature plus medicine is no stronger than nature alone. Not even so strong. Drugs add nothing to perfect health—to nature. They detract, rather. Consequently only disappointment awaits him who hopes to save life in every instance. Your medicine, your skill, cannot take the place of nature—cannot add to nature—cannot give vitality; they can only at best give opportunity to what of vitality—what of nature—there is left in the individual.

In these days of bacteriamania, the over-confident among you may imagine that you can, after a while, go about from house to house of your patients with a bacteria-bacilli-germicide, instead of a medicine case, under your arms, prepared therewith to rob afflicted humanity of all the ills its flesh is heir to.

To such I would give a word of warning and discouragement. For this purpose permit me to call attention again to facts: Koch and others assert that the baccilli—coma baccilli—of cholera have been found, demonstrated and cultivated, and that they are found *only* in the intestines of persons suffering from or dead of cholera.

Drs. Gibbes and Klein, who have carried on extensive investigations of cholera at Bombay and Calcutta, assert positively that they are found in many other similar diseases and even in the mouths of

persons in full health ! Koch *et al* assert nine other facts in this connection ; Gibbes and Klein as positively deny them.

" When such learned doctors disagree, who shall decide ? "

Until this important matter shall have been settled, it will be well to not depend too much upon the germicide. While the seed is so much in doubt it will be wiser to look to the soil in which it is to grow. The cholera does not attack all who are alike exposed to its supposed causes. The influences which produce cholera in one of a number subjected to them cause other milder affections in another, while in still others of the number no such effect is produced. The inference is unavoidable that the subjective cause in the individual is as potent a factor as is the objective cause, the so-called bacillus. Dr. Benjamin D. Howard, who has had large experience with cholera, says, in this connection : " The communicability of cholera is a subject upon which unanimity can scarcely be expected. The assertion that the coma or any other bacillus is the one and only essential germ of cholera, and that this must reproduce itself or nothing, is doubtless premature. Practically our concern regards the soil as much as the seed, and the means of sowing are many. During this recent epidemic it is said not one hospital physician or interne has had cholera. Admitting this to be true, the same may have been said many times concerning typhoid fever, scarlet fever and small-pox. Further, while none of these fortunate individuals had typical cholera, I do not know one interne who had much work in the cholera wards but who, during the greater part of the time, suffered from borborygm, colic, diarrhoea, and in a manner unknown to him under ordinary circumstances.

" Mr. McNamara relates how, in 1872, having in the morning been engaged in a close laboratory examining some monkeys to whom he had given cholera dejecta, before 4 o'clock of the same day both he and his assistant were attacked with cholera, extending afterward to collapse. In connection with the point I have mentioned, that many of those visiting cholera patients, though continuing free from typical cholera are victims of very disagreeable intestinal disorder, I may mention one fact which came immediately under my notice. A medical friend, in robust health, the day of his arrival in Paris from the seaboard, was with me for about two hours in some rather close single cholera wards. Within one hour of his leaving the hospital he had involuntary diarrhoea, and for the several remaining days of his attendance in cholera wards, borborygm, colic and offensive diarrhoea persisted in spite of treatment, and continued four or five days after his return home. The day after his return his wife, from whom he had kept his hospital visits secret, was affected, and continued precisely the same way for five or six days ; neither the one nor the other had what could be called cholera, but what both of them had could be traced to no other cause than the attendance of my friend upon patients who did have it. This is but one of several

similar facts which have come recently under my observation, showing, as I think, that the essential element of cholera may have many varieties and infinite degrees of effect, according to the condition of the respective individuals, the most perfect adaptation and susceptibility existing only in a small minority of those who have been gradually prepared by continuously bad hygiene or pernicious habits."

The inevitable conclusion to be drawn from these facts is that the true treatment of cholera patients, in conjunction with proper hygienic measures, is that used in the treatment of all other sick persons, viz.: that which is directed to the inherent morbid conditions of the individual.

It may not be altogether inappropriate in this connection to add that all necessary hygienic measures are included in cleanliness, temperance and a thorough cooking of everything taken into the stomach.

The so-called cholera bacillus has never been found in an individual until after he had had the disease. The result, as far as our information goes, preceded the cause.

In diphtheria the bacillus which is said to cause the disease is always found most abundant near the surface of the false membrane, and becomes less numerous in proportion as the mucous membrane on which it is deposited is approached. Some experimenters altogether fail to find it in close proximity to the mucous membrane. The cause would here seem to be most numerous in the result!

Animals inoculated with the virus exhibit symptoms of the disease, but they never contract it in the natural way, however much exposed to its influence. Why? Because the field has not been fertilized.

The bacillus of phthisis has been found in the sputa of those already ill of consumption. It has never been found in one not ill of that disease. Consumption is transmitted from father to child. Has the bacillus ever been found in the microscopic cause of impregnation? This dread disease frequently passes by the second generation and attacks the third. Where during those years were these potent bacilli? We know of no cases of consumption where a consumptive family history cannot be traced. Why is this so if an external influence is the sole or chief cause of the disease?

Where are these varied living so-called causes of disease uniformly formed? In the excreta of cholera, in the false membrane of diphtheria, in the sputa of the consumptive; uniformly and constantly in the disintegrated products of diseased action.

From the foregoing facts it is plain that, while there is no doubt that these external influences, bred of filth, are potent factors in causing the various diseases to which they relate, and are therefore to be seriously considered, and if possible avoided, yet it is equally true that they are not the sole nor chief influences in causing the terrible fatality attending these epidemics; but that the inherited or

acquired constitutional taint which weakens the vitality and the natural resisting powers of the susceptible individual is a greater factor, and the one which challenges the most careful attention of the physician, and most surely rewards his efforts with success.

Admitting the paramount importance of the microbe as a cause of disease, *cui bono?* The mortality of cholera, diphtheria, etc., under the treatment of the physicians who discovered the things, and who aim to kill or exclude them as their principal mode of treatment, is as great as it was before their existence was discovered. It has thus far been found impossible to kill them and let the patient live; and when we consider the inconceivable rapidity with which they multiply, it would seem improbable that they could ever by artificial means be exterminated, after they have once made a lodgment in the human body.

On the other hand, how much more satisfactory are the view and course which seek to aid nature in her ever conservative efforts to render harmless their influence by correcting the morbid condition of the individual! Here we have measures which are scientific and comparatively sure. By these means was Hahnemann enabled to predict the drugs which were to be curative, and to verify his prediction by his remarkably superior record and results when the dread scourge, cholera, finally did appear.

I have had no personal experience with cholera, but in several epidemics of diphtheria and scarlet fever, I have observed that it was the rule, where several members of a family, in some cases whole families, have been destroyed by one or other, or both, of these diseases, that a consumptive, or scrofulous, or cancerous, or syphilitic taint could be traced, and more especially when the latter was combined with either of the others. In my observation there have been no satisfactory exceptions. Sewer-gas, or some other form of malaria, has usually been the ascribed cause; and in most instances some such objective influence did exist, and was the exciting cause. So the cancer has been ascribed to a blow or other violent injury; consumption to a "cold" or exposure; the attack of ague to the miasma of the swamp. But the malaria did not kill all who inhaled its poison, all who received equally severe injury did not develop cancer, nor did all who were equally exposed, and who took a severe "cold," die of consumption.

Mankind does not inherit malaria, injuries, colds. It does inherit the predisposing causes of diphtheria, ague, consumption.

To you as homœopathic physicians it ought to be especially gratifying and encouraging to realize that all recent discoveries of scientists at home and abroad, instead of giving cause for doubting the efficacy of your practice, point in the direction of one of the great central truths of homœopathy. This was denominated by Hahnemann the *Peora* theory, he meaning thereby constitutional taint or defect of whatever character. His enemies, with characteristic nar-

rownness and bigotry, limited the definition of the word to its literal translation, the itch, caused by the burrowing of a parasite in the epidermis. The exact nature or *modus operandi* of this taint or defect neither Hahnemann nor any other has thus far been able to exactly comprehend or define. But the truth is rapidly being arrived at *via* therapeutics by ourselves, as well as by Pasteur, Koch, and others experimenting in disease causes and conditions; and I make the prediction that the ultimate conclusion will be that the prime cause of diseased conditions in general is not specific *materies morbi*, but a derangement of the nerve cells and centers.

Pasteur, as a result of persistent, patient, long-continued and skillful experiment, has arrived at the conclusion that hydrophobia is strictly a neurosis; that it is a derangement of certain portions of the medulla oblongata. He has found, further, that by inoculating dogs, rabbits, etc., each step away from the original poison lessens its virulence, until at the fifth or sixth remove it becomes comparatively harmless, and animals may be safely inoculated and given immunity from hydrophobia. Here is a "potency." The minute quantity of the virus necessary to inoculate a dog impregnates the animal's every part. But the amount of poison is no larger than the drop of tincture used in making our first potency, while the tissues of the dog—the menstruum—is infinitely greater than the nine or ninety-nine drops of menstruum of our first potency. So on up to the fifth, when it becomes harmless, but potent for good.

Dr. Dessau, Dr. Peters, of Paris; Dr. Campbell, of Liverpool; Drs. Bartholou Ringer and Phillips all now speak in enthusiastic terms of small and often repeated doses of drugs as being superior to large doses in the cure of the sick. They even use our almost trademark—the words, "the minimum dose." They recommend a grain of corrosive sublimate in *a pint* of water, and a teaspoonful of the mixture as a dose! I will make one brief quotation from a paper by Dr. Dessau published in the *Medical Record*. It will serve as an illustration of the remarkable change and progress in the last five years in old school therapeutics.

He says: "Upon the appearance of that now indispensable little work, Ringer's 'Handbook of Therapeutics,' my attention was particularly attracted to the frequency with which he recommends small doses of medicines that we have been accustomed to use in much larger doses, *for entirely different diseases*. Some of these medicines were recommended so strongly that I was induced to give them a trial, more especially as my practice among children impels me, for many reasons, to administer as little unpleasant tasting medicine as possible. Their use with children having first been found satisfactory, my position in connection with the New York Dispensary afforded me the opportunity to further test *their value in numerous cases of adults*.

"There is a form of bronchitis seen among children, where a

large number of coarse mucus rales produce a loud wheezing with an asthmatic quality of cough. The wheezing is the symptom that the mother is the most likely to complain of, and together with the cough is most intense at night, both almost entirely disappearing during the day. Such cases very readily yield in my practice under the use of tartar emetic, given in solution in the proportion of a grain to a pint of water." The italics in the above quotation are mine.

Here they recognize that there are different forms of bronchitis, and point out the "symptoms" indicating a particular drug. They are prescribing for the individual according to his symptoms, and not empirically a drug for a disease. And they give the minimum dose, as they understand it—a teaspoonful of a mixture of a grain of tartar emetic in a pint of water. But no credit is given to those who have written repeatedly and better than they of this and a thousand other kindred facts through the half century before Ringer's "*Hand-Book of Therapeutics*" was thought of. The nearest approach to it is in the statement in this same article, that "these statements are not altogether new; it has long been known to some medical practitioners that there is great potency in small doses at short intervals."

Hundreds of such quotations might be taken from the authors named. But our time is limited, and these will suffice for our purpose.

You see, therefore, young ladies and gentlemen, that everything is pointing your way; that every discovery made in medical science further confirms the truths discovered by the illustrious founder of our system of therapeutics. And you may rest assured that what is true of the discoveries already made will be as true of those to be developed in the future. The truth never dreads the light; the more brilliant the light the brighter truth shines. It is mighty, and will prevail.

Go out into your respective fields of labor, therefore, with renewed confidence and hope; and first of all be gentlemen and gentlewomen, upright, benevolent, kind. Your profession renders these qualities essential alike to consistency and success. When you are well established thus as men and women, stand fast by your law and your professional principles. There is nothing of therapeutics not embraced in broad homœopathy. Its principles and practice will serve you better than all else while there is yet hope of saving life. When that hope is gone, adopt the less of evils, and with the means best approved by your judgment and conscience, smooth the pathway of the dying to the inevitable grave.

### THE PRESENTATION OF PRIZES.

In accordance with an established custom, Prof. Vilas superintended the distribution of the following prizes:

The D. S. SMITH prize for the best Final Examination, \$25 cash, to Charles E. Colwell, of Illinois.



The HALSEY BROTHERS' prize of a buggy medicine-case for the second best, to Thomas Lowe, of Iowa.

Prof. HOYNE's prize for the best Final Examination in his branch, to Priscilla G. Myers, of Illinois.

Prof. VILAS' prize (\$20 cash) for the best report of his Clinic, to Grace E. Garrett, of Illinois.

Prof. HALL's prize for best final examination in Surgery, to Emily F. Swett, of New York.

Prof. HAWKES' prize for best prescriber in the Medical Clinic, to J. R. Scott, of Iowa; and for the best clinical report, to C. I. Douglas, of Michigan.

Prof. LEAVITT's first prize for best Final Examination in his department, from Gross & Delbridge to E. D. Perkins, of Illinois; and second prize, C. I. Douglas, of Michigan.

Prof. WHEELER's prize for best examination on Theoretical and Practical Analysis, to Ora B. Stannard, of Illinois.

Prof. FELLOWS' prize for best thesis on Insomnia, to T. R. Welch, of Kentucky.

Prof. GILMAN's prize for best thesis on Bacteria, to G. E. Bushnell, of Illinois.

Prof. LUDLAM's prize for the best report of the Women's Clinic, to Emma T. Meinhardt, of Illinois.

Dr. MARY WEEKS BURNETT's prize (of \$20) for best essay on the Effects of Tobacco, inherited and acquired, to Dr. Kate I. Graves, of Illinois.

Prof. Vilas then announced that the Board of Managers had elected Dr. George E. Bushnell, of Illinois, House Physician, and Dr. Harry F. Stevens, of Vermont, House Surgeon to the Hahnemann Hospital, after which the exercises were closed with music and the benediction.

### THE RECEPTION AND BANQUET.

At 9 of the same evening the Faculty gave a grand reception and banquet to the young graduates and the visiting alumni of the institution. The affair came off at the Palmer House, and was brilliant and bountiful in everything except in the edibles, that are so precious to the palate of the hungry student and the hard-worked doctor. Music and speeches, social chat and warm congratulations, friendly feeling all around the board, and hearty good-will over the

prosperity of the "Old Hahnemann" filled the evening, and filled the air with happiness for all concerned. At a late hour the leave-takings began, and so ended the quarter-centennial commencement season of this flourishing college and hospital.

## LIST OF MATRICULATES.

SESSION OF 1884-85.

| NAME.                   | RESIDENCE.       | PRECEPTOR.            |
|-------------------------|------------------|-----------------------|
| ABBOTT, E. S., . . .    | Maine, .         | Dr. C. M. Foss.       |
| ADAMS, Miss M. E., .    | New York, .      | Dr. O. C. Stroug.     |
| ANDERSON, G. H., . .    | Kansas, .        | Dr. M. B. Smyth.      |
| ASHBY, S. F., . . .     | Illinois, .      | Dr. A. Van Patten.    |
| AUSTIN, E. C., . . .    | New York, .      | Dr. L. T. Bottsford.  |
| AVERILL, Mrs. M. B., .  | Illinois, .      | Practitioner.         |
| AVERY, JOHN R., . . .   | Michigan, .      | Dr. A. B. Avery.      |
| BACON, E. Z., . . .     | New York .       | Dr. A. S. Couch.      |
| BACON, Mrs. E. Z., . .  | New York, .      | Dr. A. S. Couch.      |
| BAIN, R. C., . . .      | Illinois, .      | Dr. P. P. Gray.       |
| BAIRD, O. M., . . .     | Illinois, .      | Dr. J. E. Morrison.   |
| BALDWIN, Miss A. A., .  | Texas, .         | Dr. M. W. Burnette.   |
| BALDWIN, E. W., . . .   | Illinois, .      | Prof. C. E. Laning.   |
| BARFUS, O. E. . . .     | Pennsylvania, .  | Dr. J. C. M. Drake.   |
| BARNES, F. G., . . .    | New York, .      | Dr. D. D. Cole.       |
| BERSUCH, FRED, . . .    | Kansas, .        | Dr. C. A. Pusheck.    |
| BLACKBURN, R. A., . .   | Nebraska, .      | Dr. R. Carscadden.    |
| BLINN, F. G., . . .     | New York, .      | Dr. A. Ketchem.       |
| BÓARDMAN, E. W., M. D., | Wisconsin, .     | Practitioner,         |
| BOESRUP, J. N., . . .   | Illinois, .      | Dr. J. H. S. Johnson. |
| BOLLEN, C., . . .       | Australia, .     | Dr. G. Bollen.        |
| BOSSARD, C., . . .      | Wisconsin, .     | Dr. F. P. Leich.      |
| BOULDIN, J. W., . . .   | Illinois, .      | Dr. T. S. Huffaker.   |
| BOWERS, J. H., . . .    | Indiana, .       | Practitioner.         |
| BOWER, ERNST,* . . .    | Illinois, .      | Dr. W. J. Hawkes.     |
| BOYCE, A., . . .        | Massachusetts, . | Dr. N. R. Perkins.    |
| BOYD, Mrs. M. A., . .   | Illinois, .      | Dr. W. A. Boyd.       |
| BOZARTH, CHARLES A., .  | Wisconsin, .     | Faculty.              |

\*Partial Course.

| NAME.                  | RESIDENCE.    | PRECEPTOR.             |
|------------------------|---------------|------------------------|
| BRADFORD, ELI,         | Illinois,     | Dr. W. A. Paul.        |
| BRIEN, D. H.,          | W. Territory, | Dr. E. T. Balch.       |
| BROWN, MISS H. M.,     | Wisconsin,    | Dr. E. F. D. Fletcher. |
| BROWN, H. W.,          | Michigan,     | Dr. G. A. Robertson.   |
| BROWN, S. F., JR.,     | Minnesota,    | Prof. T. S. Hoyne.     |
| BRUCE, A. H.,          | N. Hampshire, | Prof. E. S. Bailey.    |
| BUCKLEY, S. B.,        | Illinois,     | Drs. Wales.            |
| BUCKNER, E. D.,        | Nebraska,     | Practitioner.          |
| BUSHEE, G. B.,         | Illinois,     | Dr. A. F. Harris.      |
| BUSHNELL, G. E.,       | Illinois,     | Dr. W. A. McDowell.    |
| CAMPBELL, MRS. A. T.,  | Illinois,     | Prof. T. S. Hoyne.     |
| CAMPBELL, E. E.,*      | New York,     | Drs. Watson & Cole.    |
| CARLEY, J. O. R.,      | Illinois,     | Dr. A. P. Wells.       |
| CARRINGTON, FRANK E.,  | New York,     | Dr. D. A. Bissell.     |
| CHURCHILL, MRS. A. E., | Wisconsin,    | Dr. W. O. Sherman.     |
| CLARK, EDWIN J.,       | New York,     | Dr. A. J. Clark.       |
| CLARK, SAMUEL H.,      | Illinois,     | Practitioner.          |
| COBURN, WILLIAM,*      | Illinois,     | Faculty.               |
| COFFEE, W. N.,         | Iowa,         | Dr. J. N. Morrison.    |
| COLE, E. M.,           | New York,     | Dr. A. B. Cole.        |
| COLLIER, MRS. A.,      | England,      | Prof. T. S. Hoyne.     |
| COLWELL, C. E.,        | Illinois,     | Dr. F. L. Bartlett.    |
| CONGDON, MRS. C. A.,   | Illinois,     | Prof. C. E. Laning.    |
| CONGDON, CHARLES F.,   | Illinois,     | Faculty.               |
| COOKE, J. W. A.,       | Illinois,     | Dr. Nicho. F. Cooke.   |
| CRAIG, J. D., M. D.,   | Illinois,     | Practitioner.          |
| CRANSON, C. S.,        | Minnesota,    | Practitioner.          |
| CRAWFORD, MISS K. M.,  | Pennsylvania, | Dr. B. Bowman.         |
| CRISSEY, W. J.,        | Michigan,     | Dr. S. F. Chase,       |
| CUNNINGHAM, MRS. M.,   | Illinois,     | Prof. W. J. Hawkes.    |
| CUSHING, MRS. C. W.,   | Illinois,     | Prof. T. S. Hoyne.     |
| CUTLER, J. W.,         | Illinois,     | Faculty.               |
| DANIELS, J. N.,        | Wisconsin,    | Dr. L. W. Giffin.      |
| DAY, C. H.,            | W. Territory, | Dr. W. W. Day.         |
| DICKSON, GUY B.,       | Illinois,     | Dr. W. S. Harvey.      |
| DOUGLAS, C. I.,        | Michigan,     | Dr. J. H. Wattles.     |
| DU CHATEAU, A. O.,     | Wisconsin,    | Dr. Olmsted.           |

\*Partial Course.

| NAME.                       | RESIDENCE.   | PRECEPTOR.           |
|-----------------------------|--------------|----------------------|
| DUNN, MRS. W. A., .         | Indiana, .   | Dr. W. A. Dunn.      |
| EDDY, V. C., M. D., .       | New York, .  | Practitioner.        |
| EMERY, MISS SARAH, .        | Minnesota, . | Dr. W. H. Caine.     |
| ENSIGN, W. H. C., .         | New York, .  | Dr. A. S. Couch.     |
| ERTL, MRS. M. S., .         | Wisconsin, . | Mrs. Dr. Melandy.    |
| ESHBAUGH, A. S., .          | Illinois, .  | Dr. W. S. Eshbaugh.  |
| EWING, MISS ALICE, .        | Wisconsin, . | Dr. N. A. Pennoyer.  |
| FARRINGTON, C., .           | Kansas, .    | Prof. R. Ludlam.     |
| FELLOWS, C. G., .           | Wisconsin, . | Drs. Kanouse.        |
| FELLOWS, GEORGE, .          | Wisconsin, . | Drs. Kanouse.        |
| FIFIELD, MISS E. M., M. D., | Maryland, .  | Practitioner.        |
| FIGG, J. J., .              | Illinois, .  | Dr. C. A. Pusheck.   |
| FINLEY, D. M., .            | Michigan, .  | Faculty.             |
| FISH, C. E., .              | Ohio, .      | Dr. F. O. Hart.      |
| FOCHT, A. E., .             | Kansas, .    | Dr. J. S. Mortlock.  |
| FOUSER, H., .               | Illinois, .  | Faculty.             |
| FRANK, MRS. C. E., .        | New York, .  | Dr. William Falkner. |
| GANTZ, B. N., .             | Iowa, .      | Faculty.             |
| GARRETT, GRACE E., .        | Illinois, .  | Dr. G. W. Foote.     |
| GERRY, MISS J. E., M. A.,   | Illinois, .  | Mrs. E. Cook, M. D.  |
| GOODALE, M. H., .           | Michigan, .  | Dr. M. Rorabacher.   |
| GRAVES, MRS. K. I., M. D.,  | Illinois, .  | Practitioner.        |
| GREEN, GEORGE D., .         | Michigan, .  | Faculty.             |
| GREEN, O. W., .             | New York, .  | Dr. H. W. Roberts.   |
| GRUBER, CARL, .             | Wisconsin, . | Faculty.             |
| HADLEY, W. C., .            | Illinois, .  | Faculty.             |
| HAINES, BESSIE P., .        | Wisconsin, . | Dr. E. S. Park.      |
| HALBERT, H. V., .           | New York, .  | Dr. W. H. Caine.     |
| HALLOWAY, J. C., .          | Maine, .     | Dr. E. F. Vose.      |
| HARCUM, THEO., .            | Wisconsin, . | Dr. H. Hanners.      |
| HARRIS, MRS. NELLIE R.,     | Iowa, .      | Dr. C. W. Eaton.     |
| HARVEY, C. F., .            | Wisconsin, . | Dr. G. E. Long.      |
| HASSLER, FRANK, .           | Dakota, .    | Practitioner.        |
| HASTINGS, A. H., .          | Indiana, .   | Dr. A. G. Hastings.  |
| HELIKER, E. P., .           | Iowa, .      | Faculty.             |
| HICKS, H. M., .             | New York, .  | Dr. A. E. Wheeler.   |
| HILL, MRS. ANNA S., M. D.,  | Dakota, .    | Practitioner.        |
| HINN, LOUIS, .              | Wisconsin, . | Dr. L. A. Bishop.    |

| NAME.                   | RESIDENCE.    | PRECEPTOR.            |
|-------------------------|---------------|-----------------------|
| HODGDON, FRANK A.,      | Vermont,      | Dr. C. B. Davis.      |
| HOLDEN, MISS NETTIE,    | Kansas,       | Dr. M. A. Kester.     |
| HOLTON, C. S.,          | Kentucky,     | Drs. Martin & Holton. |
| HOLTON, G. H.,          | Kentucky,     | Drs. Martin & Holton. |
| HOOVER, P. N., M. D.,   | Indiana,      | Practitioner.         |
| HOTTLEMAN, OTTO,        | Wisconsin,    | Faculty.              |
| HOWARD, F. H.,          | Iowa,         | Dr. M. Y. Baker.      |
| HOWLAND, F. A.,         | Kansas,       | Dr. W. G. Graham.     |
| HUBBARD, W. A.,         | Iowa,         | Practitioner.         |
| HURON, WILLIS B.,       | Indiana,      | Dr. F. H. Huron.      |
| JONES, A. C.,           | Missouri,     | Dr. S. E. Miles.      |
| KARST, AUGUST,          | Illinois,     | Dr. C. A. Pusheck.    |
| KELLEY, E. E.,          | New York,     | Dr. W. S. Todd, Sr.   |
| KEMBERLING, ISAAC,      | Michigan,     | Practitioner.         |
| KEMP, N. C.,            | Iowa,         | Dr. A. H. Pearson.    |
| KING, EDGAR A.,         | Wisconsin,    | Dr. E. W. Clark.      |
| KINLEY, J. B.,          | Colorado,     | Dr. G. H. Patchen.    |
| KNEELAND, W. C.,        | Michigan,     | Dr. Robertson.        |
| LÄGER, MRS. B.,         | Sweden,       | Prof. G. A. Hall.     |
| LAMAR, H. L.,           | Indiana,      | Dr. J. S. Beeler.     |
| LANDON, C. C.,          | Michigan,     | Dr. M. Rorabacher.    |
| LANDRETH, MRS. M. H.,   | Illinois,     | Dr. Sara J. Allen.    |
| LANDSTAD, MAGNUS,       | Michigan,     | Practitioner.         |
| LANGSTAFF, H. W.,       | Illinois,     | Dr. W. H. Stiles.     |
| LAUGHTON, F. D.,        | Wisconsin,    | Dr. G. E. Richards.   |
| LAUGHTON, W. R.,        | Wisconsin,    | Dr. G. E. Richards.   |
| LEE, W. H.,             | Pennsylvania, | Dr. C. H. Lee.        |
| LEIGHTON, J. A.,        | Michigan,     | Practitioner.         |
| LILLARD, Z. F.,         | Missouri,     | Faculty.              |
| LOCK, D. A.,*           | Michigan,     | Practitioner.         |
| LOCKWOOD, B. F.,        | New York,     | Dr. C. M. Kellogg.    |
| LOWE, THOMAS,           | Minnesota,    | Dr. A. M. Tuttle.     |
| LUDLAM, R., Jr.,        | Illinois,     | Prof. R. Ludlam.      |
| LYMAN, MRS. G.,         | Wisconsin,    | Dr. L. S. Ingman.     |
| MACKAY, MISS JENNIE I., | Illinois,     | Dr. A. Van Patton.    |
| MACY, E. E.,            | Indiana,      | Dr. W. A. Dunn.       |
| MARTIN, J. H., M. D.,   | Pennsylvania, | Practitioner          |

\*Partial Course.

| NAME.                     | RESIDENCE.    | PRECEPTOR.            |
|---------------------------|---------------|-----------------------|
| MASON, A. E., . . .       | Illinois, .   | Prof. R. Ludlam.      |
| MAYCOCK, B. J., . . .     | New York, .   | Dr. A. C. Hoxie.      |
| MAYER, C. R., . . .       | Louisiana,    | Dr. J. A. Bell.       |
| MAYNARD, C. K., . . .     | Wisconsin, .  | Dr. H. N. Marvin.     |
| MCADAM, ROBERT, . . .     | Iowa, .       | Faculty.              |
| McFATRICH, J. B., M. D.,  | Illinois, .   | Practitioner.         |
| McMACHEN, W. H., . . .    | Ontario, .    | Dr. J. H. Johnson.    |
| McPHERSON, A., . . .      | Pennsylvania, | Dr. R. Faulkner.      |
| MEINHARDT, MISS EMMA,     | Illinois, ,   | Prof. E. S. Bailey.   |
| MENZEL, L. W., . . .      | Wisconsin, .  | Prof. T. S. Hoynes.   |
| MILLER, MISS ELIZA M.,    | Illinois, .   | Dr. S. M. French.     |
| MORRISON, J. N., . . .    | Iowa, . . .   | Practitioner.         |
| MORSE, J. N., . . .       | Illinois, .   | Practitioner.         |
| MUELLER, G. A., . . .     | Pennsylvania, | Dr. H. J. McClelland. |
| MUMMAW, H. A., . . .      | Indiana, .    | Dr. W. A. Whippy.     |
| MURRAY, E. W., . . .      | Michigan, .   | Prof. E. S. Bailey.   |
| MURRAY, MRS. E. W., .     | Michigan,     | Prof. E. S. Bailey.   |
| MYERS, MISS PRISCILLA G., | Illinois, .   | Dr. C. M. Dinsmore.   |
| NEWTON, J. A.,* . . .     | Indiana, .    | Practitioner.         |
| NEUMEISTER, A. E.,† . .   | Wisconsin,    | Faculty.              |
| OGLESBEE, E. C., . . .    | Ohio, . . .   | Dr. G. M. Ireland.    |
| PARMLEY, JOHN P., M. D.,  | Wisconsin,    | Practitioner.         |
| PATTON, R. L., . . .      | California, . | Practitioner.         |
| PAUL, I. N., . . .        | Iowa, .       | Prof. E. S. Bailey.   |
| PAUL, PH. D., . . .       | Illinois, .   | Practitioner.         |
| PEASE, W. A., . . .       | Illinois, .   | Dr. F. P. Stiles.     |
| PEASLEE, MISS CLARA W.,   | Michigan, .   | Dr. Sara J. Allen.    |
| PEERY, BESSIE E., M. D.,  | Missouri, .   | Practitioner.         |
| PENNY, L. E., . . .       | Minnesota, .  | Dr. W. S. Briggs.     |
| PERKINS, E. D., . . .     | Illinois, .   | Dr. G. E. Gray.       |
| PERRIGO, MISS STELLA H.,  | Wisconsin, .  | Dr. L. C. Ingman.     |
| PETERS, W., . . .         | Ohio, . . .   | Dr. Flower.           |
| PETTET, L., . . .         | Illinois, .   | Dr. J. Pettet.        |
| QUICK, ASENETH, . . .     | New York, .   | Dr. A. P. McDonald.   |
| ROASBERRY, W. H., . . .   | Ohio, . . .   | Dr. H. P. Mera.       |
| RUDOLF, PAUL, . . .       | Illinois, .   | Dr. F. H. Van Lew.    |
| RYAN, JAMES E.,† . . .    | New York, .   | J. D. Cole.           |

\*Special Course.

†Partial Course.

| NAME.                        | RESIDENCE.    | PRECEPTOR.            |
|------------------------------|---------------|-----------------------|
| SANDERSON, P. C., .          | Pennsylvania, | Practitioner.         |
| SCHULTS, C. L., . .          | Wisconsin, .  | Dr. J. R. Pipgras.    |
| SCHULTZ, MRS. MARY C.,       | Louisiana,    | Prof. E. S. Bailey.   |
| SCOTT, J. R., . . .          | Iowa, . . .   | Dr. G. E. Smith.      |
| SEARLES, O. I.,† . .         | Illinois,     | Dr. W. H. Missick.    |
| SHAFFER, JOHN, . .           | New York,     | Dr. L. Shafer.        |
| SHATTUCK, J. F., A. M.,      | Vermont,      | Dr. George B. Rowell. |
| SHEPARD, E. L., . .          | Illinois,     | Dr. W. A. Shepard.    |
| SHEPSTONE, JAMES ALBERT,     | Illinois, .   | Prof. E. S. Bailey.   |
| SHORT, J. L., . . .          | Kansas, .     | Practitioner.         |
| SHULTS, J. W., . . .         | California,   | Dr. G. McGavren.      |
| SINGER, J. D., . . .         | Pennsylvania, | Dr. D. W. Arbuckle.   |
| SMITH, MRS. JENNIE, .        | Iowa, .       | Dr. C. W. Smith.      |
| SMITH, SEDDIE P., . .        | Illinois, .   | Dr. A. E. Small.      |
| SNYDER, WALTER, . .          | Michigan,     | Faculty.              |
| SPATZ, J. E., . . .          | Illinois, .   | Drs. Wales.           |
| SPAULDING, CHARLES W.,       | Michigan,     | Dr. M. W. Slocum.     |
| SPENCER, E. E., . . .        | Wisconsin, .  | Faculty.              |
| STAFFORD, C. E., . .         | Michigan,     | Dr. Colman.           |
| STANARD, O. B., B. S., .     | Illinois, .   | Dr. G. W. I. Brown.   |
| STERNE, T. W., . . .         | Ontario, .    | Prof. T. S. Hoyne.    |
| STEVENS, H. F., . . .        | Illinois, .   | Prof. H. B. Fellows.  |
| STRADER, A. G. H., . .       | New York,     | Dr. G. H. Smith.      |
| SWETT, EMMA F., . . .        | New York, .   | Dr. R. S. Bishop.     |
| SYLVESTER, W. O., . .        | Illinois, .   | Faculty.              |
| TAYLOR, MRS. B. M., . .      | New York, .   | Dr. Myron Adams.      |
| TAYLOR, G. J., . . .         | Illinois, .   | Prof. J. E. Gilman.   |
| TAYLOR, W. B., . . .         | Illinois, .   | Dr. D. W. Robinson.   |
| THIELE, A. B. P. J., . .     | Illinois, .   | Dr. C. A. Pusheck.    |
| THOMAS, R. A., . . .         | Indiana, .    | Dr. G. W. Higbee.     |
| THOMPSON, JAMES H., .        | Pennsylvania, | Dr. L. H. Willard.    |
| THORPE, MRS. E. L., . .      | Iowa, . .     | Dr. M. Y. Baker.      |
| TRACY, POLLY S., . . .       | Pennsylvania, | Dr. E. T. Woodworth.  |
| TRACY, S. P., B. S., . .     | Michigan, .   | Dr. C. C. Miller.     |
| TUBBS, J. F., . . .          | New York,     | Dr. F. R. Norton.     |
| TURNER, PORTER, . . .        | Indiana, .    | Dr. A. L. Fisher.     |
| VEENSCHOTEN, T., JR., A. B., | Iowa, . .     | Dr. C. C. Shinnick.   |
| VAN VELZER, C. A., . .       | Illinois, .   | Dr. R. F. Lowry.      |

\*Partial Course.

| NAME.                   | RESIDENCE.    | PRECEPTOR.          |
|-------------------------|---------------|---------------------|
| VINCENT, C. H., . .     | Michigan,     | Dr. G. C. Vincent.  |
| VIOLET, MALCOLM, . .    | Wisconsin, .  | Dr. H. W. Wells.    |
| VOLMER, JACOB, . .      | Michigan,     | Dr. M. M. Knight.   |
| VRADENBURG, H. L.,*     | Illinois, .   | Faculty.            |
| WAGGONER, M. C., . .    | Iowa, .       | Dr. M. R. Waggoner. |
| WALKER, MRS. KATE, . .  | New York, .   | Dr. A. S. Couch.    |
| WARDEL, BERTHA, . .     | Illinois, .   | Faculty.            |
| WATERHOUSE, MISS F. M., | Pennsylvania, | Prof. E. S. Bailey. |
| WATSON, C. M. E., . .   | Michigan, .   | Dr. J. S. Wheelock. |
| WEBSTER, B. N., . .     | Wisconsin,    | Drs. Sawyer & Wade. |
| WEBSTER, EDWIN, . .     | Illinois, .   | Dr. J. H. Carper.   |
| WEEKS, G. H., . .       | Illinois, .   | Dr. M. W. Burnett.  |
| WEIDNER, W. F.,† . .    | Iowa, .       | Practitioner.       |
| WELCH, T. R., . .       | Kentucky,     | Dr. J. C. Welch.    |
| WELLS, SARAH M., . .    | Michigan, .   | Dr. J. P. Dake.     |
| WESTERFELT, ROBERT, .   | Sweden, .     | Faculty.            |
| WHEELER, MRS. F. M., .  | Illinois, .   | Dr. Lelia Bedell.   |
| WHEELER, T. B., . .     | Illinois, .   | Faculty.            |
| WHITELY, MRS. E., . .   | England, .    | Prof. A. E. Small.  |
| WHITTIER, G. N., . .    | Colorado,     | Dr. B. A. Wheeler.  |
| WILCOX, MISS S. C., . . | Iowa, .       | Dr. M. Y. Baker.    |
| WILLER, A. M., . .      | New York,     | Dr. N. R. Haviland. |
| WILLIAMS, MRS. H., . .  | Ohio, .       | Dr. B. C. Stimson.  |
| WILLIS, ROBERT, M. D.,  | Wisconsin,    | Practitioner.       |
| WITHERELL, GEORGE, . .  | Iowa, .       | Faculty.            |
| WYCOFF, PETER, M. D.,   | Pennsylvania, | Practitioner.       |
| YATES, TANDY G., . .    | Kentucky, .   | Dr. W. M. Hill.     |

Total number of students, 257.

### THE SECOND ANNUAL MEETING OF THE ALUMNI ASSOCIATION.

According to announcement, this Association held its second annual meeting on the evening prior to the College Commencement Day, viz.: Wednesday, February 25, at 8 o'clock, in the club-room of the Palmer House. The attendance was larger than many anticipated, there being about 150 present. Fully an hour was devoted to

\*Matriculate only.

†Partial Course.



chatting and visiting one with the other before the regular order of exercises was begun.

In the unlooked-for absence of the President, the first Vice-President, Dr. E. M. P. Ludlam, was called to the chair, and conducted the meeting to its close. Among the reports made by the officers of the Association was that of Dr. J. P. Cobb, Treasurer, who said that he had the munificent sum of \$31.55 on hand; also that of Dr. E. A. Ballard, who told something of the Executive Committee's work for the year; and the report of the Necrologist, Dr. E. S. Bailey, as follows:

MR. PRESIDENT: I would have been glad, could I have offered a report that death had not taken away during the past year one of the 1,223 graduates of "Old Hahnemann." Were we to count only the numbers, happily the list would be a short one, but we remember with sorrow that each name that must hereafter be marked as having died means also that a life-work has been ended, a family circle broken and a professional tie severed. We feel that our losses have been much in the personal worth of those who left us.

In the Faculty death has claimed Nicholas F. Cooke, M. D., Emeritus Professor of Special Pathology and Diagnosis. He died of heart disease, February 1, 1885. He did not graduate at this college, but he did much to establish this institution of medical learning.

Dr. W. F. Dodge, of Earlville, Ill., class of 1867, died in September, 1884.

Dr. D. H. Kleckner, of Davis, Ill., class of 1878, died in August, 1884, of typhoid fever.

Dr. J. A. Bettes, of Michigan, class of 1883, died in June, 1884, of small-pox. He literally sacrificed his young and promising life in seeking to save the lives of others. Heroically he died, as does the soldier at the cannon's mouth.

Dr. Charles E. Stinson, of Illinois, class of 1873, died in February, 1883, of consumption.

The President having been gracious enough to forward the manuscript of his address, so that the alumni at the meeting might hear him, even though they might not see him, the same was read by the Secretary, and as its reception was both hearty and merited, it is appended in full, in order that many more alumni may feast thereon.

## THE ALUMNI ADDRESS.

BY L. A. BISHOP, M. D., PRESIDENT, FOND DU LAC, WIS.

FELLOW ALUMNI:—With mingled feelings of pride and pleasure I welcome you to our second annual reunion. So noiseless and fleet have been the feet of time that I can scarcely realize that one whole year, with its lights and shadows, its frowns and favors, its reverses and achievements, has come and gone since a goodly number of the graduates of Hahnemann Medical College and Hospital of Chicago met in the Grand Pacific Hotel and organized "The Alumni Association of the Hahnemann Medical College of Chicago." So well did they do their work, so harmonious were they in their grand undertaking, and so zealous in carrying out the details then enacted, that from the necessarily absent ones came but one response and that was none other than universal congratulation. Why the organizing of this association was left these many years for you and for me to accomplish has, and ever will, no doubt, remain until the end of time, to me at least, an unsolved problem.

In thinking over the many advantages to our *alma mater*, our neighbors and ourselves that are possible and should follow the development and growth of such a society, a few points in particular, it seems to me, are worthy of more than a passing notice, and which I would most respectfully submit to your careful consideration. The first and principal object is "social intercourse," the meeting and clasping the hand again of old friends and classmates after many years of separation, the talking over of old times, the reviving of old associations long since forgotten, the comparing of notes, the interchange of ideas, the meeting of more recent graduates, the introduction to brothers and sisters born into medicine and surgery since we left our maternal hearthstone. We have heard of them often, we have formed a very favorable opinion of them, and look forward with delight to our annual reunions where we may meet and grasp them by the hand and wish them, too, God-speed.

We come together from the Northland, from the Southland, from the East and from the West and from the far-off islands of the sea, for the interchange of thought and feeling, for social interest, for social pleasures, for social benefits, for social happiness and for social duties. Then let us endeavor to make these family gatherings as attractive as lies in our power, by the arranging and carrying out a programme so attractive that attendance positively leads to chronic devotion, so that "we all of us" shall look forward to its coming as the New England families in days of old looked forward for weeks and months to the coming of the annual Thanksgiving dinner at grandfather's house as an event which sickness alone was a loyal excuse for absence.

I would suggest the founding of a pathological museum to be known as the "Alumni Museum," in connection, if possible, with Hahnemann College, the specimens to come direct from the members of the alumni association, each specimen to be accompanied with a clinical report, there to be properly labeled and the report filed for future reference. Even one specimen a year from each member would, in a short time, form an aggregate of immense proportions and intrinsic value.

I also suggest, that in after years when the association shall have acquired sufficient growth and zeal, the erection of a suitable building adjacent to the college campus for the sole use and purpose of the alumni association, to be known as "Alumni Hall."

There is another matter I would most respectfully call your attention to, and that is the furnishing of short, concisely written clinical reports for our medical journals. I am loth to say it, but I think I express the sentiment of the profession when I say that our medical journals as a rule are not supplied with that amount of good, reliable clinical matter from eminent surgeons and physicians that our extended patronage as a school demands and positively requires in order to keep abreast with the rapid strides made by the dominant school of medicine. The fault lies either with the editors, or with many practitioners, whose heads are white with the frosts of many winters and whose memories are replete with the experience and successes of infinite value to the younger practitioner as well as those not much younger than themselves, and it is for that knowledge that we younger physicians are as clamorous as a child is for its mother's milk.

I would also most respectfully call your attention individually, not as an association, to the inestimable benefit to be derived from judiciously spending on an average not less than one hour out of every twenty-four in the study of medicine and surgery. I would suggest that you select some one of the many departments and give it your special attention, and by so doing you will be astonished at the additional fund of knowledge you will acquire. One can scarcely comprehend that with the above amount of study in from three to five years he can commit every word in Gray's Anatomy, know the location and name of every nerve, blood vessel and muscle, minutely describe the location, structure and function of every organ. When we meet such an individual we call him learned—and so he is—and look upon him with mingled feelings of wonder and surprise. There is but one way of acquiring this additional knowledge, and that is by continuous study and investigation. We never cease being pupils, though some of us may be teachers. Our knowledge constitutes our stock in trade. When a business man wishes to enlarge his business he increases his capital, thereby enabling him to increase his income; so, with the professional man, if he is contented to do business with only the stock in trade which he received in the medical college, he

must be contented with a limited business with limited remuneration, but if by study and investigation he is determined to each day acquire more knowledge than he possessed the day before, the time will certainly come when his opinion and services will command a lucrative consideration and become the possessor of increased facilities for amusement and recreation.

There is a query that has often presented itself to my mind, viz.: Why is it that the expectancy of life among physicians, as a class, is not greater than his fellowman? His knowledge of how to care for one's self should more than balance the exposure to the inclemency of the weather and the depressing influence of contagious diseases. I can form but one solution of the problem, and that is that the medical man does not live up to the knowledge he possesses, or in other words, he does not "practice what he preaches." There is another point to which I wish to call your attention, and that is the hearty endorsement by this association of the efforts of our *alma mater* to substitute clinical for didactic instruction. I positively believe that the time is coming when the major part of a college course will consist in practical clinical instruction verified by ocular demonstration in the hospital dispensary and clinical amphitheater, and the Faculty of Hahnemann Medical College of Chicago is entitled to congratulations for its effort to make it the leading clinical college of the world—not only congratulations, but our undivided support. It is not only eminently proper, but advisable, that we show our filial affection and devotion to our *alma mater* by assuring her that we are ever mindful of her interests, that we weep over her misfortunes and rejoice over her triumphs.

With these few suggestions on the requirements of the "Alumni Association of the Hahnemann Medical College," I bid you God-speed.

The sportive season of the meeting was inaugurated when the chair called for the "five-minute speeches," and considering the natural volubility of some, the speakers generally kept marvelously well within the limit of time. Those who thus spouted were Drs. M. H. Parmelee, of Toledo, Ohio; E. W. Beebe, Joseph Lewis and C. W. Carlson, of Milwaukee, Wis.; S. M. Spaulding, of Minneapolis, Minn.; George Fellows, of Appleton, Wis.; William H. Wheeler, of Hartford City, Ind.; C. H. Vilas, S. Leavitt, J. E. Gilman, T. C. Duncan, G. F. Shears, E. S. Bailey, E. A. Ballard and R. Ludlam, of Chicago.

The suggestions advanced in the Presidential address were heartily endorsed, especially the one relating to the establishment of a pathological museum, and a vote of thanks was tendered to Dr. L.

A. Bishop by the unanimous approval of the Association for his excellent address.

A list of twenty-seven names passed muster before the Executive Committee, and all were elected to membership of the Association.

Then came the election of officers for the ensuing year, with the following result :

Dr. E. M. P. Ludlam, President ; Dr. W. B. Carmen, Vice-President, New York ; Dr. J. E. Gilman, Vice-President, Illinois ; Dr. G. A. Mueller, Vice-President, Pennsylvania ; Dr. P. S. Wyckoff, Vice-President, Dakota ; Mrs. Dr. C. A. Risdon, Vice-President, California ; Dr. Charles G. Fellows, Vice-President, Louisiana ; Dr. S. M. Spaulding, Vice-President, Minnesota ; Dr. M. H. Parmelee, Vice-President, Ohio ; Dr. Joseph Lewis, Vice-President, Wisconsin ; Dr. C. Farrington, Vice-President, Kansas ; Dr. C. A. Walsh, Vice-President, Michigan ; Dr. D. H. Brien, Vice-President, Wyoming Territory ; Dr. A. K. Crawford, Secretary ; Dr. J. P. Cobb, Treasurer ; Dr. E. S. Bailey, Necrologist. Executive Committee.—Drs. O. W. Carlson, Milwaukee, Wis., and E. A. Ballard and G. F. Shears, Chicago, Ill.

The association then adjourned to meet again a year hence. If the fair foothold it has already gained in so short a time among the old-time graduates of the Hahnemann, and the harmony and goodwill which pervaded this anniversary meeting can be taken as an omen of its future, then the Alumni Association is to become a power for good, an institution for progress, the "fair-haired boy" of its *Alma Mater*.





**J. E. GILMAN, M. D.**

**PROFESSOR OF SANITARY SCIENCE IN THE HAHNEMANN MEDICAL COLLEGE AND  
HOSPITAL, CHICAGO.**

# THE CLINIQUE.

---

VOL. VI.]

CHICAGO, APRIL 15, 1885.

[No. 4.]

---

## Original Lectures.

### NERVE INHIBITION.

A LECTURE BY C. E. LANING, M. D., PROFESSOR OF DESCRIPTIVE AND PRACTICAL ANATOMY, AND OF THE DISEASES OF CHILDREN, IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

*(Continued from Vol. V. page 438.)*

To understand this in the fullest sense requires a careful study and analysis of the symptoms due to pathological changes arising from drug action or other morbid agents. So far as drugs are concerned, the lesions arising from their influence are such as result from a plus or minus of the physiological action of the tissues involved. Hence they may be divided into two main or primary classes, viz.: those which stimulate, hasten the discharge of pent-up nerve force, and those which act as narcotics or sedatives, retarding the giving out of nervous energy in the afferent nerves and lessening the capacity of the efferent for conveying any of the various sensations of which they are capable in a normal state.

It is claimed by various authors that almost all drugs have a twofold action, stimulating one organ or set of tissues and depressing another, or at one time stimulating a given tissue, and later depressing it, or the reverse. I do not believe they do so.

Dr. H. O. Thomas, in his work on Nerve Inhibition, says, "This error has arisen from insufficient attention to the fact that each drug has a special affinity for certain structures, thus causing a temporary defect of co-ordination." It is undoubtedly true that too little



attention has been given to this fact. Nor is it comprehended how comparatively limited, in the strict sense of the term, this action is.

Thus, special nerve cells upon which a drug acts being either stimulated or depressed, their influence upon other cells or centers is modified, and corresponding symptoms arise, without the medicine having literally acted upon the secondary group of cells at all. Now, if the effect of the morbid agent has been such as to cause a depression of the centers directly acted upon, the adjacent ones will have their functional activity modified in one of two ways. If the centers primarily involved have exerted upon the secondary group an inhibiting influence, then will the said group of nerve cells give rise to a series of symptoms indicating an increase of their functional activity, apparently having been stimulated by the drug, while the first group have been depressed.

It is then certainly apparent that the drug has not, in the true sense of the term, stimulated one center and depressed the other. If, acting first upon inhibitory centers in such a way as to increase their restraining power upon other structures, in short, if it stimulated them, there would result diminished action of the tissues under their control, another instance of apparent stimulation of one center and depression of another by the same drug.

Still bearing in mind the fact of drugs having an affinity for certain tissues, we shall see another reason for their supposed dual action. Not only do they act upon a certain set of tissues, but they attack them in a definite order.<sup>6</sup> The structures first affected are also the first, as a rule, to react, so that in administering a drug for the purpose of studying its physiological action, the fact must not be lost sight of that after a given length of time there will be two sets of symptoms present, one due to the reaction of the tissues primarily affected, and the other to the action of the drug upon the last ones involved. Later on, these give place to the symptoms of reaction, and thus, apparently, the medicinal agent has had a double action upon all the structures affected.

It is certain that just as a lesion due to some morbid agent outside of the domain of drugs gives rise to many reflex symptoms, so does a drug lesion. Hence symptoms may be noted in regions upon which the drug has no specific, real action. Nevertheless, these symptoms are not to be discarded as "merely reflex," since a given lesion, all things being equal, will give rise to certain definite reflexes,

which often aid us materially in locating the lesion and selecting the remedy.

This brings us to the point where we are prepared to understand why medicines selected in accordance with the law *similia similibus curentur* cure diseases. Why should they not do so if given upon the opposite principle of the old school—*contraria contrariis curentur*?

You are undoubtedly familiar with the various theories advanced in regard to this matter, as, that all diseases are like plants, having certain stages to pass through in arriving at maturity, and then passing into decay. The deduction to be drawn from this, then, is that the appropriate remedy acts upon the disease as does the greenhouse upon the plant—hastening it in an unnatural manner to maturity and likewise decay.

It has been asserted that two diseases of a like nature cannot occupy the body at one and the same time; the inference in this case being that the drug disease, having the greater strength of the two, displaces the natural (?) one, and it (the drug affection) being self-limited, in a short time disappears.

This seems far more reasonable and tenable than the former one, still I do not believe it to be the true explanation. To make my idea clear I must elucidate one or two points having a bearing upon the case.

If a given number of persons are exposed to disease-producing influences, all are not affected; of those affected, if left to nature, some recover—some do not. This demonstrates that not all persons are *acted* upon by disease-producing agents; and further, that of those *acted* upon, *all* do not *react* without assistance.

With drugs it is different; a dose of *Arsenicum* of a certain strength may be given to many persons, and with rare, if any, exceptions they will *all* be *acted* upon by the poison, and if the dose is not necessarily lethal, they will *all* react. From this fact, then, comes the basis of our knowledge of the scientific use of drugs. Unless the vitality be reduced below a certain degree, a given drug will always produce its action, and likewise its reaction.

Now it is clear that if a drug has influence upon the economy sufficient to cause action, there *must* result reaction. It is as certainly evident that, if the action of the drug represents health, its reaction cannot; that is to say, if the organism, laboring under dis-

ease, a plus or minus of physiological action, can be made to assume the conditions of health through the *action* of a drug, then only an apparent cure has been effected, since the reaction must follow sooner or later, and will be away from health, moving in the direction of the original aberration for which we prescribed.

If, on the contrary, a certain set of tissues are affected, but cannot react, and a drug is given which acts upon these tissues in the same or a very similar manner to the disease, the structures involved are first acted upon by the drug in such a way as to increase temporarily the original malady; this is, remember, however, only the action of the medicine, the reaction must follow, and is of necessity in the direction of health. If the *reaction* excited by the drug is in the direction of health, it is all we can wish.

As illustrative of this, notice the different manner in which Digitalis is used by the schools for the purpose of regulating the heart's action.

Suppose, in a given case, the heart is beating too rapidly. Allopathy gives digitalis, the *action* of which is to diminish the frequency of the heart's movements by stimulating its inhibitory nerve, the vagus. If a sufficient quantity be given, health, so far as the pulsations of the heart are concerned, is established through the action of a drug. But the reaction must come, and unless the heart be held in abeyance by repeated and increased doses of the drug, and even this must have a limit, the difficulty for which it was prescribed will return with more than its original severity, the disease being augmented by the reaction of the nerve against the drug.

On the other hand, when the heart is beating too slowly, Homoeopathy prescribes digitalis; the action of the medicine is in the same direction as that of the disease, it nevertheless excites the nerve to reaction, which must, as a natural consequence, be toward health.

It is true, cases of palpitation are sometimes, at least apparently cured by digitalis. This is only where the parietic state of the vagus-nervus is transitory, self-limited; the lesion, therefore, which caused the paresis may pass away while the nerve is under the influence of the remedy. In such a case, when the drug was discontinued there would be the inevitable reaction, causing a temporary paresis of the nerve, which would soon pass off, leaving the heart to resume its normal action.

We can now comprehend why, in making application of the law

of similars, we must select the remedy so carefully, since it is absolutely necessary that its action must be upon the tissues affected; and, further, that its action upon them must be *very* similar to that of the morbid agent which originally produced the disease.

Unless our investigation not only determines the class of tissues involved, but also the manner in which they are deranged, any prescription based upon such investigation will be erroneous.

To decide these points is not always an easy task. Thus, in cases of constipation, we must not merely know that there is present ineffectual urging, in order to select *nux vomica*, but we must know that this is due to a spasmodic action of the nerve cells in the cord from which the intestinal nerves receive their motor impulses. For if the ineffectual urging was due to vaso-motor disturbances, as under sulphur, the *nux* would certainly do no good. The sulphur produces flushings of the muscular and mucous coats of the intestines, as it does of the integument; this suddenly augmented quantity of blood in the structures causes an irritation of the sensory nerves distributed to them, and reflexly gives rise to temporary peristalsis. You see, then, that we can no more prescribe for a symptom unless we know in some way that it is one of a group to be removed by *nux* or sulphur, than for a mere name of a disease, since a symptom, as ineffectual urging, may convey as much and no more intelligence to the physician than would the name of a disease.

In order then to cure in the true sense of the word, we must prescribe our remedies in such a way as to have them act upon the nerve centers primarily involved in the production of the disease.

Many, in fact the greater proportion of symptoms present in disease are due not directly to the original lesion, but indirectly, through its influence being conveyed to other parts through some of the various nerve fibres which pass to or from it. Many of the phenomena of disease are misunderstood or entirely overlooked, that is, particularly those belonging to the nervous system proper, because physicians have come to look upon this portion of the organism as consisting entirely and distinctly of motor and sensory nerves. The various nerve fibres which travel in and constitute the *rami communicantes* are seldom studied in their connection with disease, and yet the part they play is of the greatest importance. It is largely, very largely through these that reflex symptoms are carried. As I have already said, this class of symptoms should, and I am sure will,

receive their proper share of attention at some future period. If correctly interpreted, they signify much; not only the location of a lesion, but also the character and severity of the same, also the class of nerves affected. We must keep before us the functions of the various nerves contained in the *rami communicantes*. They all belong to the group of afferent nerves, and are known as reflex excito-motor, reflex excito-secretory, and reflex excito-inhibitory. That the symptoms which are developed through irritation of any of the groups be not confounded with another set of symptoms, we must remember that the efferent nerves may give rise to very similar ones, the outgrowth of lesions quite remote from and dissimilar in character from those affecting the afferent reflex nerves. Thus, while we have reflex excito-motor, etc., in the last group, in the first there are found motor, secretory, inhibitory, vaso-motor, trophic, calorific and frigorific nerves.

It can easily be seen that while a lesion at the origin or along the course of a motor nerve will naturally give rise to motor symptoms, it is not always remembered that motor phenomena may be present without any direct lesion of a motor nerve, due to irritation of some reflex excito-motor nerve. For this reason the location of the pathological change producing the symptoms is often obscure and at quite a remote point from that where we recognize its effects.

If symptoms arise in some of the tissues supplied by the ulnar nerve, we naturally expect there is difficulty somewhere in the course of the nerve, or at its spinal origin, or possibly still deeper in the brain. When careful investigation shows this to be untrue, we come to realize the fact that this nerve may be affected from some different source, i. e., through some of the filaments of the reflex excito-motor nerves coming from the heart, stomach, lungs or intestines, as the case may be. Not only may symptoms indicative of motor disturbance be manifested through this nerve, but also those of sensory, trophic, vaso-motor, etc.; while unnatural growth of the nails, as clubbed, fissured, brittle, etc., may be due to an obstructed subclavian vein, they might and more frequently are due to trophic disturbances, either directly in the cord or reflected to it from some adjacent organs or tissues. The reflex excito-inhibitory nerves play an important role in disease and therapeutics. In some abdominal diseases the pulse is slow, in others rapid. In the first case the abdominal lesion acting upon and through the reflex-inhibitory nerves

diminishes the heart's action. It is evidently necessary to ascertain whether the lesion affecting the heart is at the origin of the vagus, somewhere along its course or merely reflected to it through the reflex excito-inhibitory nerves. Inasmuch as any nerve which exerts a restraining influence upon an organ is virtually inhibitory in its function, it has been my custom to consider vaso-motor nerves as in some cases inhibitory. It is true that a diminished action of an organ, due to lessened blood supply, cannot properly be considered inhibitory action, still the effect is often similar, and certainly needs to be taken into consideration. Thus the inhibitory nerves of the kidneys are certainly the least or renal splanchnics. By inhibitory in this case I mean the power which these nerves have to diminish or entirely suppress the flow of urine. This influence is certainly exerted through the vaso-motor filaments contained in these nerves, showing that vaso-motors have in this instance, as in many others, an inhibitory effect upon certain organs. This brings us once more to the consideration of the importance of understanding the *true* pathological condition which has given rise to a certain symptom or group of symptoms. In the case of the kidneys we find that while under *Apis* the urine is scanty or suppressed, it is through the action of that drug upon the renal splanchnic, causing irritation of its vaso-motor filaments, and thus diminishing the lumen of the renal arteries to such an extent that the kidneys appear pale and are almost bloodless, the cause for the suppressed urine being of course obvious.

On the other hand, a similar condition may exist under *Aconite*, *i. e.*, a scanty or suppressed urine, but the kidney is in a very different state from what it was under *Apis*, viz., highly congested down to the finest capillaries, illustrating that extremes meet, identical *symptoms* produced by diametrically opposite causes. In a former lecture I have spoken at such length upon the direct and reflex inhibition of the intestines that it is unnecessary to devote any time to it now.

And this brings us to my next point, which is, since most or perhaps all organs have inhibitory centers controlling them, the question naturally arises, From what source do these centers receive their restraining influences? For is it any more reasonable to suppose that an inhibitory nerve cell will not throw out, unless restrained, more energy than is necessary for the regulation of the organ under its control than it is to presume that an excito-motor cell will unless inhibited? In short, what inhibits an inhibitory center?

While this question must remain unanswered for the present, let me draw your attention to the fact that inhibitory centers are many times reflexly affected, either so as to increase or diminish their activity. You must not, however, forget that very similar, sometimes identical, symptoms arise from opposite causes. Thus the pulse may be increased in frequency on account of diminished inhibitory influence, or again because of increased excito-motor energy being evolved. We observe that in some gastric and intestinal lesions the heart is slowed, because through the reflex excito-inhibitory nerves the center in the medulla is stimulated, and a diminished pulse results. In peritonitis the pulse is increased in frequency and diminished in volume. This is not because of a parietic state of the vagus, but because the reflex excito-motor nerves arising in the inflamed membrane convey a stimulus to the excito-motor nerves of the heart, increasing its activity; at the same time the nerves traveling upward in the *rami communicantes*, which reflexly affect the vaso-motor centers, stimulate them to such an extent that the caliber of the arteries and capillaries are diminished, hence there is a rapid, tense, wiry pulse. The law of compensation comes into play here to such an extent that we cannot state positively after all whether the heart and vessels are reflexly affected as a direct consequence of the peritonitis or whether the heart is first influenced in such a way as to hasten its impulse, the contraction of the vessels then occurring in a compensatory manner, or are the vessels first contracted and as a result the heart's rapidity multiplied? Without stopping to give you my reasons for so believing I will say that I think the heart and vessels are both affected reflexly by the inflamed peritoneum.

You can see what an immense field this subject of the relation of the nervous system to disease covers, and so without telling you half of what I had wished to, my time is more than exhausted. There are many other points of which I should have spoken, particularly of the therapeutical side of the question, but must desist until some other time. I hope you will, however, continue to study and investigate in this direction, as I believe it will lead toward a more positive and scientific knowledge of medicine.

---

## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

APRIL MEETING, 1885.

The regular monthly meeting of the Clinical Society was held in Parlor 44 of the Grand Pacific Hotel on Saturday evening, April 4. The President, Dr. J. E. Gilman, occupied the Chair, and Dr. J. B. S. King acted as Secretary. Twenty-eight physicians were present. The proper report was presented by

### THE BUREAU OF OBSTETRICS.

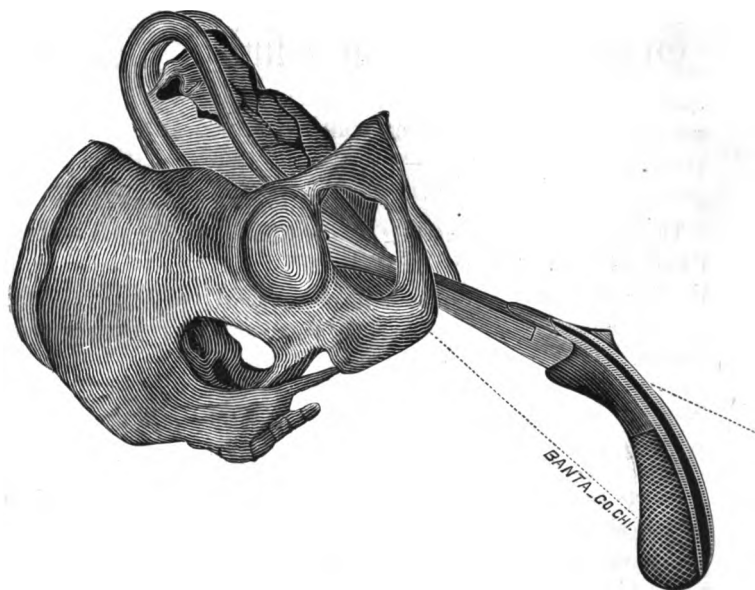
S. LEAVITT, M. D., CHAIRMAN.

**AXIS-TRACTION FORCEPS.**—Ever since the introduction into obstetrical practice of the long forceps, there has been a sensible need in certain cases of some peculiarity in the form of the instrument which would enable the operator to make traction in the line of the axis of the plane of the superior strait. The difficulty lies in the curve of the parturient canal, which, from brim to outlet, is considerable, as will readily be seen when we remember that, in the erect position of the woman, the plane of the brim is at an angle of  $60^{\circ}$  with the horizon, and the plane of the outlet at an angle of  $11^{\circ}$ .

But when we recollect that the head of the fœtus does not come into the world on the plane of the outlet of the bony pelvis, which faces somewhat backward, but on a plane, the posterior boundary of which is the posterior commissure of the vulva, and which looks almost directly forward, we have a better idea of the extent of the curve of the parturient canal.

The long forceps, as ordinarily constructed, are provided with a curve to conform to the curve of the pelvic axis, and therefore when the instrument is applied to the head lying at the superior strait, or above, and traction made, a certain part of the force is dissipated, owing to our inability to make traction in the direct line of the pelvic axis. This effect is easily demonstrated on the manikin, or on the dry pelvis, and is illustrated in the accompanying drawing made from the objects which it represents.

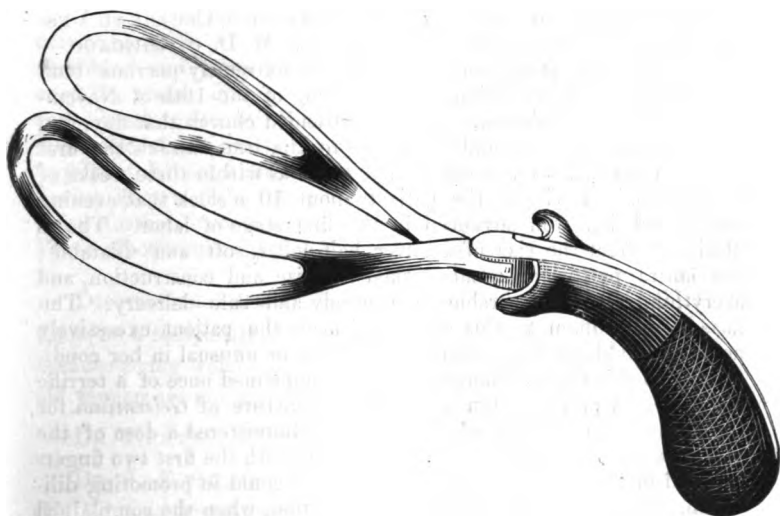




To be sure, the difficulty presented in the majority of cases in which the forceps are used at the pelvic brim or above it, is sufficiently well overcome by the long forceps as ordinarily constructed; but occasionally the brim is either so considerably diminished in its diameter, or the foetal head so hard and so greatly augmented in its volume that only by dint of powerful traction, and the most expert management, is the labor brought to a successful termination. It is in such cases, and perhaps also some of those which ordinary forceps cannot terminate, that the axis-traction instrument is peculiarly serviceable. With it the head can be drawn into the brim in a direct way, while with the other instruments the head is drawn toward the symphysis pubis as well as toward the pelvic inlet.

As an example of what inventive genius has done toward providing us with an instrument by means of which direct axis-traction can be employed, we may mention Tarnier's forceps, which are generally regarded as a practical instrument, but one expensive, heavy, clumsy and extremely difficult of application by any save experts. The cut of this instrument is probably familiar to the greater part of those present. I regret my inability to exhibit these forceps to you, but upon searching the instrument shops they could not be found.

My main design in bringing this subject to your notice to-night is to direct attention to the obstetrical forceps which bear my name. About two years and six months ago the first instrument of this pattern was made by Otto & Co. for Messrs. Gross & Delbridge, and since that time a great many have been sold.



They are now manufactured by most of the instrument makers, and are on sale at nearly all the instrument shops.

Yet during this time I have not called any public professional attention to the forceps, and this will be the first time that they have been exhibited to a company or society of physicians.

So far as the main features of the instrument are concerned, I claim no originality. The blades are the same as those of Elliott's forceps, than which, for general obstetrical use, no better, I believe, are to be found. The handles do not differ materially from those of Dr. Aveling's instrument, long since designed.

But the combination is mine, and, from repeated use, I am satisfied that it is a good one. These forceps can be effectually, and with equal facility, applied to the head in all situations—above the brim, at the brim, in the pelvic cavity and at the outlet. In other words, it answers the purpose of any other instrument, while it also serves an exceptionally good purpose in difficult cases at and above the brim, by enabling us to make traction in the line of the axis of the pelvic inlet. I need only to add that, in such cases, the weight of traction effort should be made near the extremity of the handle.

There are other features of the instrument which commend it to me, not least among which is the excellent and unwearying hold which, from its peculiar shape, the handle affords; but I will not take up your time with details and comparisons. In my own practice, I now use no other pattern, though I have two or three of them; nor have I yet discovered any feature in it which I would like to change. You, however, may suggest improvements.

**SUDDEN DEATH FROM THE RUPTURE OF A CEREBRAL VESSEL DURING LABOR.**—BY W. S. HARVEY, M. D., OF CHICAGO.—*Case.*—Mrs. P., primipara, æt. 32, of an extremely nervous temperament, was taken in labor on the evening of the 16th of November last at about 8 o'clock. She had attended church that day, and was in her usual health and spirits up to the time she felt the first pain. According to her calculation she was within three weeks of "full term." I visited the patient about 10 o'clock that evening and found her well advanced in the first stage of labor. The os uteri was about the size of a silver half-dollar, soft and dilatable; the entire parturient canal normal in size and construction, and everything seemed favorable to a speedy and safe delivery. The false pains common to this stage had made the patient excessively nervous, but there was nothing remarkable or unusual in her condition up to this time, although she had complained once of a terrific headache. I prepared ten drops of the tincture of *Gelsemium* for the headache in one-half glass of water, administered a dose of the medicine and sat down by the patient's side with the first two fingers inserted in the os to be of what assistance I could in promoting dilatation. Scarcely had I assumed this position, when she complained of a numbness, and confessed that she had experienced similar sensations several times during the afternoon, especially in the lower extremities, which I attributed to the pressure of the child on the crural and pelvic nerves. The pains were now increasing in frequency and becoming less difficult to bear. I assured her "that it would not be long before it was all over," and was about to rupture the membranes, when she suddenly complained again of feeling numb, and almost in the next breath exclaimed twice in quick succession that she was "dying," and never did she speak the truth more unerringly. Her eyes became at once set and staring, her face blanched, her breathing stertorous and her body limp and motionless, and from that moment she never moved a muscle. Without delay, I ruptured the membranes, and with my forceps delivered the apparently dead mother of a living, vigorous child. This all occurred within an hour after I first entered the house. I worked hard the four succeeding hours endeavoring to resuscitate the woman, trying every available means at hand, such as artificial respiration, applying mustard drafts over heart, pit of stomach and soles of feet, injecting sub-cutaneously stimulants, *Digitalis*, etc., and applying to nostrils aromatic spirits of ammonia. But it was all in vain. The patient was beyond resuscitation. Though dumbfounded and non-plussed, I believed her death was caused from shock and paralysis due to a ruptured blood-vessel in the brain, which diagnosis Dr. Gilman subsequently re-affirmed.

A *post-mortem* was held after the body had been placed in the vault, to fully satisfy the husband for all time as to the cause of his wife's death. The diagnosis previously made was fully confirmed.

Later on I learned that this woman had always had a great amount of trouble with her head, having always been subject to nervous, throbbing and congestive headaches, which at times almost threatened her reason, due, as one physician had told her, to an attenuated and dilated condition of the cerebral blood-vessels. The object of this paper is to record a very rare complication of labor, and to inquire if, having known all these sad denouements in advance, and having known fully the physical history of the woman, could anything further have been done to have averted this catastrophe? What effect would chloroform have had if administered early?

DISCUSSION.—DR. H. B. FELLOWS. Cases of cerebral hemorrhage as a complication of labor are not frequent, and this is simply because young women are not apt to have cerebral hemorrhage, and old women are not apt to have children.

DR. HARVEY. This lady was insane at one time.

DR. J. E. GILMAN. I told the husband that there had probably been an aneurism at the base of the brain which had ruptured from the strain of labor. For a long time previous the patient had complained much of headaches brought on by any excitement, the effect of which was to make her very irritable and to induce the numbness spoken of.

Our diagnosis was fully confirmed by a post-mortem held by another physician and the husband. I do not believe that chloroform, or the use of any drug with which I am acquainted, would have altered the result. The husband was fully satisfied, feeling that Dr. Harvey's rapid action in applying the forceps had saved the life of the child.

DR. E. S. BAILEY would like to ask what degree of numbness had preceded this precipitate labor. His idea was to learn whether the interference with the cerebral circulation might not have brought on the early labor.

DR. HARVEY.—I believe she was subject to occasional attacks of numbness, and had complained of it at intervals early in the day on which she died.

DR. LUDLAM had seen this woman two or three times in the early months of pregnancy, but knew nothing of her previous history, nor of her headaches. He believed that nothing anybody could have done would have changed the result, and that Dr. Harvey should be

heartily congratulated upon having saved a human life in a terrible emergency.

DR. G. F. SHEARS.—This paper reminds me of a case of aneurism that occurred in our clinic a year ago with similar symptoms. Pains in the base of the brain, making the patient irritable, morose and almost insane, were the chief features. There was also the peculiarity that, on becoming very angry, the face would become mottled or purple in spots. These symptoms were supposed to be due to a solid tumor, but an operation revealed an aneurism at the base of the brain.

DR. LEAVITT.—How soon after the apparent death of the woman did Dr. H. complete the delivery?

DR. HARVEY.—I could not say just how long; probably two minutes.

PUERPERAL SECONDARY HEMORRHAGE.—BY DR. W. S. GEE, OF HYDE PARK, ILL.—Two puerperal conditions are looked upon with special dread, viz.: Convulsions and hemorrhage. These are opposite in objective symptoms, but are equally destructive to the patient. In one the patient and friends are very demonstrative. In the other she is quiet and conscious of the fatal drain. With both these conditions the accoucheur should be very familiar. With the former he may know some previous condition of the patient which arouses his suspicions and puts him on his guard. While the same, in a measure, is true of puerperal primary hemorrhage, it does not apply to the variety given special emphasis in this report. McClintock describes secondary hemorrhage as "commencing after the patient has been six hours delivered, and within a month from this event." Cazeaux and Tarnier say, "after two or three days, and occasionally even after three, five or six weeks."

*Case 1.*—Mrs. H. aet, 27, of frail body but strong will power, was confined in her second labor September 14, 1883. The labor was painful and tedious, as had been her experience in first confinement, and, on account of exhaustion, the delivery was affected by the help of the forceps. The placenta, to all appearances, was expelled entirely. She made a good recovery to the end of four weeks. While sitting up in bed and holding the baby she was surprised by a gush of blood from the vagina accompanied with faintness and nausea. She lay down, but the flow, although slight, continued during the rest of the night and next night. At 5 P. M. of first day two large clots were

expelled, followed by the gushes as before. This was repeated during the night and second day. Ergot in a half-teaspoonful dose was given and an attempt was made to empty the cavity of the uterus, but the flow persisted. The third day was similar except that the patient was much weaker. *Bell., Puls., Sab., Ham, Croc. Sat., Trill., Spec., Sec. Cor.*, and hot water were all used with but little effect. Tampons of borated absorbent cotton were used during the night, and the flow was apparently checked, but it was discovered next morning that the blood had gone through the tampon. Another trial was made with ergot, hot water and tampons with no better effect than to check the flow for a short time.

Prof. Fellows was called in consultation and after learning what had been given and again carefully looking over the case, we decided upon *Phos.* In recalling the symptoms this one stood out boldly: "Profuse hemorrhage pouring out freely and then ceasing for a short time." *Phos. 6* was prescribed, a powder every half hour for three doses, then every hour until improvement was evident. The effect was highly satisfactory. The tampons were removed in the evening and a hot water injection used. No other tampons were necessary and the case made a slow but perfect recovery.

*Case 2.*—Mrs. B., aged thirty, multipara, was confined February 28, 1885. The child presented by one hip, which was, after some difficulty, changed into a breech presentation, and labor terminated normally. The placenta was expressed by the Credé method, assisted by slight traction on the cord. It appeared to be wholly expelled. She suffered from after-pains, at intervals, for three days. During the next few days the patient was restless, nervous, irritable, fidgety, but had nothing unusual in pulse or temperature. Her recovery was slow but sure until the close of the tenth day. On arriving at the bedside, after an imperative summons, I found her flowing profusely. The nurse administered a slight amount of chloroform by inhalation, while I proceeded to empty the uterine cavity. The vaginal canal, as well as the uterine cavity, was filled with coagulated blood, and a constant bright red stream of blood was saturating the bedding. The uterine walls were soft and relaxed, and no difficulty was experienced in dilating the uterus to the full size of the hand. The internal surface was smooth as normal, and no adherent parts of placenta were discovered. A teaspoonful of ergot was given, the fingers of the right hand gently irritated the os uteri and, with the left hand, firm pressure was made in the hypogastrium over the uterus. These combined influences, as well as dipping the fingers into cold water and applying them over the uterus, were but partially successful. The flow continued, in a less degree, although remedies were given, including *Ip. China, Phos. Cham., Ig., Sec-cor.*, and others with the help of pressure, hot water, lowering the head, and other like expedients. When observing more closely, I was able to group these symptoms: *Mouth, tongue and throat dry.* The patient complained

most of that condition. *Weakness, gasping for breath*, says there is plenty of air in the room, and she can feel it, but she cannot get it into her lungs. Is nervous, fretful and easily annoyed. *Legs tired, must move them from place to place. A feeling of weight in the chest, not on the chest, but "in the region of the breast-bone."* Transposing these symptoms to have them in the language of the provers, they read: *Mouth and throat dry; changeable mood, now laughing, again crying; disposition to faint; legs tired, must move them from place to place; dyspnœa, with feeling of weight in the chest.* Other symptoms before unrecognized were well covered by the same remedy, such as: *Restless sleep, from congestion of blood to heart and head in uterine complaints. Uterus remains uncontracted.* Having the 200th of *Nux Mos.*, one dose of the 200th was placed on her tongue, and ten drops of the tincture dropped into a third of a glass of water. A teaspoonful of this was given, and repeated after ten minutes. Soon after the second dose the faint pulse became perceptibly stronger, and the hemorrhage was under control. Later, instead of the bright red flow a *dark, stringy* flow was substituted, with *dark clots of an offensive odor.* The flow was *worse on motion.* For this change *Croc. sat.* 6 was given with good effect. The case required one or two other remedies for subsequent symptoms, but had no return of the hemorrhage.

*Causes.*—Comparatively few obstetricians have written of secondary hemorrhage. Whether it has been omitted intentionally or was overlooked is for the authors to decide; but certain it is that all cases of childbirth do not escape this critical complication. Cazeaux and Tarnier give the supposed causes as: I. Secondary Inertia; II. Congestions of the Uterus; III. Alterations of the Blood; IV. Inflammatory Ulceration of the Cervix.

Accepting this classification, we find as causes of *Secondary inertia*: Relaxation of the uterine muscular fibres from the presence of parts of adherent placenta, clots of blood, retention of a separately developed placenta (spuria or succenturiata), polypi, malignant growths in and about the uterus; also from debility or hepatic disorders.

*Congestions of the uterus* occur more frequently in the hemorrhagic diathesis, or cases of the "molimen hemorrhagicum" of Madame Lachapelle. Many of the causes enumerated above may induce congestion, and that in turn produce a hemorrhage. This is true of inversion of the uterus and of carelessness or violence in replacing an inverted uterus or removing a retained placenta; irritation of adjacent parts, as from impacted feces in the rectum, the removal of which relieves the whole trouble; shock from unexpected

news, either pleasant or unpleasant, or the use of stimulating drinks, ice water or ice cream.

*Alterations of the blood*, such as remove its coagulating property and nutrient principles; anæmia, from whatever cause; debilitating discharges, so devitalizing the patient that the uterus will not contract even under powerful drugs.

*Inflammatory ulceration of the cervix* is named as a cause, and this view is entertained by Bennett, Fordyce Barker, Byford and others.

Our observation, as well as that of others, I think warrants us in adding one more, viz.: *Laceration of the cervix*. This opinion has been held by some authors and discarded by others, but that there is a class of cases which are not otherwise explained can not be gainsaid. In Volume III of Smellie's "Clinical Reports," edited by McClintock, we find in the report of a case the following:

\* \* \* \* \*

(After he felt the uterus tear when introducing his hand). "To me it seemed probable that this flooding might proceed from some of the large vessels being torn which enter at the side of the uterus."

McClintock remarks: "Smellie is most probably correct in ascribing the violent hemorrhage from the vagina, which came on a day after delivery, to the laceration in the neck of the womb. His treatment,\* based on this supposition, was most judicious, and proved successful in stopping the hemorrhage."

However, McClintock expresses a doubt as to the frequency of these cases. In these days of *hasty* if not "*meddlesome* midwifery" the extensive lacerations are more frequent, and cases of this variety more common. It is not to be understood that the opening of the small blood-vessels in the cervix is the only source, but that as over-excitation later begets relaxation, the circular fibres of the body of the uterus relax their grasp, and after a slight straining movement of the patient, such as an attempt to lift something near the bed, rearranging her back hair, or having a paroxysm of coughing, allows a gush of blood from the uterine sinuses. We all know the effect of irritation of the external os in securing contraction of the uterus and how the introduction of dilating tents will cause a hemorrhage. Then is it not reflexly† by the laceration that the uterus loses much

\*A sponge dipped in a strong solution of alum and applied to the cervix.

†It is now claimed by obstetricians that the "hour glass contraction" is reflex from the presence of a portion of adherent placenta. Hemorrhage from impaction of the rectum is reflex. Our study of the "reflexes" has only just begun.



of its contractility? May it not be in *these* cases that the "ulceration of the cervix" is a frequent cause of alarming hemorrhage coming on days after delivery? Case I falls under the "Secondary Inertia," the result of debility, the patient being very anæmic. Case II will class under "Lacerations of the cervix," as there was an old laceration remaining from first labor with a probability of a fresh tear, even though of slight character. She having suffered from obstinate constipation before labor, the "hepatic disorders" of the first class may have caused a predisposition to this complication. Lastly, the reward that follows pays a hundred fold for the close observation and arduous study necessary for the adaptation of the true homœopathic remedy.

DISCUSSION.—DR. R. LUDLAM.—Dr. Gee's paper is one of the most practical that we have had before us for a long time. If there is any criticism to be made upon it, it is that the clinical history of his cases, from the close of labor to the date of the hemorrhage, is not given. Nothing is said of the pulse, nor of the temperature, and nothing of the character of the lochia, all or either of which might throw some light upon this unlooked-for hemorrhage. I think it probable that each of these cases had a distinctive puerperal history which is not included in the paper. So far as the time of the occurrence of the hemorrhage is concerned, these cases might properly be classed under the head of secondary hemorrhage, but not perhaps in some other respects. If we ascribe a hemorrhage occurring six weeks after delivery to a laceration of the cervix, it would be quite important to know whether there was a primitive hemorrhage from the same cause after labor. If there was not laceration enough at that time to cause an immediate hemorrhage, it would hardly be fair to ascribe a secondary hemorrhage occurring four or six weeks later to the same lesion.

There was, probably, in both cases, a history of endometritis, and in the absence of fuller details, the strongest argument we can offer to prove it is that *Phosphorus* and *Nux moschata* relieved the cases so promptly, for these remedies are addressed directly to lesions of the uterine epithelium, and not to its muscular tissue.

DR. GEE.—In one case the hemorrhage occurred on the tenth day; the woman never had a chill; never a temperature above 101°; never any abdominal tenderness; nor was the lochia at any time offensive; but owing to the talkative proclivities of the nurse she

lost a good deal of sleep. In the second case, *Phosphorus* had no effect whatever, and I had to stay right by the patient for two hours and a half.

I should have mentioned that in the first case the woman had always been very feeble, and had fainted some half dozen times during her labor; and I should like to ask if hemorrhages of this alarming character could depend upon endometritis without some signs or symptoms of that inflammation being present?

DR. LUDLAM.—Of course it would be unusual, but it is quite possible. The chill is not necessary, nor the local pain, but an almost infallible sign is offensive lochia, a symptom for the existence of which, especially if we see the puerperal patient at long intervals only, we must depend upon the nurse's statement. If the secondary hemorrhage had depended upon a tear in the tissues of the cervix, the treatment first adopted by Dr. Gee, *id est.*, hot water locally, and *Secale cornutum* internally, would certainly have controlled it; and if it had depended upon a lack of tonicity of the uterine walls, a real lack of contractile power, the *Secale* would undoubtedly have answered the same purpose. On the other hand, the fact that the remedies *Phos.* and *Nux moschata*, so skillfully and so aptly chosen by the doctor, remedies addressed almost entirely to lesions of the lining membrane of the uterus, did relieve the case promptly is, I think, the best kind of evidence of the existence of a latent endometritis.

DR. S. LEAVITT.—It has not been in my experience to run across such cases, so that I have little to offer. About three weeks ago, however, I was called in haste to see a lady, whom I had delivered a week previous, on account of a profuse hemorrhage. The flow had ceased before I arrived at the house, and did not again return.

As to the effect of lacerations in causing secondary hemorrhage I know nothing, but I have noticed that women with cervical or perineal laceration are much more apt to suffer from primary postpartum hemorrhage than others.

A CASE OF INVERSION OF THE UTERUS.—REPORTED BY W. C. ROWE, M. D., CHICAGO.—*Case.*—Mrs. F., of Lake View, aet. twenty-six, was confined on September 21, 1884, and gave birth to her second child. She was attended by a mid-wife of "thirty years' experience" (?). There was nothing remarkable about the labor, but in removing the placenta the mid-wife used so much traction on the cord—taking hold with both hands—that she not only turned the uterus inside

out, but dragged it completely outside the vulva, and, sad stupidity on her part, not knowing the womb was inverted, she simply placed it back in the vagina and left it wrong side out. The patient fainted away several times, when they called a physician of the old school, who gave her some medicine and said she was "all right." And then, as if there were not enough mischief done, she was allowed to go three days without voiding urine, when she was relieved by a catheter. On the fifth day the woman seemed to be so distressed and feverish they sent for me to relieve her. Upon making a digital examination I found the uterus entirely inverted, lying within the vagina like a huge ball four inches in diameter. It was black, and the discharges from it were fearfully fetid. Allow me to say that I thought at first it might be a *uterine tumor*, but being unable to find the *os uteri*, I was convinced there was *inversion*. I called Prof. S. Leavitt in counsel, who examined and confirmed my diagnosis. We administered chloroform and worked faithfully about two and one-half hours to overcome the inversion. The *os* was contracted to its normal state, and the uterus being in such an oedematous condition, made the task doubly difficult. Let those who think it an easy task to accomplish, undertake it and they will have occasion to change their mind. Before performing the operation her temperature was 103°, pulse 125; September 27 (the next morning), temperature 103°, pulse 130; evening, temperature 104°, pulse 135; 28th, temperature 103°, pulse 130; evening, temperature 103½°, pulse 132; 29th, temperature 102½°, pulse 125; evening, temperature 103°, pulse 130; 30th, morning, temperature 102½°, pulse 125; evening, temperature 102½°, pulse 128. For the next three days there was no decline in the pulse, but the temperature came down one degree. After that, however, there was greater improvement, so that by October 6 the thermometer showed only 99½° and the pulse about 100.

*Treatment*:—I ordered hot water injections *per vaginam* and into the uterus to be kept up for forty-five minutes at a time, three times in twenty-four hours. At the close of each injection a solution of *Eucalyptus* tincture and water (about 1 to 15), was used to cleanse the parts. Internally, *arnica* was administered for the sore, bruised condition, and *arsenicum* for the foul discharges, peculiar thirst, prostration and septic condition. Afterward, when I found there remained an everted condition of the *cervix* resembling hemorrhoids; and finding she had suffered for years with *piles* and stiffness of the back, *Aesculus hip.* was given, which worked like a charm, relieving both conditions in a short time, much to the gratification of the husband and wife, for she had taken treatment of a celebrated old school "pile doctor" for a year or more (incisions, injections, etc., etc.), without much benefit. About October 20 she complained that an itching, corroding leucorrhea remained, for which a few doses of *Kreosotum* were administered. About two months after the operation I made an examination and found the uterus in position and sound in every particular.

**PELVIC CELLULITIS IN A GIRL OF TEN YEARS.—**By W. A. BOYD, M. D., of ROCKFORD, ILL.—*Case.*—On February 20 I was called to see Minnie W., aged ten years, a bright, active, well-nourished girl, of a nervous temperament. I found her complaining of severe paroxysmal pain in the hypogastrium, with some tympanitis, no tenderness to touch, but severe pain on deep pressure just over the pubes and in the left iliac fossa. She could straighten the limbs easily without increasing the pain. Pulse 115. I did not take the temperature, which seemed to be very little above the normal. The tongue was moist, with a slight yellowish coating, and no thirst. The bowels moved the day previous. On careful inquiry, there was no history of injury or over-exercise with roller-skates or skipping-rope; but the mother thought she caught cold from sitting in a draft at school. There is no evidence of a tuberculous or scrofulous diathesis in the family, and the home surroundings are very good.

My diagnosis was, a slight attack of inflammation of the bowels, and after three or four days' treatment she seemed to be doing very well. The bowels had moved once or twice each day, the discharges consisting chiefly of a shiny mucus, with some tenesmus. She also complained of difficulty in urinating; but she could turn herself readily in bed, and the paroxysms of pain were quite relieved.

On the sixth day she became much worse; the pain was quite severe, with a considerable increase of the tympanitis, and tormenting tenesmus and strangury, which did not yield to remedies. The catheter was used. The pulse was at no time over 115, and there was very little perceptible change in the temperature. The case continued without much change, only the patient was getting more restless and nervous, but on March 7, the fifteenth day of her illness, much to my surprise, she discharged per vaginam about half a pint of thin, foul-smelling pus, which gave her almost instant relief. I ordered injections of hot water and Labarague's solution as an antiseptic, and gave a few powders of *Hepar sulphur*, and although she is still having a very slight discharge, she has a good appetite, a clear, healthy color, and is out doors every day when the weather is not too cold. This is the first case of pelvic abscess that I have seen in a patient of such tender years.

**REMOVAL OF THE KIDNEY.—**By DR. G. A. HALL.—Dr. Hall presented a tumor which he had removed that afternoon by abdominal section. The patient, a woman forty-four years of age, had noticed twelve years previous a growth which seemed to be located to the right of the umbilicus and about midway between it and the superior spine of the ilium, as near as the patient could remember. At that time it was about the size of an orange, somewhat oval in shape, and presenting two distinct nodules. The tumor gradually enlarged, until, at the time of examination, several days before the operation, it occupied the whole of the right side of the abdomen

extending from the iliac fossa to the ribs and across the median line to the left side. The tumor was irregular, nodulated, firmly anchored and quite sensitive to the touch.

In taking the clinical history of the case, it was found that four years before the discovery of the tumor the patient had a severe attack of diphtheria which was followed by a protracted renal trouble the precise nature of which could not be learned. There had been more or less nausea without vomiting and at times severe pain. The clinical history of the case indicated a tumor connected with the kidney, but the location below the renal line, the normal condition of the urine, the irregularity of the growth, and the lack of constitutional involvement, led to a doubt of the correctness of this view. Its location and growth proved it was not an ovarian or uterine tumor. In this connection it may be said that previous to the appearance of the tumor the menses were accompanied by much pain, but have since been natural, except that there has been a gradual decrease in the quantity of the flow. An exploratory incision was made extending from the umbilicus to the symphysis and the tumor found to be not connected with the ovary or uterus. The incision was now extended two inches above the umbilicus and the tumor fully exposed. It was strongly encapsulated and firmly adherent to the intestines, the transverse colon occupying a line two inches below the umbilicus. The capsule was carefully separated from the tumor and what appeared to be a pedicle was ligated and the tumor removed. Examination revealed the fact that the right kidney was absent. The tumor was opened before the Society and found to be filled with thick, creamy pus. The walls of the tumor bore no resemblance to the cortical substance of the kidney, and were probably the result of inflammatory deposit, some parts being very thick, while others were thin and easily ruptured. The patient reacted nicely, and twelve hours after the operation was resting quietly.

CEREBRAL TUMOR (WITH MORBID SPECIMEN)—BY S. M. SPAULDING, M. D., OF MINNEAPOLIS.—*Case*—Mrs. W., aged thirty-two years, married, one child, not living.

I was first called to see her November 14, 1884. She was then under the treatment of a magnetic healer (clairvoyant), who diagnosed "uterine trouble, affecting the spinal nerves, etc." I could not discover anything of that nature, and so stated; saw nothing more of her until December 10, when I was again called and requested to take the case. She was then having spasms from the pain in the head, which was located in the right supra-orbital and temporal regions; when most severe extending to the occipital with opisthotonos at times extreme. The limbs would become rigid, the hands clenched, the jaws set, the eyes rolled upward, and the friends thought her dying. These spasms lasted from ten to thirty minutes.

There was excessive hunger; she could not eat enough, and,

having been allowed to eat at any and all times, the stomach would rarely retain any solid food. She would retain generally liquids, and to these her diet was restricted; the bowels were constipated. After two days the spasms ceased, and she was comparatively comfortable until January 5, 1833, when the severe headaches again returned, lasting four or five days, but there were no spasms. With this attack there was dysphagia, at times so severe that she was unable to swallow even a spoonful of water without choking. The urine was passed involuntarily and in excessive quantity. This last condition continued for nearly three weeks, when she was able to control the flow and had no return of the difficulty. The bowels in the meantime had become quite regular, moving naturally every day. She was now quite comfortable most of the time, until about the 25th of January, when she began to complain more of her eyes—photophobia; was obliged to darken the room; said there was “a weight drawing them back into the head.” At the same time she complained of a sore feeling, as she expressed it, inside her head on the affected side; this disappeared in a few days and again there was a comparative respite, with occasional days of the severe headache, until near the 1st of the present month (March) when she became totally blind; no more pain in the supra-orbital region, but all was now located in the temporal and the occipital regions. From this time on she failed rapidly, the last few days suffering intensely from the occipital pains. She retained consciousness to the last. At no time during her illness did she locate the pain at the point of greatest pressure as revealed in the autopsy.

The only causative history of injury elicited was the falling of a trap-door, striking on the right side of the head as she was descending into the cellar about seventeen months ago. She was under medical treatment for about one year, first by old-school physicians in the country where she lived, but from not improving she came to this city in October last, hoping to get relief.

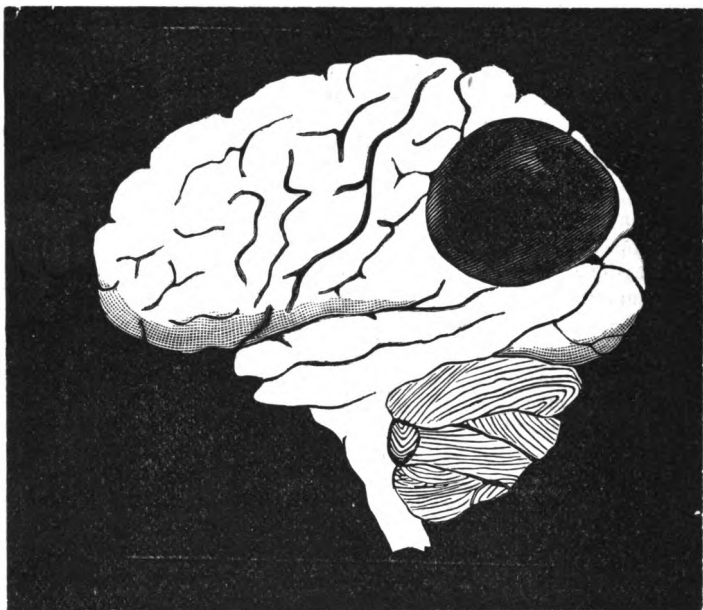
The remedies used were *Gels. Nux v.*, *Cuprum* and *Apis* with occasional treatments with the battery.

The autopsy revealed the following: Mrs. W. died at 2 A. M., March 28, *post-mortem* at 3 P. M.

Blood, dark, fluid, oozes under the knife in cutting through scalp. The calvarium shows in the right parietal region just in front of lambdoidal suture, a roughened necrosed spot about one inch in diameter on the under surface extending nearly through the bone. Dark blood escapes freely from the longitudinal and lateral sinuses; the dura-mater presents posteriorly many enlarged veins with occasional aneurismal swellings of the same, and a highly congested condition over the entire surface.

In the right parietal region this membrane is softened, thinner, and presents several small openings through which cerebral substance pouts for a space of an inch or more, with adhesions between the

arachnoid surfaces in right parietal region from three to four inches in diameter; elsewhere the tissues are normal. The vessels of the pia-mater and the cortical substance are congested. The right parietal region discloses a large growth three inches in diameter, seemingly protruding from the substance of the brain, and of softer consistence than adjacent cerebral substance. The ventricles and sub-arachnoid cavities filled with serum only.



*Microscopical Examination of the specimen by Dr. E. S. Bailey, April 4, 1885.* The pathological specimen was received six days after death, and in a good degree of preservation. Upon removing the wrappings, the parts referred to in the above report came away from the brain mass almost intact and in the form of a very soft encephaloid substance, leaving in the brain a cup-shaped depression, having the following dimensions—longitudinally three inches in diameter, transversely two and three-quarter inches and at the center of depression one inch, with edges distinct and very shallow. The convolutions of the brain involved in this destruction were the gyrus angularis, supra marginalis, superior parietal and ascending parietal. The easily detached portion of the brain mass, when tested with the microscope, was found to be destitute of stroma or cell structure—save that the substance was simply softened and

consisted of brain tissues in varying degrees of destructive changes. Pus corpuscles were also very numerous in all parts of the mass that had been removed. From evidences as given by disorganization and the microscopic tests, it seems that the destructive changes were in the line of formation of pus, and not in the growth of any neoplasm.

**DISCUSSION.—DR. H. B. FELLOWS.**—This case strikes me as having been one of pachymeningitis, dating from the time when the blow upon the head was received. The blow, probably, first detached the dura-mater from the bone and set up a low grade of inflammatory action. Suppuration took place later, and finally broke through the other membranes. Such an inflammation followed by chronic suppuration is often the result of such an accident. In these cases you usually get dull chronic headaches and more or less emotional disturbance, and I judge these symptoms were present in this case.

The spasms, as described, seem to have been general, and here is one of the peculiarities of the case, for usually in irritative lesions of this kind you get at first only local spasms, affecting a single muscle or group of muscles. They often begin in an arm or in the face, and only gradually spread over the greater portion of the body.

It seems singular, too, that paralysis is not mentioned among the symptoms of the case, as a large portion of the tissue of one of the lobes of the motor region is evidently broken down. This is hard to explain, unless, indeed, it was a post-mortem change.

In looking over this specimen I noticed a good deal of congestion about the base of the brain and membranes. This makes it probable that in the later history of the case, the inflammation spread lower down, producing an irritation of the floor of the fourth ventricle, and it explains the profuse flow of urine which occurred before death. There is no question of its being an abscess rather than a foreign growth.

**INSOMNIA.\*** That the brain is not as freely supplied with blood during rest and sleep as it is during cerebral activity might be inferred from analogy; but it has been proven by direct experiment. Increased activity in the brain functions means an increased blood supply, and diminished activity a lessened supply, so that in sleep this change in the circulation is more marked. Are we, therefore, to conclude that this diminished circulation of the blood in the brain is the cause of sleep? That such idea has been prevalent in the profession is true, and has so far influenced the therapeutical thought that a tourniquet for compressing the carotid arteries has been added

\* **INSOMNIA AND OTHER DISORDERS OF SLEEP.**—By Henry M. Lyman, A. M., M. D., Etc. Chicago: W. T. Keener, 96 Washington Street.



to the armamentarium of the physician as a means with which to woo gentle sleep. That there is some change farther back in the series of physiological events which induce sleep we have always taught. The following extract from Dr. Lyman's book gives his idea of this:

"In all such observations it is worthy of note that the nervous impression is the primary event so long as artificial disturbances are not intruded. The changes in the blood-pressure and circulation were invariably secondary to the excitement of nerve tissues. Sleep, therefore, must be regarded as the cause, rather than the consequence, of the so-called cerebral anæmia which obtains in the substance of the brain during repose. This condition of anæmia is nothing more than the relatively lower state of circulation which may be remarked in every organ of the body during periods of inactivity. Every impression upon the sensory structures of the brain occasions a corresponding liberation of motion in those structures. The movement thus initiated arouses the vaso-dilator nerves of the cerebral vessels and excites the vaso-constrictor nerves of all other vascular apparatus. Hence the superior vascularity of the brain so long as the organs of sense are fresh and receptive. Hence the diminishing and varying vascularity of the different departments of the brain as sleep becomes more or less profound. Three modifications of the brain and its circulation are well illustrated by the effects of a moderate degree of cold applied to the cutaneous nerves of the body, as not infrequently happens when the night grows cool toward morning. The disturbance of the sensitive nerves of the skin is transmitted to the brain. The excitement of this organ causes dilatation of its vessels, and increased irritability of the cortical instrument of perception. This becomes the starting point for the projection of impulses upon the field of consciousness, producing dreams, or even a complete awakening from sleep.

The cause of sleep must, therefore, be sought in the molecular structure of the brain, rather than in fluctuations of blood-current. In the present state of our knowledge it must be negatively represented as the consequence of a deficiency in the amount of movable oxygen in the nervous tissue. This deficiency may be the result of immaturity, as in the foetus, or in the new-born infant; or it may result from the accumulation of an excess of the waste-products of intra-molecular oxidation during functional activity—products which hinder the further passage of oxygen into stable combinations with the oxidizable elements of protoplasm."

Under the chapter, "Remedies for Insomnia," the author says:

"Recognizing the fact that changes in the circulation accompany and sustain every change in the activity of the cerebral cortex, we, however, attach the greatest importance to the condition of the nervous substance itself. For a clear understanding of the proper mode of medication it is important to ascertain whether the cerebral substance is in a state of normal activity, or whether it is in a state

of healthy but excessive activity, or whether its seeming excitement is merely the result of irritable weakness."

The hygienic remedies for insomnia are well discussed. The medicines are written up from the allopathic standpoint.

In the chapter on dreams there is a manifest disposition to run into the marvelous, and some of the statements partake more of wonder-struck credulity than of clear analytical insight. In the paragraphs on "Prophetic Dreams," page 142, the following instances are given:

"A lady who was about to embark upon the ill-fated steamer Arctic dreamed so vividly of shipwreck that she refused to take passage, and thus escaped the frightful disaster which overwhelmed the ship and its numerous passengers. Max Simon relates the case of a lady who, in spite of a similar warning, embarked upon a steamship and lost her life through the explosion of the boiler during the voyage. On another occasion a noble lady dreamed that a wing of the palace in which her children were sleeping was about to fall down. Starting up she called her waiting maids, and insisted that they should bring the children to her chamber. \* \* \* At last the servants reluctantly brought the little boys from their room. They scarcely reached their mother's apartments when the disaster of which she had dreamed was realized, and the bedroom from which they had just been carried was crushed into a mass of ruins."

What says the author in explanation of this class of dreams? "The psycho-physiologist must content himself at present with the attempt to show that it may not be incompatible with natural law for coming events to cast their shadows before them through the forms of a dream." It is more in accordance with what we know of the physiology of dreaming to suppose the "slightly morbid condition of the brain" was acted on by the thought of the voyage and its dangers, and the possible associations of thought incident to this, and probably by some physical reaction of the system on the cortex of the brain. The latter instance may be explained in the same way. The coincidence remains, and is no more wonderful than other coincidences that are happening every day, and which we do not seek to throw into the realm of mystery and wonder. I have lately been attending a very worthy lady of more than usual mental ability, with "a slightly morbid condition of the brain," who had many of these dreams wherein her children were often sacrificed by some terrible accident, and which dreams were intense enough to sometimes project themselves into her waking moments; but notwithstanding this experience has passed over many months the "events" have not followed the "shadows," and the children are well and happy." This part of Dr. Lyman's book is by far its weakest part, but space will not allow of its further notice. There are chapters on Somnambulism and Hypnotism.

H. B. F.

## Hospital Notes.

### THE SURGICAL CLINIC.

#### SERVICE OF PROFS. HALL AND SHEARS.

**SUBCLAVICULAR DISLOCATION OF THE HEAD OF THE HUMERUS.**—*Case 18,133.*—Delia K—, aged sixteen years, while standing on the closet-shelf, lost her balance and fell backward, striking upon her right hand, sustaining an injury of the shoulder. It was supposed to be a strain and received no treatment for two days, then she was taken to a physician who made a diagnosis of fracture of the head of the humerus and applied a splint. Five days after the accident the patient was brought to this clinic and the following appearance presented: The right shoulder was swollen, with marked prominence below the clavicle, the body was bent toward the affected side, the elbow was directed back and separated from the chest, the arm, measuring from the acromion to the condyle of the humerus was shortened one inch. Great pain on attempting to move the arm. Diagnosis of subclavicular dislocation of the head of the humerus was made. The patient was anæsthetized and reduction accomplished by extension and counter-extension. Velpeau's bandage was applied and allowed to remain several days, when it was removed and passive motion was employed. At the end of three weeks full motion was obtained.

**FEMORAL HERNIA.**—*Case 18,134.*—Mr. D—, aged fifty-four years. When a boy this patient was injured in the right inguinal region by falling upon a plow. Soon after he observed a lump at the point of injury, which after remaining for some time disappeared. No further trouble was experienced until four years ago, when a slight swelling made its appearance at the site of the former trouble. This tumor disappeared at night, or upon lying down, and produced little inconvenience at any time except a feeling of weakness in the right leg. About three months ago the tumor suddenly increased in size, became exceedingly painful and could not be reduced. After rest and prolonged hot applications the larger portion of the tumor disappeared with a gurgling sound, but a small portion of it remained. One month later the same symptoms reappeared, since which time the slightest effort is attended with an increase of the tumor and severe pain. Examination disclosed a soft fleshy tumor at the external inguinal ring, but apparently not proceeding from it. An incision was made over the tumor, the parts carefully dissected back, and the incarcerated sac of an old femoral hernia discovered. The sac was carefully returned to the abdominable cavity, the borders of the

ring brought together with cat-gut, the external parts united by means of silver wire sutures and dressed with antiseptic dressing. The patient made a good recovery in three weeks.

**HARELIP.**—*Case 18,150.*—Herbert K—, aged nine years. This little patient had at birth what is known as double harelip, a condition which is due to arrested development of the superior maxillary bone. This bone, instead of uniting, consisted of three separate divisions, two lateral portions, and a median, or intermaxillary piece. The lip was similarly divided, having a large ugly cavity. As you see, an operation has already been performed, the intermaxillary bone removed, and the two sides of the lip brought together. The operator, however, failed to secure the intermaxillary integument, and it stands now almost straight out from the septum of the nose. The parents have been advised to have this excrescence removed. It should not be removed, but should be inserted into the upper portion of the lip, giving support to the nose and filling in the cavity at the base of the septum. The edges of the triangular piece are pared and a small piece of the lip removed from the upper portion in the median line. Into this cavity the intermaxillary piece is placed and held by harelip pins. A firm compress is placed over the lip, and a dressing of carbolic acid and glycerine applied. The patient made a good recovery in three weeks.

**HARELIP.**—*Case 18,152.*—F—, aged six and one-half months. This child is a cousin of the preceding case, and is afflicted with the same trouble. Here you observe the prominent intermaxillary piece, which resembles very much a little tub adhering to the extremity of the nose, a fissure running up into each nostril, and a pronounced separation of the palate bone. The steps in the operation consist, first, in a separation of the integument of the lip and intermaxillary piece from the bone; second, the replacing of the intermaxillary bone; third, the freshening of the edges of the fissure and the union of the edges of the lip and the intermaxillary piece.

The integument covering the intermaxillary bone is now carefully dissected up to the septum. The attachments to the lip on either side to the maxillary bone are freely severed, the dissection extending as far as the alæ of the nose. As the intermaxillary bone cannot be pushed back into place by force a V-shaped piece is cut out of the septum with a strong pair of scissors; this permits of the pushing back or replacing of the intermaxillary piece on a level with the right and left superior maxillary bones. The edges of the lip are now pared, a diamond-shaped piece being removed from each side and the denuded surfaces are brought together with harelip pins. The intermaxillary integument is used to form the septum of the nose and fill the aperture at the upper end of the incision. A compress is placed over the lip and one on either cheek, and the whole secured with adhesive straps. A very good result was attained in three weeks.

**CALCULUS. LITHOTOMY.**—*Case 18,154.*—Fred S—, German, æt. fifteen. When about three years of age this boy suffered from some bladder difficulty of an acute character. Since that time he has had more or less trouble in passing urine. About one year ago he came under the observation of a Homœopathic physician. At that time there was retention of urine, necessitating the use of the catheter for some time. The patient now complains of a constant sense of uneasiness in the anus and perineum, with a constant desire to urinate. The urine has a strong odor and a very pronounced reddish color. Although he urinates frequently the urine dribbles away, at times saturating the clothing and giving to everything the patient wears a strong ammoniacal odor. The most distressing symptom is a smarting, pricking sensation in the urethra at its orifice. This irritation is somewhat relieved by pulling the penis, and as a result the prepuce is markedly elongated. All these symptoms indicate a stone in the bladder, but are not in themselves positively diagnostic. The only absolute evidence is furnished by the use of the sound. A medium sized metallic sound easily enters the bladder. Upon moving it up and down a grating sound is heard, and a sensation of rubbing against a rough body is conveyed to the fingers. Although the sound is not as distinct as could be desired, it is sufficient in connection with the other symptoms to warrant the operation of lithotomy. The lateral operation, the one usually made in this clinic, will be made in this case.

The operation was made in the usual manner and the staff withdrawn, but no calculus could be found with the finger in the bladder. Feeling sure that as the sound was withdrawn a grating sound was heard, the staff was introduced into the urethra, and at the neck of the bladder came in contact with the calculus. It was pushed by means of the sound and the finger in the bladder back into the bladder and then easily removed. The stone was about three-fourths of an inch long and one-half an inch in thickness, and spindle-shaped. The wound healed nicely, the urine passing through the urethra upon the sixth day, and firm union being obtained at the expiration of two and one-half weeks.

**FRACTURE OF THE ACROMION PROCESS.**—*Case 18,162.*—This man is sent here by his friends, and volunteers the information that his shoulder is out of joint. An attempt has been made to reduce it but it will not stay in place. This is not a dislocation of the head of the humerus, although the head can be felt in the axilla; it is a fracture of the acromion process. The reason for this diagnosis is found in the rounded depressed shoulder instead of the prominent acromion, as in fracture, the disappearance instead of the increase of the deformity upon raising the arm, and the existence of crepitation.

The history of the case aids also in the diagnosis. He was injured by being thrown out of a saloon and striking directly upon the shoulder.

The arm will be placed upon the antero-lateral surface of the chest, the humerus being pressed up against the top of the shoulder so that its head may serve as a splint to hold the acromion in place. A Velpeau bandage is applied.

**FATTY TUMOR.**—*Case 18,167.*—Mrs. S., aged forty years. This enlargement which you see just below the left breast is not, as it appears from its size and form, a second mammary gland, but a fatty tumor, originating in the subintegumental tissue. It has been growing for six years, and has occasioned the patient great inconvenience. It has been supposed to be in some way connected with the gland because of the regularity with which it increases during the menstrual period. An elliptical incision similar to that made in amputation of the breast is made around the tumor and the mass carefully dissected out. The elasticity of the skin permits the easy coaptation of the edges of the incision through their entire length. An antiseptic dressing is applied. Union took place by first intention, and the patient was discharged in two weeks.

**AMPUTATION OF THE LOWER THIRD OF THE FEMUR.**—*Case 18,173.*—Four years ago this young man, while working in a coal mine, was crushed under falling coal and sustained a fracture of the upper third of the right tibia and fibula and a comminuted fracture of the bones of the foot. An attempt was made to save the leg and foot. This seemed for a time successful, but the foot seemed to lack vascular supply, and any attempt to use the foot was followed by repeated abscesses. During the three years that followed the injury several operations were made for the removal of the necrosed metatarsal and tarsal bones and the opening of fistular tracts. This proving ineffectual, the leg was amputated at the lower third. Upon making the posterior flap the tibial vessels were found to be atrophied and surrounded by a firm cartilaginous tissue. Some fear was expressed concerning the circulation of the flap, but inasmuch as the tissues were firmer and sound, the amputation was completed. The flaps healed, but later abscesses broke out in the stump and the bone became necrosed. This condition of things is probably due to the lack of nutrition produced by the atrophied condition of the tibial vessels. These vessels and their sheaths were undoubtedly injured by the fracture of the tibia at its upper third, and it is probable that this condition exists up to the seat of fracture. If this be so an operation below this point would be of no service.

Amputation was performed at the upper third of the tibia and the vessels found to be in condition similar to that found at the previous operation. A reamputation by the circular method was made just above the knee and the femoral vessels found to be in normal condition. The parts were dressed in the usual manner and a most.

satisfactory result was obtained. In three weeks the patient was discharged.

**FLATFOOT.**—*Case 1,819.*—Ella M., æt. fifteen. This young woman comes to this clinic for a sprained ankle, although she has no definite idea when the injury occurred; she only knows that the ankle is weak, and that prolonged standing or walking causes her great pain. There is no sprain as ordinarily understood, but rather a condition known as flatfoot or talipes varus. The difficulty consists in a loss of the arch of the foot, so that when this girl stands you observe the entire sole rests upon the floor and bears the weight of the body instead of it resting upon the heel and balls of the toes. As you look at the sole you see it is perfectly flat, the external malleolus is uncommonly prominent, and the whole foot looks clumsy and ill-shapen.

There is no operation to be made in this case. The foot should be showered with cold water followed by friction with some stimulating liniment. The patient should wear a mechanical support for the ankle and be provided with shoes in which the arch of the foot may be maintained by stiff steel insoles. The patient should not engage in any employment that necessitates prolonged standing. As in most persons afflicted with this disease, there is a strumous predisposition, the patient should be well fed. *Calcareæ Carb.* 6x will be given.

---

### THE WOMEN'S CLINIC.

---

#### SERVICE OF PROF. LUDLAM.

**A SUPPURATING FIBROID OF THE UTERUS.**—*Case 17,399.*—Mrs. T——, aged thirty-eight, is married and has had four children, the last of which was born five years ago last July. The first three died shortly after birth, the fourth lived for ten months. Shortly after the birth of the last child, a tumor could be distinctly felt in the right side. It was hard, round and presented all the characteristics of a fibroid. She got up slowly from her labor, and sixteen months after parturition a huge abscess appeared and opened externally on the right side in the vicinity of the tumor. Before this she had had hemorrhages per vaginam, but from that time there has been a bloody flow which is sometimes free from the fistulous opening nearly every month. After a time the opening on the right side closed, and then the left side began to swell, but she experienced no relief until the former orifice reopened and began discharging pus. She now flows a good deal at the month, has no appetite and is in a debilitated condition. *Hepar Sulph.* 2.

April 3. Local examination shows the uterus to be immovable,

and retracted toward the right side, the right broad ligament being involved. The cervix is short; there is an induration of the cellular tissue in the right iliac region which comes and goes; and a sensation of heat, but no swelling, on the left side. There is no tumor on the right side now; the old fistulous orifice is plainly seen and pus still occasionally flows from it. *Silicea 6.*

Several points of interest were made in this case. Suppurating fibromata of the uterus are rare enough, and when they do occur almost always discharge themselves either through the womb or directly into the peritoneal cavity. But this kind of a case in which the purulent collection developed by a fibroid in process of degeneration has dissected its way and discharged itself through the abdominal parietes is a very remarkable one. The pus has continued to flow and to furnish a sort of safety-valve, but the tumor has disappeared. When the orifice is closed there are symptoms of a relapsing peritonitis, and she suffers greatly until it has opened again.

This could hardly have been a fibro-cyst of the uterus, else it would have become sarcomatous, and something like the cancerous cachexia would have been developed.

The suppurating process must have invaded the oviduct or there would be no periodical hemorrhage from this orifice in the right inguinal region. She flows every month, and freely too, from this opening, just as one of my patients did for three years after I had made an ovariectomy in which the pedicle was secured by a clamp. It is not probable that this fistule will close spontaneously until the climacteric, after which the danger from tuberculosis will be greatly increased.

Prof. Ludlam also stated that this woman was a private patient of his, and that for the last six years she had been under his eye and care; that he had several times examined her directly following her last labor and identified the fibroid; and that the record was true in all of its details, including the monthly flow through the fistulous opening.

#### MENSTRUATION AT THE SEVENTIETH YEAR.—Case 17,390.

—Mrs. S.—, aged seventy; widow; had one miscarriage in early life. She began menstruating at eighteen, and the flow ceased at fifty-seven. Without exception her menses were always regular, and the flow finally ceased by degrees. Saving a slight attack of malarial fever, she has never had a sick day in her life. Last January (1885) she had pain in her breasts of the same nature and degree as that which always preceded her menstrual periods. Four weeks later, in



February, she had a discharge of blood per vaginam, lasting four or five days. Twenty-eight days later, in March, she had the same catamenial discharge again. The flow was not excessive, and was merely attended with the same symptoms which she had during her menstrual life. She has thus had three perfectly natural "periods" after a complete interval of thirteen years, or from her fifty-seventh to her seventieth year. In January she consulted a physician, who told her that she had a hemorrhage, and gave her a strong astringent preparation which made her feel worse, and so she stopped taking it.

This case illustrates the possibility of a recurring menstruation at an advanced age, and after an interval of many years. It also illustrates, and forcibly, too, the propensity of many physicians to prescribe under any and all circumstances without exercising a little plain common sense. We should in all cases know enough to know if a woman, young or old, menstruates normally or not; and have "gumption" enough to withhold our remedies when they are not needed. \* \* \* \* \*

There is a condition, however, in which an *apparent* return of the menses in one who is supposed to have passed the climacteric some years before is suggestive. It may signify that the woman has been attacked with a serious lesion of the uterus, or, in other words, that she has an incipient cancer of that organ. In such a case she will not have a regular monthly return of the flow for three or more months, as this patient has done, but it will come irregularly, and be accompanied by a bad odor, and more or less pain and suffering. It is because such cases are treacherous and insidious that it is best oftentimes to examine them with a speculum in order to determine their exact nature while they are in a curative state.

PELVIC PERITONITIS WITH SLIGHT RETROFLEXION.—*Case 17, 394.*—Mrs. S—, aged twenty-six; married; has had no children, but had a miscarriage two years ago at the fourth month. She says the mishap was induced by the introduction of the uterine sound by a physician whom she consulted for the relief of some pelvic discomfort. She has not been well since that time. The menses are regular and not painful, but are attended with such prostration that she is obliged to keep her bed for three days during each month. She has a constant leucorrhœa, which for a few days before each period is as excessive as a normal flow. It is very offensive, of a dark, yellow color, stiffens the linen and sometimes contains membranous shreds. She is never free from a pain in the left ovarian region, and she cannot bear the least pressure about the abdomen. The bowels never move without an enema, but micturition is normal. A local examination finds the cervix in the center of the vagina; the uterus is low down and of normal depth, but slightly retroflexed. There is a swelling which completely fills the Douglas cul-de-sac, the result of inflammation of the peritoneum. ✓ *Terebinth* 3 four times a day. After the second dose of the remedy she began to feel very much

better. Yesterday she was able to do a large washing. To-day she feels almost well, "better than she has been at any time during three years." *Terebinth* 200.

The remedy was ordered for this case in the third decimal, but there being none of that potency of Tereb. in the hospital pharmacy the patient was given the two-hundredth with the result stated. Whether it will be permanent remains to be seen.

**PSEUDOCYESIS, OR SPURIOUS PREGNANCY.**— *Case 17,397.*— Mrs. —, aged twenty-eight, has been married eight years, and has two children aged six and three years. She has never had a miscarriage. Her monthly flow always has been and still is regular and normal.

When about eighteen years old she strained herself by lifting a basket of peaches, and has had trouble with her back ever since that time. Her business requires her to be on her feet most of the day, and for the last few months the pain has constantly increased.

Last summer (1884) she believed herself to be pregnant, and expected to be confined the 15th of March, 1885, at which time she had severe labor-like pains. She had the clothes made for the little one, and all her preparations completed for its reception. Her menses had come at the regular periods, but she had morning sickness for a short time; the abdomen was enlarged, though not to the extent it had been in her former pregnancies, and she had felt distinct motion for a long period before the time of expected parturition. She still feels the motion, which is a little greater in the evening than during the day. At first she could only lie on her right side, but now she can sleep on either side. Her rest at night has been good, and her appetite is and has been good. She has suffered somewhat from malaria and from neuralgia during the past year.

On local examination the cervix is found in the hollow of the sacrum; the external os-uteri is hard and cartilaginous, and is not soft or patulous. The bi-manual touch shows that the uterus is not enlarged, although it is lying pretty well forward. The abdomen is resonant on percussion, and there is no appearance of a foreign growth. She has not had any severe hemorrhage, or any other symptoms of extra-uterine pregnancy during the past ten months. The abdominal aorta can be distinctly felt, and while there are present no signs of an aneurism of this artery still it is quite probable that the unusual strength and force of its pulsations have given rise to the sensation of motion which she has experienced. It is a case of pseudocyesis.

In this case the error that had been made by the patient and not by her physician, was due to her having exaggerated the gastric disturbance, and to her having mistaken the beating of the abdominal aorta for the movements of the fœtus in utero. The failure to detect any pelvic or abdominal tumor by palpation or percussion, and especially by the conjoined touch, makes it clear that the woman is not in an advanced state of pregnancy.

## Miscellaneous Items.

The genial face of our excellent Professor of Sanitary Science, and President of the Clinical Society, Dr. J. E. Gilman, graces the present issue of the CLINIQUE.—Dr. C. Farrington, '85, has formed a copartnership with Dr. Johnson, of Atchison, Kan.—Dr. W. W. Wisner has located at Tacoma, W. T.; Dr. C. R. Mayer at Downer's Grove; Dr. C. M. E. Watson at Lansing, Mich.; Dr. E. S. Abbott, Bridgeton, Me.—Dr. H. R. Diessner, '83, was married to Emma C. Kuntz, February 12.—Attention is called to the facts presented by the Drs. Farnsworth in our advertising department.—Prof. A. K. Crawford is enjoying a well-earned holiday in Florida.—The Illinois State Homœopathic Association will meet in Peoria, May 19 and 20; Homœopathic Medical Society of Ohio in Cincinnati, May 12 and 13; and the American Institute, in St. Louis, during the last week in June.—Part I, *Abies-Agaricus*, of the new Cyclopedia of Drug Pathogenesis, issued under the auspices of the British Homœopathic Society and the American Institute of Homœopathy, thanks to its editors, Drs. Richard Hughes and J. P. Dake, is on our table. Being documentary and not *clinical*, it does not come within our province to review it, but we endorse it as promising to be a very valuable publication.—The Practitioner's Term in the "Old Hahnemann" closed on Tuesday, March 31.—The Bureau of Clinical Medicine, Prof. W. J. Hawkes, Chairman, will report at the next meeting of the Clinical Society, May 2.—The Women's Department of the Hahnemann Hospital, Chicago, is in excellent condition for the reception of private patients during the spring and summer. Address the editor of THE CLINIQUE.—Prof. Hoyne is organizing an excursion to the International Homœopathic Convention, to be held in the city of Brussels, in June, 1886.—We go to press without any news from the Southern Institute, which was to have been formed in convention in New Orleans, April 8 and 9.

# THE CLINIQUE.

---

VOL. VI.]

CHICAGO, MAY 15, 1885.

[No. 5.]

---

## Original Lectures.

### *REST AND EXERCISE.*

ONE OF A SERIES OF THREE LECTURES DELIVERED IN THE PRACTITIONERS' TERM OF 1885, BY J. E. GILMAN, M. D., PROFESSOR OF SANITARY SCIENCE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

In the description of different forms of rest that of a physiological rest must not be overlooked. You will often have cases of pain so unendurable, engendering such nervous action that without narcotic or anæsthetic influence the nerve irritation will withstand medicine, and the doctor who succeeds you (if you refuse and he uses the opiate measures) will gain the heartfelt thanks and neighborhood resounded praises of the relieved patient and friends. In this connection let me add as to the use of morphia and other drugs that relieve pain or nervous irritability, "Do not lose your head and fly all to pieces" (to use a homely phrase) at your cases of pain or nervousness. Case after case can be relieved by our medicines, and by the different soothing and quieting measures I shall point out from time to time, without recourse to anything else.

The cases where I have found it necessary to use them internally are not frequent. In fact, in a busy practice I am often three to six months without departing from a strict similia rule for prescription; but should consider it the best thing that could be done for a patient to use these palliative measures when necessary to control the case, if convinced no other method will accomplish it. When a disease is self-limited, like the formation of a boil or an abscess, the pressure

of the inflamed tissues on a nerve, if one is involved, will give intense pain, a pain that is relieved by the discharge of the pus. This pressure is a prolific source of neuralgia, and a knowledge of nerve distribution will often aid you in giving local anæsthesia without interfering with medicinal action. When a disease is an incurable one and the pain is intense, and every hour out of pain is an hour gained, it would be a grievous wrong to carry our hostility to opiates to an extent to allow a patient to suffer when so much might be avoided. Of course, when surgical operations are to be performed there can be no doubt of the propriety of using anæsthetic measures.

There are cases of sleeplessness where habit has made the patients wakeful. Sleep has become a stranger to them, and night is a terror from the nervousness accompanying it. A night's rest will make an interruption in this habit that will allow nature to restore her energies sufficiently to do without enforced rest. This compulsory sleep, however, should not continue more than two or three nights at the most, or you may make a habit of dependence on drug action rather than nature's aid, and too long continuance paves the way for desire that may deepen into a chloral or an opium habit. A patient through deep grief has from the profound shock lost the ability to sleep. It is imperative to restore the equilibrium, and ten to twenty grains of chloral in half a glass of water will often do more good than you could possibly effect otherwise. Kindly nature will during the hours of rest and oblivion repair the shattered and vibrating nervous organization.

I also use opiates or anæsthetics when there is acute spasmodic action or such nervous hysterical conditions as presage and threaten immediate convulsive action. As an example of this last I was called one night to attend the patient of another physician, who was not at that time to be found. The case was that of a young lady suffering from severe hysterical convulsions. The cause of these was given me by a member of the family on my way to the house, so that on my arrival I should lose no time. The week before, while attending an infant, her only nephew and a dearly-loved pet, the young lady accidentally scratched the child's face—a slight injury that in almost all cases would have healed without any further trouble, but in this instance the infant had that unfortunate heritage, a tendency to hemorrhage. Its father came from a family of what is familiarly called bleeders, and the puncture of the skin was a large enough opening

to allow the exit of all the life fluid in spite of the efforts of the attending physician to stay its flow. The young lady was frantic with grief at the result, and watched day and night over the child until the fatal end, when, worn out with the anxiety, the loss of sleep and the self-accusations of being the murderer of the babe through her own carelessness, her nervous system exploded with frightful spasms and hysterical insanity. Reaching the house I found four strong men, two on each side of the bed, who had all and more than they could do at times to control the patient from doing herself a great injury. Handfuls of her hair were strewn about,—the tresses having been clutched and forcibly torn from her head during her convulsive movements. At one moment there would be almost complete opisthotonos and in a few moments she would throw herself wildly from one side to the other, tossing the attendants about almost like feather-weights. Then would come a momentary quiet, followed by a renewed outburst of frightful convulsions. As speedily as possible I administered twenty-five grains of chloral in solution, and in five minutes as much more, and in fifteen minutes had the pleasure of seeing the patient drop off into a quiet slumber which removed the danger of further difficulty.

But it is in the abuse and not in the use of these measures that we should be judged. All of these cases are simply furnishing a physiological rest. We have other examples of this physiological rest in local anæsthesia and mechanical actions of drugs; and in nature's methods of dealing with certain diseased conditions we gain an insight into what course we should adopt to relieve our patients.

An individual with enteritis or peritoneal inflammation lies upon the back with the thighs flexed upon the abdomen, thus relaxing the abdominal muscles and giving quiet to the inflamed surfaces. The pain of pleurisy is much mitigated by strapping the chest with strips of adhesive plaster or a broad band that is to be drawn tightly enough to prevent much thoracic movement, giving the required rest to the inflamed pleura. The pain of sciatica and lumbago is much relieved by the use of plasters so applied that they prevent motion of the muscles of the back. For instance, if the plaster is applied with the patient in a stooping position it will become wrinkled and give no support when the individual is in an erect position, but if applied when the shoulders are thrown back and the body straight, forward motions will be found quite difficult and the

pain consequent upon motion will be correspondingly lessened. It gives a physiological rest.

In diarrhoea and dysentery the obstinate patients, who persist in keeping about and attending to their customary duties, are the ones who give you most care and help to fill the bills of mortality, while those who lay by and allow nature an opportunity, recover. When the eye is inflamed the eyelid closes naturally to protect it from the light which would stimulate it to activity, and tears are secreted freely to alleviate the irritation of friction. In the treatment of iritis, the iris must be made fixed and immovable to allow it to recover; a drop or two of a solution of atropine applied to the conjunctiva, will not only relieve largely the pain, but place the iris in the only position (as your professor of ophthalmology will tell you) in which the disease may be overcome without injury to the sight. In glaucoma, however, the atropine would produce physiological action and irritation, the effect being to bring an increased pressure on the already distended organ. You must know what effect you wish to produce before making a move in the treatment of any case.

Apropos of the subject of rest of this organ, Hilton reports a letter received as follows: "Do you remember, in 1857, little J. G. burning his face and eye with gunpowder? I got credit for my skill in that case and pocketed it, but the credit was really due to you in having instilled into my mind a deep-rooted idea of the importance of rest in surgical practice. J. G. was letting off a squib; the powder did not ignite well, and he lowered his face close to it and blew to kindle the flame, which he succeeded in doing, and in an instant the squib exploded, burning his face and eye. I saw him almost immediately, and found him in excruciating agony, the face darkened, skin ingrained with gunpowder, the conjunctiva of one eye black and looking puffy and half roasted. The cornea had a peculiar appearance, the outer lamina and conjunctiva over it had shrivelled, presenting an uneven, opaque surface, with a sooty dirt ingrained, and deeply pitted on its surface. The eye was washed with warm water, the lid then closed down, a drop of sweet oil having been first inserted under the lid, and a piece of plaster applied to keep the lid closed but not to press upon the eye. The other eye was then also closed. Two days afterward the inner canthus was washed with warm water, but the eye was not opened. On the fifth day I opened the lid and found the cornea bright and clear, and a new and healthy

layer of epithelium covering the entire globe. Under the influence of rest, healthy nutrition had effected complete repair. The patient got quickly well."

He also relates a case that is very instructive, illustrating how carefully a physician should notice surrounding circumstances. It is of a patient "who had received a blow upon the chest by a fall upon the part, and as he was, after several days suffering, in a good deal of pain in breathing, the physician in charge asked me to see him in reference to the possibility of fractured ribs. I could find no fracture, but I observed that the patient had a most worrying wife. She was incessantly talking to him day and night, and there were continual contentions between them upon domestic affairs. I suggested to the physician that the sole cause of the pain was in all probability produced by the patient moving the injured or bruised soft parts by using his chest and lungs in speaking. All that I recommended was that he should hold his tongue and have his chest bandaged. I requested that his wife would not say a word to him, but would provide him with a slate and pencil, so that he might write down all his desires. From that time he got well quickly by local rest."

The imponderable forces in nature have great influence on man's physical condition. The creak of a cart, the monotonous sound produced by the filing of a saw, the clatter of the before-mentioned cause of irritation, are wearying disturbances that set the nerves on edge, and excite a patient sometimes to a point little short of distraction, and the boys' slang phrase of "Give us a rest" takes on a deep philosophical meaning. Woman's nervous temperament is more readily overstrained and disordered than that of the sterner sex. The numerous little worries of a woman's domestic life that, one by one, are too insignificant to count, in the aggregate bring about by their numbers the condition of nerve-tire known as neurasthenia, a disorder that in these days is becoming painfully common. This is a disease that is induced by excessive mental and bodily overwork, especially worrying work. There is an old saying, "Care killed a cat; a cat has *nine* lives, yet care killed a cat."

Anxiety and those teasing, carking cares that corrode the daily life, especially if occurring in neuropathic individuals, are very apt to induce this form of spinal irritation. It is characterized by quick exhaustion from slight exertion. There is a want of endurance, and a slight physical exercise is followed by the same muscular pain



and soreness that appears in a sound individual after severe, prolonged and unaccustomed exertion. A slight walk or standing will produce a tremor of the legs, sense of weariness and backache. There is more or less sensitiveness in the region of the spine and the movement intensifies the pain in the sore places. There is a mal-nutrition or lack of nerve nutrition, apparently, and that irritable condition that will not allow continuous use of the nerve tissues. In these cases there are infinite numbers of symptoms, kaleidoscopic in character, changing so from day to day that an attempt to follow them and fit a remedy to the case, covering the symptoms developed daily, would exhaust speedily the whole pharmacopœia. There is a general hysterical tendency and disturbed will-power. Often the morbid will forces the weakened organization to tasks that are impossible to perform without producing complete exhaustion, and the nervous tension is so great at these periods that reasoning with the patient is useless; you are met with the reply, "I must do so and so, I can not do otherwise," although to an evenly-balanced mind the necessity is not at all apparent. This morbid will spurring on to increased exertion is a potent factor in increasing the disorder. It is in effect to the individual what the whip is that stimulates the flagging movements of the horse over-used and deprived of oats; for continued too long, the end is collapse. As a sequence to this follow a train of secondary disturbances, all symptomatic of exhaustion. There are irregularities in the circulation, for these physiological disorders evidence the effect the nervous matter has on the circulation of the blood. There is asthenopia, which forbids study or reading; there are local anæmias, or the opposite, local congestions, generally with the hyperæmia or congestion of internal organs and the anæmias of peripheral parts, cold hands and feet with excessive sensitiveness to cold draughts of air, with, often, sensation of fever, while the thermometer and the pulse indicate neither increase of normal heat nor undue activity of the heart's action. There is frequently severe congestive headache, or a headache of passive congestion which is really an anæmic headache, these coming on from slight causes. Sleeplessness or heaviness and difficulty of concentrating the ideas on any subject. There is dyspepsia, the exhaustion of the stomach revealing itself by capricious appetite, indigestion, flatulence and acidity; and as a woman's nervous organization centers about the sexual sphere, when her nervous equilibrium is broken down the reproductive organs

exhibit a great variety of phenomena in diseased and deranged action. The anæmia of the uterine organs is demonstrated by scant menstruation made painful by neuralgia and hysterical torments, the converse, the hyperæmia, by congestion and excessive menstruation, leucorrhœas, uterine flexions and displacements, and the list of subjective and objective symptoms that follow in their train.

The mal-nutrition of the nerve centres produces a lack of red blood corpuscles and poverty of the blood, and with it comes an especial susceptibility to emotional disturbances. There is hypochondria and a desire to talk much about her sufferings and ailments, and a great readiness to shed tears or indulge in excessive laughter. There is a depression of spirits, and a general sense of illness and excessive sensitiveness on the subject, and an irregularity in this direction, that one minute or hour she may seem quite well, and the next hardly able to move, so ill is she. This condition left to itself and the cause continuing will result in a state of hopeless invalidism. These cases are frequent and are of greater or less severity. They occur in men, but women are the most frequent victims. Young girls in the effort to attain high rank in their schools, with the earnest hopes and fears and eagerness for success, working early and late, often at a time when the menstrual period makes a serious drain on them and unfitting for steady work, are becoming frequent sufferers with this difficulty. What shall we do to relieve such cases? The key note of cure is rest; that is, rest from the cause that is producing the morbid impression. If prolonged study,—close the books. If excessive work at the sewing-machine,—lock it and lose the key, it is too often a woman-killer. If the cares of a house are too wearing, the patient must change scene and avocation. The next thing to do is to endeavor to restore the equilibrium of the circulation and the nervous tone. How are you going to do it? Well, fresh air is indispensable. If unable to exercise, sit in the open air, and as strength comes ride or take what open air exercise can be borne well. Furnish good food and in abundance,—food that is easily digested and furnishes a large nutritive material in proportion to its quantity. Spirits in form of wine or stronger alcoholic preparations will often quiet the nervous excitability when nothing else will. This is a disorder of weakness and depression, and the alcoholic drink stimulates and relieves from the exhaustion and procures the ability to sleep, and during the sleep nature recuperates the strength. The whiskey

in this manner will aid very materially. The moderate use of cold water bathing, graduating the temperature to the patient's strength and ability to react, will impart an increase of vigor and power, and following the bath massage will improve and equalize the circulation. Remember we are dealing with a disease in which the will-power is weakened, or in a morbidly active condition, and our patient must be at rest to recover. Some of these cases are so weak, or so easily made tired, that exercise is one of the things that, however needful it may be to keep the organs of the body in full functional activity, they are quite unable to take. When a muscle is at absolute rest, with this quiet prolonged for a considerable period, it has a lessened nutrition. Active exercise brings a supply of blood to the active part. The muscle in its movement absorbs its nutriment from this increased blood supply, and resting to regain its power of contractility will retain what it has gained, while with prolonged disuse and the consequent lessened afflux of vital fluid there comes a weakening of the tissues. Activity and freedom of circulation means a building up of muscle, and nature so abhors laziness that she deteriorates and destroys an unused part. A patient lying day after day in bed lessens not only the frequency of the heart's beats, but the muscles remaining quiescent fail to receive the stimulus and nutrition necessary to keep them in normal condition, so they become shrunken and weak. The internal organs lose tone also from too prolonged quiet, and with this comes a distaste for food, a lessened frequency and readiness of action of the bowels, and this adds to the difficulty of the problem. It is a case of the old distich called the Calvin creed:

" You can and you can't,  
You will and you won't;  
You'll be damned if you do,  
You'll be damned if you don't."

For your patient needs to take rest ; in fact, can not do anything else without injury; yet if she does not exercise she can not improve, for the functions of all the organs and muscles will become impaired. We take the a b c of physical exercise then for our cases, in other words, massage. This is a kneading or shampooing of the muscles, exciting contractions without exhausting a patient's energies, and in this manner supplying the muscles with the beneficial results of exercise without much fatigue. The method of using massage as taught by Wier Mitchell is this : An hour is chosen midway between two

meals, and the patient lying in bed the manipulator starts at the feet and gently but firmly pinches up the skin, rolling it lightly between his fingers, and going carefully over the entire foot. Then the toes are bent and moved about in every direction, and next with the thumbs and fingers the little muscles of the foot are kneaded and pinched more largely, and the interosseous groups worked at with the finger-tips between the bones. At last the whole tissues of the foot are seized with both hands, and somewhat firmly rolled about. Next, the ankles are dealt with in like fashion, all the crevices between the articulating bones being sought out and kneaded, while the joint is put in every possible position. The leg is next treated, first by surface pinching, and then by deeper grasping of the areolar tissue, and last by industrious and deeper pinching of the large muscular masses, which, for this purpose, are put in a position of the utmost relaxation. The grasp of the muscles is momentary, and for the large muscles of the calf and thigh both hands act, the one contracting as the other loosens its grip. In treating the firm muscles in front of the leg, the fingers are made to roll the muscle under the cushions of the finger tips. At brief intervals the manipulator seizes the limb in both hands and lightly runs the grasp upward so as to favor the flow of venous blood currents, and then returns to the kneading of muscle. The same process is carried on in every part of the body, and especial care is given to the muscles of the loin and spine, while usually the face is not touched. The abdomen is first treated by pinching the skin, then by deeply grasping and rolling the muscular walls in the hands, and at last the whole belly is kneaded with the heel of the hand in a succession of rapid, deep movements passing around in the direction of the colon. It depends very much on the strength, endurance and practice of the manipulator how much good is done by these manœuvres. At first or for a few sittings, they are to be very gentle, but by degrees they may be made more rough, and if the masseur be a good one it is astonishing how much strength may be used without hurting the patient. The early treatments should last half an hour and should be increased by degrees to an hour, after which should follow an hour of absolute repose. After the first few days I like the rubber to keep the part well lubricated with cocoa oil, which is agreeable in odor and which keeps well, even in warm weather if a little lime water be left standing on the top of it. Vaseline, sweet oil or lard may be used. As soon as a part has

been manipulated it should at once be wrapped up. In men who are hairy it is often necessary to have the limbs shaved, because the constant pull made on the hairs gives rise to very troublesome and painful boils. The early use of massage is apt to cause in some nervous women increased nervousness and even loss of sleep, but these symptoms may safely be disregarded, because they pass away in a few days and very soon the patient begins to find the massage delightfully soothing, and to complain when it is omitted.

Women who have a sensitive abdominal surface or ovarian tenderness have, of course, to be handled with care, but in a few days a practiced rubber will by degrees intrude upon all the tender regions, and will end by kneading them with all desirable force. The same remarks apply to the spine when it is hurt by a touch, and it is very rare, indeed, to find any person whose irritable spots cannot at last be rubbed and kneaded to their permanent profit. The daily massage is to be kept up through at least six weeks, and then if everything is going along well the rubber spends half the hour in exercising the limbs as a preparation for walking. This is done after the Swedish plan by making movements of flexion and extension which the patient is taught to resist. At the seventh week the treatment is used on alternate days, and is commonly laid aside when the patient gets up and begins to move about. During the period of menstruation it is better to omit the shampooing, as in very nervous people (and all these cases are in that category) the massage may cause suppression of the flow). It is not certain to do this, but may, therefore, it is well to avoid the possibility. The massage is a thorough and complete exercise of a type gentle enough to accomplish much in the way of increasing the circulation and nutrition of the muscles without fatiguing the patient. It is the primer of exercise, and leads to the more difficult lessons in movements that come in a patient's progress toward health. You will notice that under massage the skin becomes moistened, its secretions being stimulated and its surface reddened as it would be with exercise if in a healthy condition. The muscles gain a firmness, a solidity, which becomes more and more permanent as an evidence of increased nutrition and strength. After massage has been used for a number of days, and the patient has gained something of this firmness of muscle, it is well to use a stimulating motion called muscle beating. This consists of a short, quick stroke with the ulnar side of the

hand with the hand closed loosely or with the fingers extended rigidly the blow directed on the muscular masses. The blow on the muscle causes a momentary contraction of the muscle thus struck. This motion of the muscles makes no demand on the nervous centers, so does not exhaust the patient; but following this the movements of the hands in the alternate grasp and relaxation discharges the blood from the muscles, and renews the supply in the same manner as in the healthy individual with normal forms of movement. The effect of massage is exhibited in the increased color and size of the superficial blood vessels, the veins becoming fuller and the tints of the skin showing deeper coloring, the nails turning pink, and the buccal cavity and the lips losing the extreme redness, or the reverse, the paleness and bloodlessness, and taking on a healthful hue. The sore places are worked out, "ironed out," as some patients express it, by the shampooing, and the local congestions are removed.

Massage is applicable to a large number of cases besides these I have been describing. It has beneficial effects in relieving the aching and pain incident to and following severe and long-continued over-exertion; also in removing the lameness resulting from too long continuance in one position, and the pain and debility of sprains or stiffness of the joints after inflammatory difficulties. In the treatment of rheumatic ailments I have often seen a wonderful relief and quiet gained from the racking pains that are incident to the severer inflammatory forms by the manipulation I have described. A joint that is giving its unhappy possessor a sample of the tortures inflicted on the victims of the Inquisition in olden times, a part so exquisitely sensitive and tender that even thought or eyesight are sufficient to cause pain, will bear the gentlest touch of the masseur's hand, and after careful progressive manipulation the congestion is removed and the pain is subdued so that the patient can secure sleep. With this repeated as needed the duration of the disease is much shortened.

To return, however, to our subject of the treatment of neurasthenia. After the use of massage for a sufficient period to wake up some activity of the muscular tissue electricity will be found serviceable. An induced current with interruptions as slow as one in two to five seconds is recommended by Mitchell. I have used the galvanic current with interrupted flow by breaking connection and tapping the metal end of the conducting cord on the connecting plate.

I have also used the mild induced current, but like the galvanic best for this purpose, the patient not shrinking from the touch of the poles as when using the Faradic current. The object of the electricity is to induce contraction of individual muscles, and the poles previously moistened are placed about four inches apart, following one muscle after another, making a few, and only a few, contractions of each muscle, then passing to the next, taking some half hour to forty minutes for the whole treatment. This is generally followed by an increase of temperature which fades out in a short period of time. The electricity serves the purpose of equalizing the flow of the nervous fluid, that unseen motor propelled from the brain which rules and orders the movement of muscular substance, and so aids in strengthening the movements of the muscles by regulating their incentive force. Ainstie has demonstrated that the electricity breaks up the mental attitude of morbid concentration on the hysterical or pseudo-neuralgic pains. Goodell recommends the use of the Faradic or induced current for the milder cases, reserving the galvanic current for stubborn and deep-seated pains. The electricity was applied by a general faradization, or by central or spinal galvanization, that is, using the poles of the battery as I have described, at short distances from each other on the muscle you desire to affect, or if using the galvanization place the positive pole upon the spine and the negative upon the muscle or locality of the pain. Goodell says: "In a large number of these cases there was more or less of anæsthesia in one leg, usually the left, accompanied by burning and cutting pains radiating from the corresponding ovary. Faradic excitability was always at first enfeebled on the affected side, but after several sittings the muscles began to respond to the current, and motility was restored. In not a single instance did the nerve lesions last long. The ovaralgia was, however, not so readily overcome; but it was interesting to watch how surely it was rubbed out and Faradized out, in fact, extinguished." The electricity does very much the same thing as the massage, with deeper and longer continued effect, the vaso-motor nerves and the terminal filaments of the cutaneous nerves receiving a stimulation and excitation that sets up and affects molecular changes more rapidly in the relaxed fibres, promoting more prompt nutritive action. Following the electrical treatment, as after massage, the patient is generally inclined to sleep, and we thus secure the great ends upon which we are intent, namely, nutrition, sleep, rest of body and mind and freedom from pain. In many of these cases the patient will do far better with hired nurses or with such members of the family as will not sympathize too warmly with the

patient; for the tendency of the disease is to an extreme thoughtlessness which is downright selfishness and intense egoism, and will make on the uncomplaining, self-sacrificing mother or sister demands that are too great for the good of either patient or nurse. In the course of a long illness these calls upon the nervous energies of a devoted relative may lead to the breaking down of her health, or even to her death, and the sacrifice is made without doing any pronounced benefit to the invalid; in fact, the sympathy, the pitying references to the affliction only intensify and prolong it. So you may have to isolate your patient from such influences if you find that the necessities of the case demand it.

The milk diet is recommended by Mitchell, Jacobi and others. In private practice, when your patients are under home care, this restriction of the diet is difficult to maintain. In hospital practice it can be used with good effect, and in those somewhat rare cases, where the patient and friends unite in following out strictly the recommendations of the doctor. This is used in the cases of those women who though fat are anæmic, the fat seeming to come as the result of the lessening tissue consumption and increasing as the patient wastes in strength; also in those patients that are very dyspeptic. The patient is given in the neighborhood of two quarts of milk, well skimmed, daily, divided into regular amounts for once in two hours during the day. This quantity is to be reduced until the patient loses about half a pound daily. Using the massage in a short time the diet may be increased, and with very excellent results that are due to the scant nutrition previously given. You may be obliged to modify the full milk diet with some patients to continue control of the cases. You require in your treatment more of the iron hand in a velvet glove than almost any other class of diseases with which you will meet. In resuming the full diet do it gradually, giving light, easily digested articles, and at first only once daily, then twice, and so on. These cases will tax your inventive genius, your patience, and your resources, medicinal and hygienic; but they will build up your strength in a community, and your confidence in yourself if you treat them properly, as they constitute some of the knottiest problems you will be called upon to solve. Tact with the family and the patient are indispensable to win the confidence of the invalid sufficiently to gain her approval and consent to your measures, and you must have the ability to say No and place it in such a way that even the invalid must acquiesce in judgment, however much she may rebel in feeling. Each case is *sui generis*; it is a case by itself. There can be no rules given that will apply to all the varied incidents and circumstances that will arise in these conditions, and you must not be discouraged at failing in some instances in accomplishing what you have faithfully endeavored to perform. The treatment I have indicated, however, with the properly selected remedies, will leave very few of your cases uncured, or at least very materially benefitted.



## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

### MAY MEETING, 1885.

The first business of importance disposed of by the Clinical Society at its regular monthly meeting, Saturday evening, May 2, was the election of its officers for the ensuing year, which was amicably settled as follows :

President, Dr. H. B. Fellows ; First Vice-President, Dr. Corresta T. Canfield ; Second Vice-President, Dr. C. E. Laning ; Third Vice-President, Dr. W. S. Harvey ; Treasurer, Dr. G. F. Shears ; Secretary, Dr. A. K. Crawford ; Board of Censors, Drs. A. E. Small, T. S. Hoyne and W. H. Burt ; Executive Committee, Drs. G. A. Hall, E. M. P. Ludlam, Mrs. A. J. French, Mrs. C. T. Campbell and Mrs. M. A. Bowerman ; Phonographic Reporter, Dr. J. B. S. King.

The retiring President, Dr. J. E. Gilman, vacated the chair in favor of his successor, Dr. H. B. Fellows, who immediately proceeded with the business at hand by calling for

### THE SECRETARY'S ANNUAL REPORT.

It is with some degree of pride that I am enabled to present to you to-night a brief summary of the work performed by this Society in a single twelve-month, because it is so creditable a showing. The aggregate production of the Society in that short time is quite probably even greater than the active members themselves are well aware of, and certainly our associate and corresponding members, who have not the opportunity of attending the monthly sessions, must have a still fainter idea of it.

The Clinical Society year reckons from the month of May, so that the following synopsis includes the meetings from May, 1884, to April, 1885. In this time thirteen meetings have been held, twelve regular and one adjourned. The latter was necessary so that the then newly-appointed "Bureau of Clinical Hygiene" could complete its report on the Asiatic cholera question. No less than seventy papers were presented at these meetings, of which number forty-two

were voluntary contributions, and these papers gave the records of 320 clinical cases. Morbid specimens obtained from eleven subjects, alive and dead, were laid upon the table for the inspection of the members. Some of the autopsies gave a yield of several specimens each. The Bureau of Medical Literature, Book Notices, Reviews, etc., a new feature of our Society instituted in August last, has contributed something each month since then, with only two exceptions, and in that time, scarcely more than half a year, it has given to the columns of *THE CLINIQUE* reviews of eleven recent medical publications. This department will undoubtedly do much more of this special work the coming year. And, lastly, the membership of the Society has been augmented by the admission of seven new members.

---

### *THE BUREAU OF CLINICAL MEDICINE.*

ANTECEDENTS OF HEART DISEASE—By A. E. SMALL, M. D.—The frequent occurrence of death from heart disease, so sudden and unexpected, begets an inquiry into the nature of the proximate causes of so painful and startling an occurrence. Cases are not infrequent where a man or a woman, apparently lively and in good health, evincing no concern about any physical ill that may be ripening, arrests the social enjoyments of the family circle and society by suddenly falling prostrate in death. Every occurrence of the kind shocks the community for a time, while many suppose there may have been no antecedent cause for the abrupt flight of the vital spark.

On the 1st of January, 1866, Mrs. S., while receiving New Year's calls, and in the midst of a smiling compliment of the season, or at the close of a half-uttered wish of "Happy New Year" to a gentleman friend, fell to the floor in a dead and breathless faint—pulseless and cold. She had been unusually vivacious and cheerful during the early morning hours, not effacing from her pleasant countenance the gracious smile even after the spirit had fled. Nine years previous to this shocking occurrence she was the victim of wandering rheumatic pains, or fugitive drawing pains, from muscular rheumatism which she had experienced after a protracted exposure to cold and damp surroundings. Her sufferings at that time were greatly aggravated when reposing in a cold, damp air, or when any cold, damp application to her person was made. Warm applications, either wet or dry, afforded some relief. She also suffered from pains in the left shoulder and right hip. She was of a *nervo-sanguine* temperament, red hair. She suffered

for many weeks. Was finally relieved and apparently cured by careful nursing, and the third trituration of *Nux Muschata*. For four years she experienced no return. She even passed through the painful ordeal of parturition five years after, and for a year or more previous to her sudden demise, she apparently suffered but little, not sufficient to keep her in the house, though she had occasionally rheumatic pains. These, associated with the previous attack, lead to the conclusion that rheumatism was the primary trouble, which probably ended in embolism and sudden death.

Another case was that of a lad, who for some time had suffered from rheumatic pains in the lower extremities and stiffness of the muscles to a degree that deprived him of locomotion. At the same time he had palpitation and occasional syncope. His case was diagnosed rheumatism with evident tendency by metastasis to affect the heart. Remedies were prescribed in accordance with the symptoms, but not salutary. He died after four days' severe suffering. An autopsy revealed a valvular trouble of the heart. Mitral regurgitation in this case had resulted in hypertrophy.

What might have been done to avert the calamity in one so young, cannot be told. The earliest manifestation of any disease known, in many cases, to be followed by cardiac lesions, should at once receive the most careful and judicious medical attention. The vantage-ground is often lost by waiting for full development of symptoms before remedies are properly affiliated. The diseases to which cardiac suffering is secondary must receive early attention if eliminated before they spend their force on the central vital organs.

So common has it been for cardiac diseases to become secondary to some form of rheumatism, that in a tabular statement of 77 cases in which a precise early history had been obtained, 34 had suffered from one or more attacks of rheumatic fever, and 13 from rheumatic pains. Forty-seven out of seventy-seven cases would indicate the necessity of the most skillful treatment of the antecedents of heart disease, in order to protect the heart against their invasion.

Several cases of prostration from heart troubles have been observed, where the victims had complained from time to time of rheumatic lameness, but not sufficient to deprive them from attending to business. It is the manifest duty of physicians to take charge of such cases in earnest, for this is the veritable battle-ground. Such cases if neglected will soon gain a complete victory over medical skill and end in fatal cardiac lesions.

W. M., aged forty years, not very temperate in his habits, had experienced more or less discomfort from rheumatic lameness,

which cared but little for, was suddenly seized with severe pain in the heart, which caused him to faint, pant for breath, etc. The nearest physician was called, and from one to two dozen leeches were promptly applied to the præcordial region. These hungry and blood-thirsty worms soon gave temporary relief from the cardiac congestion. The rheumatic pains had fled as soon as the cardiac pain occurred. This case shows the intimate relation between rheumatic and cardiac diseases. The subject was under Allopathic treatment, and died soon after the palliative relief furnished by the leeches. Had this patient taken heed to the hints which his lameness gave, and subjected himself to a proper regimen and medical treatment his life might have been prolonged.

Many fatal cases of heart disease might be cited where the victims had suffered for months and even years with what they regarded trifling rheumatic pains. The autopsy of Mrs. P., who fell dead in the middle of a cheerful word in taking leave of one of her friends, made by the late Dr. Boardman, elicited the fact that embolism lay at the bottom of the fatal result. This lady had also neglected to give herself the requisite care and treatment for more or less rheumatic suffering during the later years of her life.

Though rheumatism is the more common antecedent of heart disease, fourteen of the seventy-seven cases before cited had not suffered from this disorder, but from indigestion or gastritis.

The late President of the Academy of Sciences for many months previous to his decease was subject to indescribable suffering, and during the time his pulse now and then would become so accelerated that it was difficult to count. We have been at his bedside when the pulse was beating 200 times a minute. Such rapid diastolic and systolic motion of the heart must have had its disastrous effect. He was subject to chronic gastritis, and this was antecedent to any heart trouble, for he had suffered intensely for many months from indigestion and ultimately from inflammation and ulceration of the coats of the stomach. Autopsy revealed the organic changes that must have taken place gradually from indigestion, and its final effect on the heart, which was greatly enlarged above the normal size.

In order to prevent a disastrous effect from dyspepsia which may fall on the circulatory organs, *Nux vomica* and its analogies should be consulted, and especially when complicated with hepatic derangement or obstruction in the portal system that is liable to be followed by hypertrophy of the heart.

Morbus Brightii, especially of the chronic form, is followed by cardiac lesions. The connection between renal and cardiac lesions is

especially important. When structural disease affects the kidneys, elimination of the urinary solids is imperfect, and their retention results in vaso-motor irritation and obstruction to the passage of the blood through the arteries, and a demand is made on the heart for increased propulsive power, and hypertrophy is the result.

When severe forms of scarlatina are badly treated, the sequel is usually albuminuria, which is apt to become chronic and thus pave the way to cardiac lesion.

Diphtheria is a disease that requires careful management in protecting the *vis nervosa*, which too frequently becomes so diminished that nervous prostration is the general result, in which partial or general paralysis occurs, and sooner or later the heart becomes fatally implicated. When this disease first made its appearance in this country, it is said that a celebrated physician lost ninety per cent of the cases which he treated. Afterward it is said by the same authority that ninety per cent recovered under a continued stimulating treatment during the attacks of the disease. Inasmuch, therefore, as both scarlet fever and diphtheria may be classed among the antecedents of cardiac disease, it follows that a correct therapeutics in their earliest stages is all-important.

In all blood diseases, and particularly in the exanthema, inflammation of the arteries is liable to occur, and thence atheroma or embolism obstructing the arterial circulation, and finally ending in valvular regurgitations or hypertrophy. In some cases venous thrombosis, or coagulation of blood in the veins, takes place in a certain class of subjects and thence putrefaction, septicemia and death.

It is therefore evident that nearly all the above diseases, including the zymotic, if improperly treated may be included among the antecedents of heart disease. And here let it be remarked, that a critical study of the therapeutics required for each and every disease that may be classed with the antecedents of cardiac troubles, while yet in the periphery of the vital domain, as well as careful affiliation of remedies indicated by symptoms in accordance with the only known law of cure, it is presumed that the defensive warfare against the lethal dregs of diseases that assault the heart would in many instances be a triumphant success.

As prolonged study, mental emotions, anxieties and disappointments are apt to impose severe labor and often violent palpitation of the heart, resulting in dilatation of its cavities or hypertrophy, it

would seem necessary to affiliate remedies for the sentient and emotive spheres, while pouring the soothing oil of religious consolation to still the troubled waters.

DISCUSSION—DR. T. S. HOYNE—I have been through this trouble myself, and Dr. Small was my physician. I suffered from inflammatory rheumatism, and I don't think there was a single joint in my body free from pain. *Bryonia* was my only remedy, and I have never had an attack since. Now there is another side to Dr. Small's paper, and that is that a person does not necessarily drop off in a hurry because they have heart disease.

I know people who are living to-day, that I treated twenty years ago for heart disease. One of them is greatly troubled with gastric and hepatic affections. *Podophyllum* clears the matter up for a while and then there is another attack; if his heart is especially troublesome, then a few doses of *Cactus* quiet it, and these are the only remedies the patient has taken for twenty years. I treated another case of a much more severe character. The patient was very dropsical, short of breath, and had all the usual signs of far advanced heart lesion. In addition there was gangrene of a portion of the legs and feet. I actually peeled off the greater portion of the calf of the legs.

Although many physicians had pronounced it impossible for him to recover, he became able to walk around the streets. Afterward he went to St. Paul on a visit and over-exerted himself; immediately his old symptoms came back again, and he died in about two weeks. From the time gangrene first set in to the time of his death, an entire year intervened. This man's wife was troubled with heart disease, and had had it as long as he had. She lived, however, to a good age, dying suddenly of apoplexy.

DR. C. E. LANING—May not the lesion in some of these cases of heart disease be somewhere else than in the heart? For instance, a patient may die more or less suddenly from paralysis of the heart, and the lesion may be in the motor nerves going to the heart, or may be due to a powerful excitation of the pneumogastric, whose function is inhibitory. Therefore, the real lesion might be in the cord, or in the brain, or along the course of the pneumogastric, or even in the stomach or bowels. For physiology shows us that the heart can be stopped by irritation of the stomach or intestines. The same effect would be produced by a destructive lesion of the excito-motor

centers of the heart situated in the spine. I think a good many of these cases are considered as heart disease, when the lesion is really not in the heart, but somewhere else.

DR. J. E. GILMAN—I remember two or three cases which are illustrative of the different ways in which heart disease may produce death. In one case the trouble dated from early life; the heart had always been irregular in action; a little over-exertion was always followed by difficulty of breathing and oppressed circulation. When sixty years old this patient was taken with typhoid fever, from which he recovered, but there was left behind a very much enfeebled heart. Then set in this inhibitory action of the pneumogastric, followed by gradual, long-continued failing of the action of the heart. I lost a patient this week from failure of the heart in another way. The patient was a lady thirty years of age who had once nearly lost her life through hemorrhage at child-birth. For eight weeks she had been confined to her bed for the purpose of preventing a miscarriage, which seemed imminent. Every movement was followed by a slight flow of blood, which required hot water injections and the use of *Trillin*, *Phos.* or *Helonin* at different times to control it. Under this treatment there seemed to be a fair prospect that the case would come to a favorable termination. The trouble in the former labor seemed to be lack of nerve force to effect sufficient contraction of the uterus. Three or four days previous to the termination there was considerable discharge of water, and the foetal movements lessened. After this I thought that labor must occur very soon, but it failed to come, although the os-uteri was dilated sufficiently to insert two fingers. Finally, as a means of inducing labor, I introduced a sponge tent, for I was satisfied that the foetus was dead. The patient was extremely nervous, almost in a hysterical condition, without becoming actually hysterical, and nervous chills came over her so severe as to shake the bed. The labor finally came on; and as I had taken every precaution to prevent hemorrhage or heart failure, I felt pretty confident of a satisfactory termination. The child was born dead, and seemed to have been in that condition three or four days; immediately after the birth there was a discharge of an extremely offensive gas. Hemorrhage set in, and was controlled with hot water; the uterus contracted nicely; pulse good, and everything seemed to be favorable; still, for some reason, I felt afraid to leave her, and sat by the bedside for nearly an hour after, then a little

hemorrhage started in again and was again controlled. All at once the patient complained of severe pains in the knees. I was afraid of embolism when this symptom occurred. A few minutes later the heart began to pain, and in ten minutes she was dead. Prepared as I was with everything likely to be of service, brandy, ammonia, nitrate of amyl, digitalis, even an electric battery, this death was a great shock to me. Undoubtedly the fatal result was due to embolism, for the blood from the hemorrhage seemed to contain an excess of fibrine, forming tough clots almost instantly.

HYDATIDIFORM MOLE.—BY HELEN M. HEFFRON, M. D., WASHINGTON HEIGHTS, ILL.—*Case*.—Mrs. P.——, thirty-five years of age, has borne three children, all living; the eldest a girl of about twelve years, and the youngest a boy of four years.

Her labors have always been hard, but not of long duration, and instruments were never required. The last labor was harder than the preceding ones, and, judging from her report, I should think the placenta was removed rather forcibly.

March 27, 1885, the patient consulted me at my office for amenorrhœa, saying she had only passed one week over the usual monthly period, but felt very much out of health. She looked anxious and worn, and her complexion was very sallow. The symptoms complained of, as nearly as can be recalled, were an aching in the back and limbs, relieved, or unnoticed, when keeping quiet, loss of appetite, much thirst, sense of fullness in the stomach, cough, and tongue coated very white. She did not think she was pregnant. Prescribed *Ant. crudem* and *Bryonia*. Did not see the patient again until April 8, when her husband requested me to call at the house. Found that she had done a washing two days before, and thought she had taken cold; was having sharp, darting pains in the right ovarian region, face red, headache and constipation. Left *Bell.* and *Nux Vom.*, and asked to be notified if she was no better. Three days after, as I had heard nothing, I called again and found she had flowed a very little that day, but the flow had ceased. Prescribed *Sabina*. The second day after found the ovarian pains renewed, and again some flow. *Bell.* and *Trillin* were the remedies chosen.

The next day I found the patient feeling very well indeed, no flow, and all pains gone except a slight pain in the left ovarian region. Left the same remedies, and said I would await a summons



before calling again. About 6 o'clock the evening of the same day I was summoned in haste; found my patient on the couch, flowing considerably, and having pains resembling those of labor. After administering remedies, and helping to get the patient disrobed, as the pains were increasing in severity, I made a local examination, and found the os uteri dilated and occupied by what seemed a small clot of blood. Seeing that the uterus must lose its contents I administered *Ergot*, and soon after the patient exclaimed, "There, it has come." Removing the substance expelled, I immediately passed the finger through the cervical canal and internal os uteri to see if the womb was empty. To my surprise, it was not, and I felt sure some growth was attached to the walls of the uterus, which seemed to be composed of small lobes. Examining carefully the mass expelled found it was a cystic growth about the size of a lemon, and upon rupturing the membrane only clear fluid was discharged. Did not think the growth the result of conception, and after making another examination before leaving, told my patient there was yet something remaining in the womb, and thought it was a hydatidiform mole. She then told me she had what she called a miscarriage last June, when a similar growth had been expelled, and the physician then in attendance told her something remained in the womb, but did not say what it was. I preserved the specimen, and showed it to Dr. R. Ludlam, who pronounced me correct in my diagnosis. The patient has made a comfortable recovery, but there is a constant discharge of what she calls "corruption." She has been for two weeks past under the influence of *Thuja* and *China*. A leucorrhœal discharge has troubled her for years.

I should like to ask if, in the opinion of the physicians present, this growth can be removed by the use of internal remedies, or must an operation be performed?

DISCUSSION—DR. G. A. HALL—Judging from the appearance of the specimen and the history of the case, I should say that it was an adherent afterbirth. Probably the foetus was discharged at an early period of gestation, leaving the rudimentary placenta and the membranes to develop into this foreign body. I have seen such cases quite often, and I believe that the majority of the serious complaints of married women arise from conception and early miscarriage, in which the afterbirth remains in the womb. Adhesive inflammation takes place, and being well supplied with nourishment, the membranes

develop into a tumor or foreign body which often loses its original character entirely. One and a half years ago I removed what had been pronounced, and appeared to be, a fibroid, but a microscopical examination showed it to be a degenerated afterbirth. All cases of miscarriage should be carefully watched, and the womb completely emptied before the doctor leaves the case.

DR. T. S. HOYNE—I call to mind a lady, who after having had a miscarriage at six months, flowed so profusely at her next period, sent to me for relief. I prescribed for her and stopped it, but between this and the next period there was a discharge resembling lochia. When her period came again, she again suffered from profuse flow and I went to see her. An examination revealed a patulous os-uteri, through which I easily removed a portion of the afterbirth.

DR. A. E. SMALL—I should like to hear some one answer Dr. Heffron's question, as to whether the condition requires operative interference, or is amenable to a skillful use of remedies alone. My own opinion is, that medicine properly administered is all that is necessary to effect a cure.

DR. HALL—In order to answer that question, we must know what is in the womb at the present time; it may be an interstitial or sub-mucous fibroid. If there is a growth in the mucous membrane remedies which contract the uterus might expell it.

DR. J. E. GILMAN—Has there been any change in the discharge since the extrusion of the pieces?

DR. HEFFRON—The discharge is more profuse than before the pieces came away.

DR. HALL—I think the nose would be a good diagnostic instrument to use in such a case. If a discharge comes from a decomposed afterbirth, it has an unmistakable odor; an odor that differs from that of carcinoma or epithelioma of the uterus, and is peculiar. My advice, is to send the patient to Dr. R. Ludlum for an examination.

INSTRUMENTAL LABOR IN A YOUNG MOTHER THIRTEEN YEARS OF AGE.—BY E. G. H. MIESSLER, M. D., CHICAGO.—I was called 9 P. M. 11th April, to attend the confinement of a primipara, aged thirteen years and four months. At my arrival the young patient was sitting in an easy chair with all the anxious signs and expressions that generally precede labor. The patient was put to bed and an examina-

tion made, which revealed that she was in the first stage of labor, vertex presenting, first position, os somewhat dilated, but the cervix markedly rigid. The outlet of the bony pelvis was so narrow that I greatly feared the necessity of instrumental aid. Uterine contractions were strong and came in rapid succession, the bag of waters protruding through the os with each pain; the membranes were exceedingly tough and hard to rupture, but when this was accomplished the head came down gradually to the pelvic floor, but no farther.

The pains continued very strong, but were not sufficient to cause the head to press through the outlet. Evidently the inferior strait was too narrow to allow nature, unaided, to complete the delivery, thus realizing my former suspicion that artificial means must be adopted. During this time the anxious parents, the only ones present, had been watching me closely, and I was questioned from time to time if no progress was noted. I deemed it now prudent to explain to them the nature of things, and that I had better apply the forceps and thus finish the labor quickly and safely. This intelligence, however, as was to be expected, caused them no little additional fear. So to please them I decided to wait and see what the next few pains would accomplish. But the longer I waited the more it became evident that it was useless, yes, even dangerous, to trust the case to nature any longer.

After farther explaining, and with additional arguments, their consent was gained to use the forceps. The patient was placed in proper position and the forceps applied, which was no easy task on account of the narrowness of the passage and the excitement of the patient. After her position had been changed and the forceps applied, the pains, which hitherto had continued strong and expulsive now seemed to stop altogether. Thus, the more the *vis a tergo* failed to aid in expelling the child, the more *vis a fronte* had to be applied. After considerable effort on my part, by slow but steady traction an asphyxiated female child was born.

Our very first effort, of course, was to restore the breathing of the still-born infant, which was done before the umbilical cord was cut, contrary to the advice of some works on obstetrics. The child was placed next to the mother, while the latter was directed to take a few inspirations. Her breathing had so marked an effect that in less than no time respiration was established in the infant, who made it known by a lusty cry.

The third stage of labor was also slow and tedious. By all appearances the placenta was attached to the walls of the uterus quite extensively. In fact, everything gave evidence of immaturity excepting the child, which was well developed, having been carried to full term. By external kneading, the application of hot fomentations, by internal peeling off as well as could be done, by properly indicated remedies and careful traction on the cord the placenta was expelled and labor finished.

The whole work occupied about five hours. The milk was very slow in coming and very hard to draw because of the nipples being so small, and in consequence of this the infant refused to take hold of the breast the first few days ; otherwise the mother and child are doing well.

VERATRUM VIRIDE IN SEQUELA OF WHOOPING-COUGH.—BY E. S. BAILEY, M. D.—Lizzie, age eleven years. Health has always been excellent, and there is no family history connected with any disease tendency. On the 15th of August, 1884, she was presented at my office, her mother giving me the following history of the case : She had whooping-cough, lasting nearly all the winter and spring months. Paroxysms at one time were very frequent and severe. With the warm weather she recovered. Little was done for her, as the "whooping-cough couldn't be helped any," as the mother remarked. Early in July the patient began to have dyspnoea, especially at night, unaccompanied by cough or inflammation. This increasing rapidly, she had to be bolstered up in bed to allow of any sleep, and if from any cause the head and shoulders became lowered, the dyspnoea was distressing, and would awaken those sleeping near her. This same distress soon extended to the waking hours, and for a period of four weeks the respiration was a constant repetition of short, convulsive acts for each inspiration, not unlike that in a violent sobbing respiration. The expiration was prolonged and the interval of rest increased to twice the normal. In inspiration the muscles of the thorax were violent in their contractions, giving a sign of powerful convulsive action ; the sternum became very prominent and the elevation of the ribs very marked. For a fortnight the child, not suffering pain, was allowed to play out of doors, and she received no medical attention. The extreme muscular effort at respiration, however, soon compelled her to remain quiet

in the house, and for the following two weeks she was constantly in sight of the mother, who, thinking the trouble would wear off much as the whooping-cough had, we presume, did but little save with domestic remedies. Tired out with seeing or listening to the child breathing, from attention during the night, and from sympathy for the suffering, which was becoming pronounced, I was asked to prescribe. There were no symptoms save those in respiration as above and mal-nutrition, the consequence thereof. Regarding the lesion as one primarily coming from the pulmonary distribution of the pneumogastric nerve, a peripheral hyperæsthesia, rather than irritation of phrenics, I gave *Veratrum viride* 3x one cone every hour. This one remedy rapidly cured the case.

October 3 I was called to attend the mother of my patient as accoucheur. The labor was normal. While attending her through the lying-in my visits happened each time to be made while the baby was sleeping, but I was asked almost every time to prescribe for the baby, "he has such a cold." The usual remedies were given without avail. Three weeks after birth I was called to see the baby for the cold and the peculiar breathing. By watching the respiration I noticed the great similarity to that described above, though not so pronounced. I exhibited the same remedy—a few drops in a third of a glass of water—and gave a teaspoonful every three hours. In two days the breathing was nearly normal, and the catarrhal symptoms had disappeared as well. The facts in this case lead me to believe that the "cold" and dyspnoea in the infant was a veritable mother's mark, the impression being upon the nerve filaments rather than upon the capillary vascular system.

CHEMICALLY PURE BORACIC ACID IN IMPALPABLE POWDER IN THE TREATMENT OF OTORRHOEA—BY G. E. BLACKBURN, M. D., SHREVEPORT, LA.—A. R. C., æt. three years. Scrofulous diathesis. While in New Orleans, attending the Exposition he caught cold, had ear-ache, was attended by a Homœopathic physician, but in spite of his treatment the inflammation progressed, suppuration came on and the membrane gave way. The ear was syringed, etc., but still the discharge continued. On their return, two weeks later, they brought the child to my office. I found a purulent discharge, very offensive, nearly one-half of the membrane gone, and the external auditory canal very much irritated from the discharge of pus.

After carefully cleansing the ear by wiping it out with absorbent cotton, I inserted a speculum, poured in boracic acid and gently packed it down with a soft pine stick just large enough to slip easily through the tube. This I continued to do until I had filled the canal. I then placed a small pledget of cotton in the ear and gave *Hepar Sulph.* 30x, a powder every night and morning. This packing was washed out by the pus in forty-eight hours. I repeated it. Again in four days I had to replace it. The result was a complete success. In three weeks I removed the hardened mass by using warm cosmoline and now the membrane is entire, hearing so far as I can judge is restored and the patient cured. I used John Wyuth & Bros'. (Philadelphia, Penn.), preparation, and I can recommend it, as well as their printed instructions as a guide in this very troublesome disease.

DISLOCATION OF THE HUMERUS DOWNWARD INTO THE AXILLA WITH FRACTURE OF ACROMION—BY E. W. CHARLES, M. D., NEVADA CITY, CAL.—About 6 A. M., March 16, I called to see I. McK., a local athlete, fifty-two years old, a wagon-maker by trade, and the best muscled man I ever saw. His arm at the shoulder measured fifteen and a half inches in circumference, and solid as sole leather, almost. A slight examination revealed the dislocation, the head of right humerus plainly and clearly felt in the axilla, the fracture not attracting my attention at the time. An Allopathic M. D. had tried for an hour to reduce the dislocation by the old plan of putting a firm compress (a base ball I believe was used) in the axilla and pressing it firmly with his foot, seizing the arm and with the help of two stout men tried in vain to reduce it, and gave it up. I seized the patient's fore-arm, and in less than one minute rotated the head into its place, and then the fracture was plainly brought to view. I put the Levis apparatus on and gave *Arnica* 1,000 and six pellets every two hours, bathing the shoulder and arm with a liniment composed of equal parts of the tincture of arnica, of aconite, and of opium.

On the 17th, when I called, the patient was found sitting up enjoying a cigar, and free from pain. Continued the treatment. Two days later the patient called at my office free from pain and doing nicely.

I did not see the patient again until the 28th, when he called.

Having removed the apparatus I could move the arm. I put the splints on again, and they remained until April 10, when they were left off, union being complete and firm. On April 20, thirty-five days after the accident, the patient was at work at the bench, and has continued since, and that, too, without inconvenience. The interesting points are, 1st. The short time from the accident to the return to regular work. 2d. The perfect bony union attained. There was no doubt of a dislocation, for all the prominent symptoms existed, and the peculiar symptoms of the fracture only came to light after reduction *vis* crepitation, the disappearance of the deformity upon raising the arm and its reappearance immediately on letting the arm drop, etc.

**MENSTRUATION AT OVER SEVENTY-FOUR YEARS**—By E. W. CHARLES, M. D., NEVADA CITY, CAL.—Mrs. T., widow for over twenty years, mother of three children, the youngest about thirty-six years old. Four (4) years ago, from being quite thin she began to grow fleshy. The limbs became plump and rounded, and the breasts as solid and prominent as any young woman's. We laughed at her and told her she was becoming a girl again. About a year ago she complained of her breasts paining and back-ache, and said, "If I was not so old I would think I was going to be sick," and sure enough the next day she had to go back to the practice of a half century ago and put on a napkin. The flow lasted three days, about as of yore in character and quantity. This has occurred regularly every twenty-eight days since.

**THE NEW ENCYCLOPEDIA OF PRACTICAL MEDICINE.\***—What the glowing industry of Dr. Hempel did for us when he de-Teutonized Baer's Therapeia, Dr. Arndt has done for the general profession in projecting this great work. Vol. I. is the joint product of fourteen contributors, seven of whom are from the Western, and as many from the Eastern States, an arrangement that balances experience with erudition, and liberality with a care for the fitness of things. The general Editor has developed the family traits, and fashioned the chapters into a homogeneous whole; so that the book looks better, reads better and is a better one than we would have supposed possible under the circumstances. For the fact is that our best writers

\*A SYSTEM OF MEDICINE BASED UPON THE LAW OF HOMOEOPATHY, Edited by H. R. Arndt, M. D., in three volumes. Vol. I. Hahnemann Publishing House, Philadelphia; F. E. Boericke; pp. 968. 1885.

have been so much occupied with *materia medica* and with medical controversy (being forced to act and to write on the defensive) that the literary and scientific sides of practical medicine were neglected by them in a large measure until recently. This is the first time that our resources and capabilities as a school have been put to the test on a large scale, and only Dr. Arndt and the recording angel know the labor it has cost.

The contents of this volume include an introductory chapter by the general Editor, and chapters on Physical Diagnosis, diseases of the Respiratory, Circulatory and the Digestive systems in detail, and in succession, to the extent of nearly a thousand broad, full pages. There are a few very excellent and useful illustrations.

Some of the chapters show that they were carefully and conscientiously prepared; a few are models in their way; the most of them will compare favorably with similar contributions of old-school writers. But there are pages that were written with the scissors, and paragraphs here and there, like coarse pictures, that are crude and sloppy enough. Some of the papers give evidence of hasty preparation, as if the editor or somebody else had nagged the writers unmercifully; but none of them, thanks to Dr. A., are disgraced by the bob-tailed English that is so much in vogue, of dropping the articles, definite and indefinite, and contracting the names of our remedies.

The general make-up of the volume is excellent; and there is more print than margin to the page, which is large and liberal. But the black-faced type, like a "patch" on a beauty, is a real blotch; and when we open the book, the head-lines at the top of the page leave us in the dark as to the subject that is being discussed. Besides, the printer, who must have been a malicious old-school chap, has turned the small end of the telescope on the indications that are given for our remedies, and thus dwarfed the distinctive part of the work into the most insignificant proportions.

These faults aside, this volume reflects credit (1) on the editor for the arduous task of collecting and correcting the MSS., for arranging the matter in such good order, and toning down its inequalities, inspecting its proofs and indexing it separately; (2) upon his co-laborers for their careful and copious contributions, which, for the most part, are written by workers in special lines of practice; and (3) upon the publishers for the general style and character of



the work, which is a credit to our literature, and which will be of the greatest value to our physicians. We shall await the two remaining volumes with very pleasant anticipations.

**AMERICAN MEDICINAL PLANTS.\***—The reputation made by the author and publishers in the first fascicle is fully maintained in this number. The book is a practical one and challenges admiration. To the members of the profession who are not botanists the greater interest will center in the physiological action of the drug, made from the plant, so accurately drawn and colored, and so thoroughly described in regard to history and habitat; the part used in preparation; chemical constituents, etc.

The author has studied plants in a painstaking manner, and has also done much to make the application to medicine accurate and comprehensive, yet we could but wish that, where provings had not fully determined the action of the drug, that the information gained from chemical experience would have been admitted to supplement the meager proving, so that the full knowledge of the drug should be found under the caption referred to. Under *Trillium*, the physiological action is referred to as obtained from a single proving, and "some excellent clinical experience." What this experience is, no hint is given, though the remedy is known to have a special action for the control of hemorrhages of bright red blood coming from glandular structures, and mucous membranes. The addition of such clinical experience is without doubt helping to solve the question of how drugs act, and the addition of this knowledge, even in a condensed form, would add much to the reading value of the book.

A commendable feature, and one that throws the burden of future developments of drug action upon the observation of the physicians, is the calling of attention to numerous drugs, with the chemistry of the same, where from the provings already made only a partial utility has been derived, as under *Cypripedium rub.* This is one of our drugs that has not been sufficiently studied. "It merits a full proving, and would, without doubt, prove more useful if the preparation be made of the whole plant, thus bringing in its action upon the skin, which as yet seems to be little known." The book, as thus far completed, contains many such allusions, where, from improved methods of preparation and parts to be selected, a more complete remedy would be placed at the service of the profession. E. S. B.

---

\*By Charles F. Millsbaugh, M. D.—Fascicle II. Boericke & Tafel, Philadelphia.

# Hospital Notes.

## EYE AND EAR CLINIC.

### SERVICE OF PROF. C. H. VILAS, M. D.

NOTE.—These cases are all taken from my clinic, and reported on just as is *known* to be the fact. Unless a cure was made and proven, no attempt is made to attribute it to a remedy. Doubtless nearly all cases not heard from again were relieved or cured, and it is reasonable to suppose that they were so benefitted. They are not, however, put in such a list, but the facts given as they occurred. In this way it is hoped that much real service can be done our *Materia Medica*.

*Case 12,296.*—June 10, 1884—Minnie A., aged ten. American.

Diagnosis—Keratitis.

Prognosis—Favorable.

History—Patient has been troubled two weeks. Much photophobia and contraction of pupil. R. *Calc. Carb.*

September 30, 1884—Improvement. Nebulous condition of both eyes still slightly present. R. *Calc. Carb.*

November 11, 1884—Improvement. Patient discharged. R. *Arg. Nit.*

*Case 12,297.*—September 30, 1884—Frank B., aged nine. German.

Diagnosis—Convergent strabismus of left eye.

Prognosis—Favorable.

History—Strabismus first noticed when child was three months old.

October 28, 1884—Operation was performed.

November 4, 1884—Patient discharged. Eyes straight.

*Case 12,298.*—September 20, 1884—Frank K., aged twenty. German.

Diagnosis—Myopia.

Prognosis—Unfavorable under medical treatment alone.

History—Patient cannot see well with right eye. Eyes examined with ophthalmoscope.

October 14, 1884—Eyes tested and examined. R. *Physo-tigma*, 3x.

October 21, 1884—No benefit. Prescription continued.

October 28, 1884—No benefit. Prescription continued.

Patient has not since returned.

*Case 12,299.*—September 30, 1884—Kittie H., aged twenty. American.

Diagnosis—Conjunctivitis.

Prognosis—Favorable.

History—Has had this trouble about four weeks. Cause, exposure to the cold. Has been in charge of the house physician, and has improved under the administration of *Belladonna*. Discharged to-day, cured.

*Case 12,300.*—September 30, 1884—Alice M., aged six years.

Diagnosis—Panophthalmitis.

Prognosis—Loss of sight.

History—Trouble caused by an injury received four weeks ago. Child, while playing, got some "powder" in the eye, which irritated the eye, causing violent inflammation. Staphyloma formed. Hot applications and *Atropine* have been used and the eye carefully cleansed.

October 7, 1884—Child much better. Staphyloma somewhat flattened by the pressure of the eyelid under a bandage.

October 14, 1884—Considerably improved. Bulging almost gone.

*Case 12,301.*—September 30, 1884—Viva P., aged eight years. American.

Diagnosis—Keratitis.

Prognosis—Favorable.

History—Patient was before this clinic four years ago with the same trouble and was cured. Trouble returned about one year ago. Was under homœopathic treatment, but without improvement. *R. Calc. Carb.* 30x.

October 7, 1884—About same. Continue the remedy. Last report.

*Case 12,302.*—October 7, 1884—Miss W., aged twenty. American.

Diagnosis—Kopiopia neurotica.

Prognosis—Unfavorable.

History—Case has been under treatment in Dr. Fellow's clinic. Has been under *Spigelia*. At first eyes were red and inflamed. Pain over both eyes. Left eye worst. *R. Spigelia*.

October 14, 1884—Patient complains of feeling worse. Mostly over left eye. R. *Argent Nit.*

October 21, 1884—Same report. Continue remedy. Last report.

Case 12,303.—October 7, 1884—Mrs. H., aged forty-five. German.

Diagnosis—Otorrhœa.

Prognosis—Favorable under proper care.

History—Has been afflicted in this way since fourteen years of age. Right ear. Considerable discharge and noises in the ear. R. *Silicea* internally.

Ear is to be syringed thoroughly with carbolized hot water.

November 18, 1884—Report same. R. *Silicea*.

This was the last report.

Case 12,304.—October 7, 1884—Mrs. T., aged thirty-three. American.

Diagnosis—Dacryocystitis.

Prognosis—Favorable.

History—Patient took a severe cold last December. Has had severe pain in left eye all winter. Much more painful at times than at others, and then cannot see as well. Some inflammation and considerable discharge. R. *Silicea* 6x.

October 14, 1884—Considerable discharge still, but better. R. *Silicea*.

October 21, 1884—Same report. Same remedy.

November 11, 1884—Great improvement. Same remedy.

Case 12,305.—October 21, 1884—Mrs. I., aged thirty-seven. American.

History—Patient complains of mist before both eyes. Dots before the right eye at times. Has been troubled in this way for one year. R. *Arg. Nit.*

Patient was to return for further examination and treatment, but failed to come.

Case 12,306.—October 21, 1884—George I., aged ten. American.

Diagnosis—Hypermetropia.

Prognosis—Favorable, with suitable lens. Eyes tested and fitted with glasses. R. Right eye, plus six lens; left, plus ten lens.

Case 12,307.—October 21, 1884—Charlie C. K., aged six years. American.

Diagnosis—Convergent strabismus of left eye.

Prognosis—Favorable.

History—Was first noticed after an attack of congestion of the lungs when the child was six months old.

October 28, 1884—A tenotomy was performed.

November 5, 1884—Patient discharged. Eyes straight.

Case 12,308.—October 21, 1884—Rachael E. K., aged thirty-five. American.

Diagnosis—Pterygium.

Prognosis—Favorable.

History—About two years ago, while patient was ironing, tested the heat of the iron and felt something fly into the eye. (?) When patient gets tired, the eyes feel weak and she cannot see well. Looking steadily at anything causes dizziness.

November 11, 1884—An operation was performed for the removal of the pterygium. Discharged, cured.

Case 12,309.—Adolph P., aged thirty.

Diagnosis—Granular conjunctivitis and pannus.

Prognosis—Guarded.

History—Trouble commenced six years ago by getting a piece of coal into the left eye. (?) Eyes have troubled him every winter since that time, with a remission during the summer. Last summer they did not improve and have been gradually growing worse. Complains of pain. R. *Aurum met.*

October 28, 1884—Eyes better. They pained him for about three days after the last clinic. Since that, much better. Continue the same remedy.

November 4, 1884—Improvement continues. Same remedy.

November 11, 1884. Still improves. Same remedy. This was the last report from patient.

Case 12,310.—October 28, 1884—Oscar R., aged ten. American.

Diagnosis—Convergent strabismus of left eye.

Prognosis—Favorable.

History—Had inflammation of eyes when two years old. Strabismus first noticed after that. Operation advised and performed.

November 4, 1884—Patient reports eyes straight and is discharged.

Case 12,311.—William G., aged thirty. American.

History—Patient ran an oat straw into his left eye on July 28, 1884. Suffered severe pain for about six weeks. After that a steady continuous pain. Continual discharge. Photophobia. Right eye somewhat involved for the last four weeks.

The left eye was removed for the purpose of preventing sympathetic ophthalmia of right eye.

Patient was placed in the ward.

November 4, 1884—The patient left the hospital.

Case 12,312.—November 11, 1884—Emma K., aged eleven. American.

Diagnosis—Convergent strabismus of right eye.

Prognosis—Favorable.

History—Strabismus first noticed when patient was eight months old. No cause assigned. Vision impaired. Patient is to return for an operation.

Case 12,313.—November 11, 1884—Mrs. E., aged fifty-six. American.

Diagnosis—Nebulous condition of the cornea.

Prognosis—Unfavorable.

History—Patient when twenty-five years old had inflammation of the eyes, which continued for nine days. Impaired vision resulted. R. *Calc. carb.*

Case 12,314.—November 11, 1884—Mary T., aged thirteen. American.

Diagnosis—Phlyctenular keratitis.

Prognosis—Favorable.

History—Trouble began eight months ago. Photophobia. Has not been able to read for three weeks. Left eye worse. R. *Puls.* internally. The eye to be flicked with finely powdered *Calomel*. No report since.

Case 12,315.—November 11, 1884—Myra B., aged six. American.

Diagnosis—Sub-acute inflammation of the middle ear.

Prognosis—Favorable, under proper care.

History—When a baby, had earache; mother put laudanum in the ear, and afterward noticed deafness. R. *Merc. Corros.* No report since.

Case 12,316.—November 11, 1884—Julia H., aged twenty-two. American.

Diagnosis—Phlyctenular keratitis.

Prognosis—Excellent. Recovery.

History—For the past two or three weeks eyes feel as though something in them. Pain. Photophobia. R. *Silicea* internally, powdered *Calomel* dusted into the eye. Cured.

Case 12,317.—November 11, 1884—Willie C., aged fourteen. American.

Diagnosis—Xerophthalmia.

Prognosis—Unfavorable.

History—Four years ago had measles. Eyes have been weak since; cannot see to read at night; gaslight causes pain. Eyes are to be carefully protected and veiled. R. *Euphrasia*.

Case 12,319.—November 18, 1884—James O'M., aged twenty-three. Ireland.

Diagnosis—Convergent strabismus of right eye.

Prognosis—Operation often not successful on account of age.

History—Patient dates trouble back ten years. Operation performed. Local anæsthesia produced by the new anæsthetic, the *Hydrochlorate of cocaine*.

November 25, 1884—Patient reports. Operation successful, and, as usual with the result of all operations, shown to the class.

Case 13,320.—November 8, 1884—J. O., aged fifteen. Jew.

Diagnosis—Convergent strabismus of left eye.

Prognosis—Favorable.

History—Patient dates trouble back twelve years, when he had spasms. Operation performed. The anæsthetic employed, *Hydrochlorate of cocaine*.

November 25, 1884—Operation successful, and patient discharged.

Case 12,321.—November 18, 1884—Minnie L., aged twenty-four. Swede.

Diagnosis—Dacryoblenorrhœa.

Prognosis—Favorable.

History—Patient's eyes have troubled her for about six years. Pain over the region of the lachrymal ducts. Passed the lachrymal probe every week for four weeks, and R. *Silicea* internally. Patient improved under the treatment.

Case 12,322.—November 18, 1884—Frank P., aged nineteen. Wisconsin.

Diagnosis—Panophthalmitis of left eye.

Prognosis—Danger of sympathetic ophthalmia.

History—Three weeks ago patient was standing by the water-gauge of a threshing-machine when it broke, and a piece of the glass flew into the left eye. Complained of a dull aching pain for two weeks, and from that time until patient came into the ward, three days ago, intense pain. Sight of left eye lost. Hot water applications and *Acon.* and *Bell.* internally. Inflammation and pain much less now.

November 25, 1884—Reports improvement. Same treatment.

December 2, 1884—Improvement. Same treatment.

December 9, 1884—Patient went home. Inflammation gone.

January 6, 1885—Patient returns and the left eye is enucleated.

January 13, 1885—Patient is discharged. Operation successful.

Case 12,323.—November 25, 1884—Owen M., aged sixteen American.

Diagnosis—Luscas.

Prognosis—Unfavorable.

Case has not returned.

Case 12,324.—November 25, 1884—Leo M., aged nine. American.

Diagnosis—Inflammation caused by lime. Left eye also has slight iritis.

Prognosis—Unfavorable.

History—Ten days ago got some lime in left eye. Pain very severe at first. Not so severe now. Cornea slightly burned. Some iritis. R. Put sweet oil in eye and treat on principles of iritis. No subsequent report.

Case 12,325.—November 25, 1884—Carrie C., aged nine. American.

Diagnosis—Ciliary blepharitis.

Prognosis—Favorable.

History—A week ago patient suffered with headache. Eye became swollen and congested, and remained so two days. This was the right eye. Sudden metastasis to left eye took place. Left eye became congested and vesicles appeared upon margin of lower lid, which soon changed to pustules. These discharged and began to dry up three days ago.

R. *Graphites.*

December 2, 1884—Patient much improved. R. *Graph.* Cured.



*Case 12,327.*—November 25, 1884—S. S. B., aged forty-nine. American.

Diagnosis—Hypermetropia.

Prognosis—Favorable, with suitable lens.

History—Sixteen months ago patient noticed dimness of right eye. Eyes examined with ophthalmoscope, and glasses ordered.

*Case 12,328.*—November 25, 1884—John C., aged eighteen. American.

Diagnosis—Syphilitic dyscrasia.

Prognosis—Unfavorable.

History—Since a child patient has suffered from deafness and impaired vision. Took no treatment, and did not return.

*Case 12,329.*—December 2, 1884—J. W. J., aged thirty-seven. Kansas.

Diagnosis—Severe injury to eyeball and fracture of orbital bones.

Prognosis—Unfavorable.

History—On October 13, 1884, patient was walking behind a harrow. The horses ran away. He was thrown against the harrow in some way and rendered insensible. It was supposed that a tooth of the harrow entered the eye. The orbital bones were fractured and the eye itself severely injured. The fractured bones have so united that they partially enclose the eye, making an operation for the removal of the remnant of the globe impossible.

*Case 12,330.*—December 2, 1884—Georgia I., aged twelve. American.

Diagnosis—Dacryocystitis.

Prognosis—Favorable.

History—One year ago last February patient had measles. Since that time a watery discharge from the eye when in the cold air. R. *Silicea*. Cured.

*Case 12,331.*—December 2, 1884—Lizzie R., aged thirteen. American.

Diagnosis—Convergent strabismus of left eye.

Prognosis—Favorable for operation after treatment.

History—Patient had sore eyes four years ago. Strabismus noticed after that. Impaired vision. To return for an operation.

(To be Continued.)

## THE WOMEN'S CLINIC.

SERVICE OF PROF. LUDLAM.

GUIACUM IN OVARIAN DYSMENORRHOEA—*Case 17,410.*—M. S., aged thirty-nine, is unmarried. Her menses first appeared when she was about fourteen years old. During her sixteenth year she fell into the water and since that time, although the monthly period has been regular, it has been exceedingly painful. The pain generally precedes the flow for three or four hours, but occasionally it comes simultaneously with it; and, at about the same time, rarely not till a few hours later, extreme nausea comes on. For many years vomiting attended the nausea, the matter ejected often being mixed with blood.

The flow is scanty, and intermits, but continues in all from six to eight days. For years, however, she has never failed to take medicine to increase the discharge. She has frequently passed membranous shreds, which at first were thick and stringy, but lately she has been under Homœopathic treatment, and is sure that she does not pass as many as formerly. In her younger years she was subject to oft-recurring attacks of "hives," but she has now been free from them for ten years; and while she is not sure, still she thinks it is about ten years since she first noticed the membranous shreds connected with menstruation.

Four years ago she had a severe attack of ovaritis on the left side, and for two weeks the left leg was drawn up. Following this attack, for a period of months, if she took the least cold she was unable to use the left limb. She has suffered almost constant pain in the left ovarian region since that time. It extends down the leg and is increased by walking. This pain is always worse two weeks after her menstrual flow ceases, and is often almost unbearable. For a year and a half she has always worn dry hops over the affected parts. The left side is always cold, and there is often a feeling of numbness from the abdomen downward. The right arm is also numb at times, and her head and face too, but the tongue is not affected. She can lie with the most ease upon her right side. Of late, both ankles swell, and are very painful, but the left is more affected than the right one. Occasionally she has pain in the right ovarian region. For years she wore a pessary for some uterine displacement.

She always has notalgia, and for two and a half years has had a constant pressing pain on the top of the head, a feeling always as if a heavy weight was resting there. The headache is often aggravated at the close of menstruation.

Micturition is too frequent, and the quantity of urine is small in amount. The bowels are constipated.

A local examination finds the cervix well back, and undeveloped, and the uterus not flexed. The left broad ligament is slightly retracted, and the left ovary is swollen and has drifted to the verge of the Douglas cul-de-sac. The rectum is natural. She has never had an excessive flow, and has never had leucorrhœa, hence there can be no endometritis. There is a family history of rheumatism. The patient has lived for years in a malarious district, and has often wondered if her sufferings were not partly rheumatic. *Guaiacum* 3, four times a day.

Of all the forms of inflammation to which non-puerperal women are subject, pelvic peritonitis is the most frequent; and one of the most familiar varieties of ovaritis is invariably associated, either as cause or effect, with that lesion. If we add that, in the same class of subjects, ovarian peritonitis is almost always either traumatic or rheumatic, we shall have stated a clinical fact that is easy of confirmation.

It is almost forty years since Dr. Oldham\* recognized that certain cases of membranous dysmenorrhœa depended upon ovarian irritation and inflammation. This view has been generally received, but it is not usual to refer ovarian dysmenorrhœa to the rheumatic diathesis, as we are bound to do in the case now before us. Bearing in mind the peculiar family history, the exciting cause of the first attack (the fall into the water), and the relapsing character of the peritonitis, as well as the absence of menorrhagia and other signs of endometritis, the actual lesion is as easy of recognition as a case of rheumatic synovitis, or of pleurisy. \* \* \* \*

This is one of the cases in which our clinical experience as gynecologists has taught us more than the provings have done. For there is nothing in the pathogenesis of the remedy that I shall prescribe for this patient that makes it especially appropriate; and yet I feel confident that she will be greatly benefitted by its use. We will give her the *Guaiacum* on the rheumatic indication and you shall know the result.

OF THE FAILURE OF EMMET'S OPERATION TO GIVE IMMEDIATE RELIEF IN EXCEPTIONAL CASES.—It is a very common thing to promise that Emmet's operation for laceration of the cervix uteri will bring immediate and entire relief from the symptoms that have been due to that lesion. But even where the operation is most

\* *Medical Gazette*, November and December, 1846.

appropriate, and where it has been most carefully and successfully performed, we sometimes find that the symptoms are slow to leave, and that the patient continues to complain of some of them for a considerable time. For this reason we ought to qualify our promises before making the operation, just as we would in other surgical cases. It is due to our patients and to ourselves to tell them beforehand that, in all probability, they will not be quite well directly they are upon their feet again.

The causes for this slow and incomplete relief are threefold: (1) the pathological conditions that have had their root in the cervical rent may have become chronic and complicated; or (2) we may have failed to remove the last bit of cicatricial tissue, or perhaps a degenerate follicle from the cervix at the time of the operation; or (3) the patient's temperament may be such that she will react and recover slowly from any illness whatever. These conditions should not be lost sight of, for we cannot estimate the value of trachelorrhaphy without them, and might otherwise conclude it to be a failure in a considerable share of our cases.

In this case, which was operated upon in my clinic in February last, you observe that, so far as the operation itself is concerned, the result has been perfect. The os-uteri is intact, and the line of union is plainly visible. There is no abrasion or inflammation of the cervical envelope, nor is there any leucorrhœal flow. The neck of the womb is neither swollen nor sensitive, and all the local conditions are normal. She says that since the operation she has nothing of which to complain excepting that the menses are tardy, and that their delay occasions a bloating of the abdomen which makes her feel very uncomfortable, and causes her to look as if she were pregnant. *Belladonna* 3 four times a day.

INTERSTITIAL FIBROID OF THE UTERUS:—*Case 17,411.*—Mrs. —, colored, is married and has one son twenty-four years old; she has also had two miscarriages, the last one thirteen years ago. She has been sick since the fall of 1871. For nine years she has had uterine hemorrhage every month without exception. Intra-pelvic pain comes on about a day before the flow, which ceases as the flow appears. The latter comes in an excessive amount for a few hours, then stops and the pain returns, which again, after an interval of varying duration, yields to the flow, and this is kept up for days and sometimes for weeks at a time. She had had a thin, watery, unof-

fensive, colored discharge constantly for one year. This has ceased since she came under the care of Dr. H., a member of the class.

Just before the regular period there is a perceptible enlargement above the pubes, which increases in size during the flow, but disappears after the flow subsides. She has never received an injury. She has been treated for a fibroid tumor by old-school physicians for nine years with a constant increase of pain and hemorrhage. The urine was very scanty, but is much more free since she came under Dr. H.'s care. The bowels are regular. She has constant notalgia, but no headache. There is no ascitic accumulation; the feet do not swell, and she can lie on either side. A local examination finds the cervix far back in the hollow of the sacrum, with the anterior lip entirely gone, the posterior lip partly obliterated and the os patulous. The bi-manual touch reveals a swelling in the left iliac region, extending two-thirds of the way across to the opposite ilium. This swelling is round, hard, firm, and dense to the touch, and is not sensitive. There is one large tumor bigger than the adult head; and on the right side two or three sprouts from it as large as marbles. Deep pressure shows that the whole mass moves with the uterus up and down; but there is only the slightest lateral motion. The slow growth, dense texture and general characteristics show it to be a uterine fibroid. The depth of the uterus is four and one-half inches. *Trillium* 3 three times a day.

Negro women are almost as exempt from ovarian tumors, and especially from ovarian cysts, as the Jews are from cancer. When a colored woman consults you for an abdominal or pelvic tumor, the chances are a hundred to one that it is a uterine fibroid. If she gives a history of the slow growth of the tumor and of menorrhagia, and especially if with these symptoms there is an absence of ascites, and the tumor is round, firm and mobile, you can scarcely be mistaken.

THE TURKISH BATH AS AN AID IN UTERINE DIAGNOSIS.—In some remarks upon a case that had "gone the rounds" of the doctors without relief, Prof. L. said: "We sometimes fail of an accurate diagnosis through a lack of appropriate means as well as from a need of more careful discrimination. Every experienced physician is familiar with what has been styled the "physiognomy of disease." The facial expression in uterine and ovarian disorders, more particularly in tumors of those organs, has been carefully studied and illustrated, and is sometimes a great aid in diagnosis. But in those cases of uterine disease which, so to speak, are chiefly rectal, nobody seems to have put the proper emphasis upon the tint of the complexion and

the hue of the skin. My own belief is that we ought to be able to recognize a share of cases of rectal disease complicating the uterine functions in women by the peculiar hue and condition of the integument, just as we do the jaundiced complexion, conjunctiva and tongue of the "bilious" subject.

In the utero-rectal disorders to which I refer, there is a dirty, sallow complexion, with unpleasant exhalations from the skin that are not natural to any healthy and cleanly person, and which can only come from the decomposition of food and the retention and resorption of fecal matters. This copræmic condition is incident to retro-displacements of the womb, to the pressure from a pelvic hematocoele, from pelvic abscess and other tumors located in the Douglas pouch, to rectal ulceration and paralysis, prolapsus, obstinate constipation and hemorrhoids. It is always accompanied by dyspeptic symptoms of a pronounced type, such as pyrosis, nausea, anorexia and flatulence, and by nervous symptoms also, which are not always to be referred to the uterus or the ovaries.

Occasionally there are accumulations of fecal matter which are mistaken for tumors, and the dirty and sallow hue of the skin which accompanies them gives rise to the suspicion of cancer. It is not very long since a prominent surgeon of this city diagnosticated the case of a lad with an abdominal tumor and the sallow complexion as one of cancer, and gave a fatal prognosis. An old nurse afterward got hold of the case, and by means of solvent injections removed the tumor and cured the boy. Doubtless the copræmic hue of the skin, which sometimes resembles the tallow complexion of cancer, was the principal factor in the wrong diagnosis.

Now, beside the usual means of determining whether the rectum is seriously involved in the case of women who are chronically ill with pelvic disorders, I recommend what I call the bath-test. If their complexion is muddy and dirty, let them take from two to a half-dozen Turkish baths on alternate days, and then see whether they are not a little bleached and a great deal the better for it. The cancer hue "will wash," but this copræmic tinge will not; and the septic stain from an old hematocoele, like the bronzed skin of Addison's disease, is also a fast color.

## Miscellaneous Items.

The veteran editor of the *North American Journal of Homœopathy*, Dr. S. Lilienthal, publishes a touching valedictory in the May issue of that journal. "Well done, good and faithful servant."—Our old Sanitary friend, Dr. Geo. W. Foote, is Mayor of Galesburg, Ill.—The newly located doctors are Emily F. Swett, at Medina, N. Y.; V. C. Eddy (late of the Hahnemann Hospital) at LeMars, Iowa; P. S. Wykoff, Turbotville, Penn., and R. M. Barrows, for the summer, at Woodlawn.—Prof. H. P. Gatchell died recently of acute pneumonia, at Ashville, N. C., aged seventy-one.—Many of our friends will be pained to learn of the death of Miss A. P. Westfall, a graduate of the class for 1880-81, from typhoid pneumonia.—The Vermont Homœopathic Society meets at Montpelier, May 27-28; the Western Academy at St. Louis, May 28-30; and the American Institute, in St. Louis, June 2-6.—Among the new books received are Fasc. II of *American Plants*, by Millspaugh, from Boericke & Tafel; *Louis Pasteur, his Life and Labors*, from D. Appleton & Co.; Vol. I. of *A System of Medicine*, etc., in three volumes, edited by H. R. Arndt, M. D., from F. E. Boericke; and *Diseases of the Digestive Organs*, by Dr. C. S. Verdi, from the same publisher.—"The I's have it," for in an article of five pages on gonorrhœa and its treatment, contained in the *Polyclinic* for April 15, the personal pronoun occurs only eighty-six times!—*Apropos* of this modest item is the following concerning the "scrimmage" over the appointment of the delegates to the Old-School International Convention at New Orleans the other day: "So the old roosters in the profession, who are used to ruling with a high hand, got a set-back that is very emphatic, for the sense of the Convention is by a large majority placed on record that there must be a representation of other places besides the cities of New York and Philadelphia."—Dr. C. W. Crary has removed from Lake City Minn., to Palmyra, Wis., to take charge of the Sanitarium.—Dr. Charles L. Thompson, Class '82, has been chosen City Physician at Muskegon, Mich.—The *American Homœopathist* has been victimized by a chap who claims that it endorsed his kidney-cure.—The Homœopathic Society of Colorado will meet in Denver, June 3 and 4.—Vol. II of Arndt's *Encyclopedia* will be ready for delivery next month.—Last, but not least, it will be noticed that Prof. Fellows has been elected President of the Clinical Society for the next year.







**G. F. SHEARS, M. D.**

**ASSOCIATE PROFESSOR OF SURGERY IN THE HAHNEMANN MEDICAL COLLEGE AND  
HOSPITAL, CHICAGO.**

# THE CLINIQUE.

---

VOL. VI.]

CHICAGO, JUNE 15, 1885.

[No. 6.

---

## Original Lectures.

### *CATCHING COLD.*

A LECTURE DELIVERED BY E. S. BAILEY, M. D., PROFESSOR OF  
PHYSIOLOGY AND HISTOLOGY IN THE HAHNEMANN MEDICAL  
COLLEGE AND HOSPITAL OF CHICAGO.

If a cold is not a cold, what is it? There are numerous theories as to what is understood by the term catching cold. So general are they that slight ailments and severe sickness, in many cases, are supposed to be from the one common source. In many minds the "cold" is a stealthy something, and just how, when or in what manner its immediate approach is to be made and a struggle to begin is undefined.

A mysterious entity is this cold, and when and how to avoid a conflict is a puzzling question. Not unlike all popular conception of phenomenon not easily defined, catching cold is known by what it is not quite as much as by what it really is. Before undertaking to describe its physiology or pathology, let us look at some of the facts of popular interest. It is an exceedingly rare thing for a person to catch a cold while the thermometer is going down. "A nipping and an eager air" is not prolific of colds, and they are rarely found when the streets are a glare of ice, or when the winds are loaded with frosts or snows, or even with cold mists. The sailor, not a stranger to any weather, the soldier within his tented home, and the pioneer with the sky only for a covering, and even the "fresh air idiot" at home, who sleeps on the back porch, or on the roof, or sits out at night in falling dew, universally escape a cold.

Before the term has been defined, it does not become me to say that catching cold is a misnomer. Yet, the fact is, that the genuine cold of which there is such universal complaint is a product of hot or warm weather, and another anomalous feature of a cold is that the patient catching it is made not cold, but instead unnaturally hot. It was said of a great lady once, that she caught her death o' cold by taking gruel out of a damp basin, and ever since, there has been in every community the foreordination of "a death o' cold" by the trespass of conventional laws, or by failing to crucify the flesh, in seeking comfort. There are at present many vague ideas concerning the causes of colds, often the term itself, and hence the thing defined, is as shapeless in the common mind as a nimbus in a summer sky. Catching cold is regarded by some physicians as a result due to some error in diet. There is doubtless a disturbance of nutrition in consequence of every cold, and it is easy to mistake results for causes, and so these changes in the bodily health are attributed to defective nutrition. Under this apprehension it is quite easy to explain why the anemic, the consumptive, the dyspeptic, the rachitic, should be such easy victims to colds. The blood is defective in its nourishment, or there is no appetite, or food disagrees or refuses to digest, or so many like failures to get well and keep well from such afflictions give some color to the theory of defective nutrition, as an explanation for having these troublesome colds.

By far the greater number of physicians who take the diet view of the origin of colds, do so, not because of the insufficiency of food, but rather from surfeit. Dr. Herring, a noted English physician, says that he noticed for a long time that a certain family with whom he was intimately acquainted, always had to be treated for a cold in the head the next day after dining on roast goose. It is also no new fact that physicians have a rush of business after feast days, like Thanksgiving or Christmas, and that very many of the cases to be treated are colds. In rural districts it used to be the custom more than now to have butchering days and corn-huskings, and the feasts spread for the laborers were bounteous in spare-rib, sausage, doughnuts and cakes, etc. At such times the people waxed fat and full. The exposures to weather or over-work were not sufficient to account for the sickness that followed, one-half of which were colds. It was rather to the surfeit, as the exposures of logging, hunting and riding in the colder days of winter were even greater, but were freed from

the dissipation of over-eating. Again, it is not unknown to the profession that the symptoms of the relapses of convalescent patients from over-eating are not unlike those of a common cold, nor has this observation escaped the popular attention, and while the doctor realizes that something has gone wrong, the friends of the convalescent patient are exerting themselves in looking around to find, or possibly to engage in plugging up the cracks in the room to keep "the colds" out. The interference with nutrition certainly gives color to the diagnosis of taking cold from over-eating. While physicians are at a loss to account for the changes that come from certain forms of exposure or improper diet, or from eating wrong things at wrong times, and so often denominate the change as due to "taking a little cold," the patients are not so far from right after the instructions they are so frequently receiving from those whose chance for better information is greater than theirs, if the imaginary form of a cold is not unlike that of a monster that must be attacked much as a policeman would use a thief; it is to be shunned, arrested or "knocked out" at all hazards.

A young lady, who was recovering from a mild attack of enteric fever, took a cold and died. Since then the family regard one of the dearest lady friends of the deceased as her murderer. She had been calling on her sick friend one day, and as she was leaving the room she stood in the door a moment, woman-like, trying to get the last word, and let a draught in. The mother of the deceased, in telling the story, said: "The poor dear was getting along so well, and had just finished a nice lunch of jelly cake and cream, when that foolish thing had to stop in the door and let a draught of air in from the parlor. About half an hour later the poor dear had a chill, and from that moment sank rapidly and died within twenty-four hours." She firmly believes a cold slipped in at the door, her daughter caught it and it killed her. It would be useless to suggest that the jelly cake and cream had anything to do with it.

It is generally understood, I believe, that colds, like ghosts, seek admission through cracks and out-of-the-way crevices, and do not so often make direct attack through open doors or on the streets. The draught of air directed to any exposed sensitive part of the body is often the immediate cause of local disturbance, as the cold that comes to the one who receives the draught through the defective window pane in a mission chapel, or in the curtained recess of a ball-

room. This stealthy breath may be just enough to start the fires of a furious neuralgia, or redden the face and eyes with an acute attack of a chronic catarrh.

It is known to hay fever patients, many of them, at least, that their sufferings are increased by high living, and while they hail the cold and frost they also know that until they come a great measure of comfort depends upon the lightness of diet and plentitude of exercise. In this disease, as in others that might be mentioned, the "hay fever cold" comes on in the midst of summer and invariably grows worse as the weather gets warmer. The worst colds, according to common consent, are those that come during the hot weather, and the question is pertinent if the causes of colds do not exist totally independent of wet and of severe dry cold.

The second theory, and one to which I only refer, as it is but a part of the third observation, is that colds are primarily nerve affections, not merely peripheral but central, and that nerve inhibition, through the organ of the skin, controls the capillary distribution of nourishment, thus making the nervous phenomena the primary cause of colds. It is not unlikely that through some form of neurosis or anæsthesia that the sensory nerve fibers are easily affected by atmospheric changes, as well as by irregularities of the distribution of food products.

The third and best description that can be offered concerning a cold is to refer it to the function of animal heat made abnormal from special causes. Taking cold is the best known of all the slight ailments. There are few persons but have "caught cold" probably many times in the course of their lives, and although they may have suffered severely on some occasions, there is no reason to believe that any tissues of the body have been damaged to any great degree, or any structural disease has been engendered in consequence.

The symptoms of a cold when first noticed, or just coming on, are quite pronounced and are easily remembered, they being almost invariably those of a special form of fever or inflammation. A cold may properly be classed in a list of febrile diseases, and hence a cold, since it is not a cold, is a mild form of fever.

The mucus membranes of the nasal passages, of the larynx, trachea and bronchial tubes, of the pharynx, and the small glands intimately connected with the respiratory apparatus, are usually the parts immediately affected. Then soon follows the sensation of

weakness, though it may only be an inclination to lie down or to go to bed for a time to obtain relief from the sense of discomfort or general uneasiness. There is then some soreness about the eyes, nasal cavity and throat. Little or no saliva is secreted; the skin, too, is often dry and hot, becoming harsh and rough. A creeping, chilly sensation may be experienced, though if a clinical thermometer be placed under the arm-pit it may indicate an increase of the bodily temperature of from one to four degrees. This sensation of heat may be, and often is, accompanied with that stage of the cold where there is the feeling of being chilly with inclination to shiver and a desire for warmer clothing, to sit by a fire, or to have added an extra blanket to the covering of the bed. Though the sensation is that of cold, the real condition is that of a mild fever or inflammation, and the degree or kind will be according to the intensity of the subsequent changes either in a general way, as in fever, or in a local manifestation, as in inflammation.

The study of the variations from the normal temperature are of the greatest moment to the physicians, and the reaction from the chill will determine very accurately the severity of the febrile attack, and there soon follow evidences of disease, soreness or stiffness, if the febrile change is of great intensity, or the pain of pleurisy, peritonitis, pneumonia or meningitis, according to the congestion and inflammation present and to follow. The stuffy feeling about the head, aching of the bones, inability of the eyes to bear the light, soreness of muscles, and thirst, which is a symptom of a supra-heated condition of the body, are among the surest evidences of having a cold. Colds are commonly caught by removing the body from a persistently high temperature to a colder surrounding medium. The blood vessels of the skin have been dilated by the continuous warmth, and if we remember the activity of the vaso-dilators of the vaso-motor system, we will recall the fact that long continued heat will suspend their function, and induce paresis or even paralysis. In the change to a colder air while the capillaries are over-distended with blood, and there is at this time a free perspiration, the vaso-constrictors do not always produce contraction of the walls of the capillaries, hence during the partial paralysis of this wonderful capillary system, there is an immense amount of arterial blood brought into contact with the cooler air, a loss of animal heat follows, and there is a corresponding increase of heat in the surface of the body at the

expense of deeper structures. The sensation of cold, or the chill, may be inversely as the heat-loss, as produced by the sudden checking of the perspiration and evaporation from the cutaneous surfaces. While the radiating heat areas are increased externally, the heat-producing area internally is made correspondingly smaller, and the evolution of animal heat is lessened, the whole system is made to suffer from the breaking up of the normal balance of heat-production and heat-loss.

There are good reasons why taking cold is limited to the sudden changes from a warmer to a cooler atmosphere, while this cooler air is relatively a warm air and is not necessarily loaded with mists or frosts. In the latter case, where the air is much cooler than the normal temperature the cutaneous nerves by contraction return the blood to the deeper structures—thus inducing the sense of cold all over the body or a general refrigeration. It is an essential factor, therefore, in catching cold, that some cause must exist, first for distending the capillaries of the skin or mucous membrane, surcharging them with arterial blood, and then for rapid extraction of heat to follow. The draught of air favors this condition best, and the cold often is felt in the parts where the partial refrigeration took place. Thus, if, when over-heated, the unprotected neck receives a wave of cooler air the local symptoms are, chill, discomfort, dull and aching pain, with lameness, or this chilly wave may excite a chronic rheumatism, or neuralgia, or cause a partial paralysis of the parts, and usually a catarrh of all the mucous membranes of the nasal or respiring tracts.

Coryza is the scientific name for a cold associated with secretions and the removal of a quantity of liquid from the nasal and mucus surfaces of the body. The getting rid of these secretions is really the resolution of the cold and the readjustment of the fluids of the body, and the restoration of the lost physiological balance.

The system, when more profoundly affected by cold, recovers this balance by the removal of the excretions that have been perverted and retained, through the increased activities of the skin, bowels, kidneys, and other channels. This is true when a cold is the immediate cause of a catarrh of the mucous surfaces, and is important according to the profound effect it has upon the system by the acute or chronic diseases which frequent repetitions may produce.

The disturbance of nutrition, and its similarity to the effects of cold, as above referred to, is to be accounted for in the unequal distribution

of liquids and solids after entering into the capillary circulation, and the temporary insufficiency of nourishment, waste and repair. The nerve centres are affected in cases of cold, but not so profoundly as are the peripheral fibers, and hence the theory of nerve inhibition as an explanation for cold is not entirely isolated from the one when the changes that take place in the capillary system are dependent upon nerve paresis.

With the full understanding of the importance of the capillary system and its marvelous relationship to nutrition, its influence upon the sources of loss or gain of animal heat, and by its perversion, the immediate febrile symptoms that are sure to follow, and rapidly, it is not so difficult to solve the mystery of taking cold, or to sum up the evil effects of their repetition. While it is wise to still retain the misnomer of "taking cold," because of the popular opinion already rooted and grounded as to its origin and extent of complication in other forms of sickness, it is incumbent that the physiological processes that are disturbed, and the pathological conditions that are created, be thoroughly understood; and it follows in direct sequence that if the causes are so well known that by the avoidance of exposure to any of the sources of danger of colds, a better condition of health will be maintained exactly in proportion as their frequency is avoided, and their severity lessened.

To avoid colds, then, it is necessary to keep the skin in good tonic action, to lessen the primitive depression of the body-temperature, and to get rid of the superfluous heat occasioned by the delayed heat-production, the pyrexia, and subsequent reactions. The domestic practice of sweating, hot drinks, packs and applications of external heat, is eminently successful, but unless followed by avoidance of reaction, and by proper precautions against similar exposures, by proper protection in dress, place of sleeping, avoidance of draughts, etc., there will be but little learned or gained. I need hardly remind you of the class of remedies to be used to dispel the effects of the colds taken. They are such as successfully combat inflammations and febrile diseases.

---



## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

---

JUNE MEETING, 1885.

The Clinical Society held its regular monthly meeting on Saturday evening, June 6, at the Grand Pacific Hotel. After the reading of the minutes of the previous meeting, and the reports of special committees were received, the call was made for

### *THE PRESIDENT'S ADDRESS.*

BY H. B. FELLOWS, M. D.

FELLOW-MEMBERS OF THE CLINICAL SOCIETY.—It has been customary for the President to make some remarks at the next regular meeting after his election regarding the work accomplished in the past year by this society, and what may be hoped from it in the year immediately before it.

In accordance with this custom I shall offer a few brief thoughts. Before entering on these matters more directly I wish, however, to express to the society my appreciation of the honor conferred on me by the election to the office of President. I am sure that it is no small compliment to be the presiding officer of a society that has been as active as this one has in the past, and one that has so uniformly produced instructive papers and discussions. This is the one-hundredth regular meeting since the society was organized, and its work has been steady in producing practical matter that has been useful not only to its members, but to the profession outside.

The report of the Secretary read at the last meeting gives a specific account of the number of papers read before it, and of the morbid specimens exhibited to it, and of such other matter as will show how regularly the supply of medical thought and experience has been garnered at its meetings.

During the past year the Committee on Current Medical Literature has been organized, and its work has been appearing in the pages of *THE CLINIQUE*. This committee will be continued, and it bids fair to gather more of the best thought into a brief space that

we may know what may be new in the medical world. It has a large field, and there is no doubt that it will be diligent in looking after matters of interest for us. The Chairmen of the regular bureaus remain the same as during the former years. They will nominate their own members. In these departments there will be some room for improvement, for in many instances these members have contributed no papers to the society. It is certainly desirable that each bureau shall consist of active members. In making up the bureaus it is requested that the Chairman will make such choice of members as are especially interested in that line of study as himself, and are willing to give the profession the advantage of their experience. If a little pains is taken with the formation of the bureaus a profitable evening will be absolutely assured whenever that bureau makes a report. Each member must feel that he has something to do in this matter, and not leave it for the Chairman to furnish the entire report for the evening, as too often has been the case.

The President would suggest that not only such members as will give us the advantage of their experience and study be appointed, but that each bureau consult together with its Chairman, and make a choice as soon as practicable, or at least some weeks before the meeting at which it is to report, of one or more subjects on which to report, and then divide that subject up into such divisions as may suit it, and assign the divisions to the individuals for them to report upon. In this way there will not only be a division of the work, but a more complete report will be had. The subject will also be announced before the meeting at which it is to be presented, and the other members will also be able to gather their experience into their minds, and take hold of the discussion with more freedom, and with less of a discursive manner than is apt to follow any talk that is made entirely without any previous thought. This will in no way conflict with entire freedom of any individual views, for each person will be responsible only for their own views. But if any new theories are promulgated, or any new methods of treatment are put forth, they can be criticized before they are given to the profession. If they bear the stamp of merit, the discussion will send them on their way without injury, but the discussion will bring out the objections to them, and the profession will be the better able to judge of the merits of them before they are called upon to test them at the bedside. A false hypothesis plausibly stated, or an unreliable method of procedure in a case of

sickness, may do much harm if given to the profession with a quasi-endorsement of this Society, but after a fair statement of the objections to it by other members, even the tyro in medicine will adopt it with a just warning.

Where the views are not strictly new, but are modifications of those which have been already held, or are merely a restatement of some that have been held heretofore, this method of working up the report, and the previous statement of the subject, will enable those taking part in the discussion to get at the kernel of the matter much better, and both speaker and listener will be benefited by having a chance to turn over in their minds previously the lessons of their experience.

The exhibition of rare cases to the Society adds to the experience of all, and makes the meetings more interesting, as well as being in the direct line of clinical work. It is, therefore, desirable that as many such cases should be brought before the Society as is possible, and it is to be hoped that each member will consider him or herself a committee of one to furnish the Society something of interest in this direction. The same may be said of pathological specimens. They tend to fix the points of the case in our minds, and none of us are too wise to gain knowledge from these object lessons.

It will not by any means be found that the wisdom of any branch of medicine will be locked up in the drawers of the bureau that has charge of that subject, and therefore it is hoped that many will volunteer to give the Society the benefit of their thought and experience. Cases with special difficulties in, which have been successfully met, are instructive; or cases in which such difficulties occurred that could not be overcome, will be finger-posts of warning to others.

The past of the Clinical Society of the Hahnemann Hospital is a pledge to the world that it will be in the future a source of light to its members and the profession at large, and that its members realize that much is expected from them, and that they will not fail in their well-doing.

After the reading of the above the Society appointed a committee, consisting of Drs. Bailey and Crawford, to report on the recommendations contained in the President's address at the next regular session.

REPORT OF THE DELEGATES TO THE AMERICAN INSTITUTE OF HOMOEOPATHY.—In response to a call for a report, Dr. Ludlam said that while Drs. Small, Hall and himself had attended the meeting of the Institute in St. Louis, which closed its sessions yesterday, they had prepared no formal communication to this society. He could, therefore, only give his personal impressions and observations of this meeting of our national body. The attendance, as judged by the number present at the hour set apart for the election of officers for the next year (which was the only occasion that brought all the visitors together), did not exceed 150, or about half as many as we muster every month during the busy season in this Clinical Society.

Although the Chairmen of the Bureaus were most of them absent, the reports were presented promptly according to the printed programme. The quality of a number of these reports was, however, he thought, not up to the average. As a rule they contained very little that was original, and almost nothing of a clinical, practical character. He felt quite confident that the published journal of our local Clinical Society for the current year would show a larger yield for medicine in its practical branches than the big volume of transactions of the American Institute covering the same space of time.

If the \$6,000 or \$8,000 which the St. Louis meeting has cost its members in money, and not merely in loss of practice while they were away from home, could have been spent a little differently, he, for one, would have been very glad. But for a lot of physicians to pass four days in congress without seeing a clinical case or an operation, or hearing a practical clinical talk or a lecture, or witnessing a demonstration in any department of medicine, surgery or obstetrics, or even getting a glance at a hospital or a college, smacks of retrogression and puerility. We must set the old Institute an example of earnest endeavor to contribute something to our literature that shall be of value at the bedside, and a blessing to those who put their confidence in us and in our curative resources.

The town-meeting plan of conducting the sessions of the Institute commits the papers that may have been carefully prepared to the tender mercies of a noisy gathering, in whose presence their reading and discussion are anything but satisfactory or creditable either to the author or to the audience. There is not a society of such proportions anywhere that could or would try to sustain itself with-

out doing its work by sections, thus devoting the proper time to the consideration of practical subjects.

The report of the Bureau of the Diseases of Children being called for, the following papers were presented.

INTESTINAL OBSTRUCTION.—BY H. P. HOLMES, M. D., SYCAMORE, ILL.—*Case*.—May 14 — Georgie C——, aged seven years. Found the boy suffering from severe cramping pains in the umbilical region. For several days there had been severe rheumatic pains shifting from place to place, appearing at one time in the shoulder, at another in the wrists, legs, side, etc. The pain seemed to settle in the bowels a little above and to the left of the umbilicus. Has remained there for over twelve hours. Bowels moved twice yesterday with large free movements and have been perfectly regular up to that time. Since the pain in the bowels commenced he has been free from pain in all other parts. The pain comes on suddenly with griping and cramping, doubling the child up, and so severe at times as to cause him to scream out in agony. The child seems prostrated, is thirsty, but is afraid to drink water as it "hurts his stomach." The face is pale and shiny, tongue perfectly clean, temperature normal and pulse 120. Prescribed *Arsenicum* and *Colocynth* in 3x attenuation, to be given hourly in alternation until better.

When three years of age this little fellow had a severe attack of inflammatory rheumatism, and his case was considered hopeless for several days. He astonished physician and relatives by living through it, and now bears a few of its marks in the way of enlarged wrists and knees, and almost daily twinges of his old enemy.

May 16.—Was called again to find the patient a little worse. Pains not quite so severe, but showing more of an inflammatory nature. Bowels slightly tympanitic and quite sensitive to touch and pressure throughout the whole umbilical region; has vomited some; no appetite and no thirst; tongue perfectly clean. The bowels can be seen writhing and twisting through the abdominal parietes. The pulse is 120, and temperature 101 degrees. Prescribed *Belladonna* and *Mercurius vivus* in hourly alternation.

May 17.—The patient is nearly free from pain; temperature normal and pulse 116; tympanites increasing. Toward evening he vomited a dark brownish and greenish looking substance. This was followed in a few hours by faecal vomiting. Our diagnosis is intes-

tinal obstruction. *Kreasote* 3x, twenty drops in one-half glass of water, a teaspoonful to be given every hour.

May 18.—No improvement; temperature normal; pulse 118. The abdomen is fearfully distended, and gives the same sound on palpation as in rubbing the fingers over a rubber balloon. The bowels are not in the least sensitive to pressure. Patient seems to feel well, laughs and jokes at times, and says he is in no pain. Stercoraceous vomiting, however, has continued at intervals of six to ten hours. There has been no movement of the bowels even when copious enemata of castile suds were used. Castor oil administered was vomited ten hours afterward. No appetite. The smell of victuals is intolerable to the patient. *Lycopodium* seems to be the nearest similia, and was given in the 30x attenuation in hourly alternation with *Kreasote* 3x. Will repeat the oil and enemata.

May 19.—No change for the better. Stercoraceous vomiting has continued at frequent intervals since yesterday. Tympanites increasing. No pain, no appetite, no fever, and pulse 116. Loud rumbling in bowels is heard almost continually. The patient is greatly prostrated, tongue and lips showing a brownish, sticky coating. Consider the case very grave and gave a fatal prognosis. Continue the *Lycopodium* 30x in alternation with *Podophyllin* 3x.

May 20.—It is one week to-day since the bowels have moved. The case is very desperate, and we will try a little reasoning on the case. Somewhere along the course of the intestines there is an obstruction. It is not an impaction of the rectum, because the last movement of the bowels was free and profuse, and there was no history of constipation up to the time of the attack of enteralgia or rheumatic enteritis. Copious enemata were given and could be plainly felt distending the transverse colon. Severe pain also was felt fully below the transverse colon. No particular percussion dullness could be found, owing to the great abdominal distension. This would settle it as being an obstruction of the small intestine. It is not an intussusception, because of the absence of pain and inflammatory symptoms; because of the absence of the characteristic bloody serum-like discharge, and the slow, deliberate manner in which the case has progressed. This obstruction must be caused by spasmodic contraction of the circular fibres of the intestine, by paralysis, or by structural changes in the intestinal coats until the canal has become obliterated. That it is not the latter we are led to

believe by a former argument; the bowels have always been regular with good free movements, which would not be the case had the intestinal canal at any part been undergoing a gradual narrowing process. If the obstruction be caused by a spasmodic contraction of the circular fibers we must give a remedy whose action will dilate the circular fibers, hence *Belladonna* in one and one-half drop doses to be given every two hours. If paralysis be the cause of the obstruction, then something must be done to excite the nerves to bring about the peristaltic action. Galvanism will be the best remedy in such a case. Used a McIntosh eighteen-cell galvanic and faradic battery. Placed the positive electrode three inches up the rectum and the negative electrode connected with a tongue-plate on the tongue; used progressively one, two, three and four cells of the galvanic current, all that could be borne by the patient. This was continued fifteen minutes, when the tongue-plate was removed, a spoon was attached and rubbed over the bowels with five and six cells attached. This was done at 11 o'clock A. M.

May 21.—10 o'clock A. M.—Found the patient better. There has been no vomiting since 7 A. M. yesterday, and there have been two natural movements of the bowels this morning. Patient feels easier, is in no pain, and has a little appetite. *Belladonna* and galvanism continued as before. A profuse evacuation followed withdrawal of the rectal electrode.

May 22.—Patient still improving, although the tympanites still remains. The appetite is improving and the strength returning. *Arsenicum* 3x and galvanism.

May 23.—A profuse watery diarrhoea commenced last night. This has greatly reduced the tympanites, and has been a benefit in the case, providing the new symptom can be controlled. *Aloes* will be given every two hours.

May 24.—Diarrhoea under control, bowels in regular order, appetite returned and everything doing well. Patient considered out of danger and case discharged.

DISCUSSION.—DR. BAILEY.—Papers or reports with this history are always have a peculiar interest for me, for I have had such cases but have never been as fortunate as the physician who reports this one. Owing to the originality of the treatment I feel as if I have been instructed in an important way upon one or two points. This is a novel and apparently successful application of the electric current.

by placing the two electrodes one at each extremity of the alimentary canal, is something worth remembering.

My experience in such cases is that it is not very long before the formation of adhesive bands take place; and the fact that before these bands had time to form, before paralysis had set in, and before the spasmodic condition had become permanent, the patient was relieved, shows that the treatment was very effectual.

DR. R. LUDLAM said that, although the general subject of the diseases of children was foreign to his special work, that of intestinal obstruction was included in abdominal surgery, and, therefore, he had been greatly interested in the history of this remarkable case. Dr. Holmes' diagnostic points were, he thought, well made. The absence of any signs of local inflammation, strangulation or fever; the excessive tympanites, and the frightful character of the matter vomited; the persistent constipation and the subsequent recovery, were carefully analyzed and made available for us. The history of the case, he thought, would preclude the possibility of obstruction by hernia, intussusception, or peritonitis. A mere spasm of the gut could not have continued for so long a time; and if there had been a marked paralysis of the bowel, there would not have been such persistent antiperistalsis with feculent vomiting.

The only question that could be raised in the case as reported concerned the stercoraceous vomiting. On this point a very recent and responsible author has said: \*

"When the obstruction occupies the lower duodenum, or jejunum, the vomited matters are usually very copious and always deeply stained by bile. They can never become really stercoraceous, although if very long retained they may become discolored and acquire so offensive a smell as to be possibly mistaken for feculent matters. In the same way the vomiting in examples of obstruction in the middle of the ileum can never be stercoraceous in the strict sense of the term. If, however, the contents of the bowel have been long retained, as in cases where the vomiting has been subdued by opium, then they may become so altered from decomposition as to have a feculent odor."

The combined effect of the belladonna and electricity in this case helped to clear up the diagnosis, and suggests the kind of intestinal obstruction to which these remedies are applicable. He had never before heard of the current being passed through the digestive

\*Intestinal Obstruction; Its Varieties, with their Pathology, Diagnosis and Treatment, by Frederick Treves, F. R. C. S.; 1884; p. 366.



tract from the mouth to the anus, but could not see why this method might not directly tend to restore the inverted peristaltic action, and thus at the same time stop the vomiting, and open the bowels.\*

DR. H. B. FELLOWS.—Such cases of simply nervous obstruction are certainly very rare. Whether it was simply from paralysis, or due to spasmodic action is a question that, perhaps, can not be answered with certainty, but in either case intussusception is very apt to occur, and may have occurred in this case to a small extent.

It is not uncommon for faecal matter to get lodged in small quantity, and set up spasmodic action and produce obstruction in that way.

There might possibly have been some adhesions originating from the old inflammatory rheumatism, as that not infrequently attacks the bowels.

There is quite a strong tendency among European authors to treat cases of obstruction by the expectant method, that is, letting them alone or giving them a little opium, and condemning all cathartics and enemata as more likely to increase than to lessen the risks of the patient.

As far as the method of applying the electricity goes, I am not sure but what it would have answered just as well to have applied one electrode over the bowels, the other being in the rectum, not merely moving the moist sponge over the bowels but applying it with deep pressure. To get the electric action upon the bowels this

\*In this connection the reader may appreciate the views of Dr. Treves concerning the value of electricity in these obstructions. He says: "So far as I can ascertain, the cases of cure by electricity have been wholly, or for the most part, examples of ileus depending upon faecal accumulation. In these cases, in which a paresis of the gut takes so prominent a part, the mode of treatment is intelligible, and may be expected, *a priori*, to be of benefit.

"Electricity may also be of use in some cases of obstruction due to foreign substances of various kinds. It may also prove of service in some instances of stricture or of stenosis where an accumulation has taken place about the narrowed part, which the unaided contractions of the bowel are unable to relieve.

"It is very difficult, however, to understand how electricity can have the least curative effect in acute strangulation, as by bands, or through slits and apertures. If it acts by increasing peristaltic movements, then its use in cases of this kind would appear to be peculiarly undesirable. The same observations apply to acute or sub-acute intussusception and to volvulus. In these affections a moderation of intestine movements is a condition to be desired, and if the main effect of electricity is to stimulate these movements, then the measure is calculated to do harm rather than good. I have met with accounts of a large number of cases of intestinal obstruction treated by electricity, in all such of these cases as were not due to faecal accumulation or to temporary obstruction in cases of incomplete stenosis, the treatment appears to have been of no avail." *Ibid*, page 434.

deep, firm pressure is always necessary, for in this way you bring the moist surfaces together, and the current always travels by the wet ways rather than by the dry ones.

When so applied there is nothing that will relax spasms quicker than the galvanic current.

PARESIS OF THE VOCAL CORDS—BY DR. J. B. S. KING.—

*Case 1.* Miss H., a young lady of healthy appearance, the possessor of a fine soprano voice, applied to me for relief from the following trouble :

She notices, and her teacher has observed, that her voice is gradually losing its clearness, and she is, of late, continually embarrassed by an inability to strike the note that she wishes to, on first beginning to sing ; when once properly started, however, the remainder of the musical phrase is usually sung correctly. The trouble is experienced after pausing to breath, and also when rapidly changing the note from low to high, or vice versa. Hence she is frequently singing false, a fault of which her ear is painfully conscious but which her voice is unable to correct, except after several efforts.

This state of affairs has reduced her to despair and compelled her to give up singing almost entirely ; for she has found that practicing rather increases the trouble.

About four years previous she was sick for a period of two weeks with diphtheria, an attack that for a long time, after apparent recovery, impaired the purity of her voice, and since that time a cold, however slight, fastens upon the larynx producing a huskiness which lasts for several weeks.

As a careful examination of the larynx and throat revealed nothing abnormal, the condition was, undoubtedly, paresis of the vocal cords, owing its origin, probably, to diphtheria, and kept up or increased by numerous attacks of laryngitis. *Spongia*, *Gelsemium* and entire rest of the vocal organs produced no amelioration.

*Causticum*, recommended by Meyhoffer in similar conditions, produced a satisfactory and so far permanent cure. It was used internally and locally by means of steam spray.

*Case 2.* FOLLICULAR PHARYNGITIS.—Prof. A. P., teacher of singing, complains that as a result of frequent colds his voice is becoming impaired. Frequently during conversation a sharp pain is suddenly felt in the region of the larynx, choking off his voice for

a few seconds, and necessitating empty-swallowing or short cough. At same time tears come into his eyes as if he was choking from dust. In singing he is not so much troubled, but after singing, and after teaching all day, his throat aches and feels tired, and his voice grows hoarse. Moreover he is unable to sing higher than F, whereas he formerly sang as high as A. An annoying cough was often present, especially at night. It occasionally produced vomiting. His throat was so irritable that a laryngoscopic examination was out of the question.

The posterior wall of the pharynx and the fauces were of a dark, purplish-red color, evidently the seat of a venous congestion. The pillars of the fauces and the uvula were flabby and relaxed. Enlarged follicles were present here and there on the pharyngeal wall and a thick stream of mucus could be seen pouring slowly down the throat from the right posterior nares. The throat was excessively sensitive, the slightest irritation producing gagging.

*Phosphorus* relieved the pain and choking sensation in the larynx, and helped the cough somewhat, but a long course of *Sulphur* internally and by means of spray, and of *Kali jod*, administered in the same manner, together with entire rest of the voice, was necessary before his throat was in condition to sing or to teach with comfort. He came of a gouty family. Hemorrhoids, from which he formerly suffered much, were relieved, during the treatment of the throat.

He regained the upper notes of his voice after a time, but even now any long-continued vocal effort will make his throat ache, and the mucous membranes of the pharynx and fauces are far from presenting an entirely normal appearance.

DISEASES WHICH GENERATE CARDIAC LESIONS.—BY A. E. SMALL, M. D. About ten per cent. of the cases of heart disease may be congenital or idiopathic. It is impossible to arrive at a definite conclusion concerning the condition of the heart in these cases, except by the physical signs. One of the earliest signs is cyanosis. It is known by the color of the skin, which is blue, caused by the stagnation of blood in the cutaneous capillaries and by heart disease. The therapeusis of *cyanosis cardiaca* must necessarily be palliative, even if guided by the characteristic symptoms, because when rightly interpreted they show a congenital organic defect; nevertheless pains can be somewhat alleviated by treatment.

When a child cannot be turned in bed, or suddenly moved without the appearance of being faint and sick at the stomach; or if with chilliness and cold hands and feet, with blue lips, tongue, nails and a manifestly irregular pulse, give *Digitalis*. If it has suffocating attacks on touching the larynx or moving the chest *Lachesis* may afford some relief. In older children which have a slow and feeble pulse, and whose breathing is almost imperceptible with slight moaning, give *Laurocerasus*.

It is the purpose of this paper to consider the non-congenital heart troubles by instituting an inquiry as to their source, and the nature of the medical treatment required. Non-congenital heart disease seldom commences in the heart; the *materies morbi* appear to be generated from localities remote from the heart, and if not eliminated perfectly, by imbibition they are liable to reach the heart, and be productive of cardiac lesions. Cardiac lesions in a majority of instances originate from diseases which begin in the periphery of the body *Rheumatic fever* when it accompanies acute rheumatism is usually very marked, with temperature ranging from 102°, 104°, 104.9° F. in exceptional cases, but generally the temperature rarely exceeds 100° or 101° F. during the fever. The pulse in some instances becomes accelerated to 100 beats a minute, but more frequently its rapidity is not much above the normal. The heart palpitates and the respiration is often accelerated. The skin takes on an additional degree of heat and transpires profusely without producing amelioration. Acute rheumatism may attack the synovial membranes of the joints, which generally become inflamed and swollen. From the acute the chronic form may originate. *Acute muscular rheumatism* has its seat in the muscles.

It is well known that the synovial membranes of the joints are composed of the same anatomical elements that enter into the structure of the pericardium and endocardium. This consideration renders it probable that a metastasis or transfer of the inflammation to a similar structure to that of its primary location might occur, and therefore to successfully defend and protect the heart and its surroundings, arthritic rheumatism and synovitis should receive prompt medical and hygienic treatment as soon as the primary symptoms and fever become apparent. A gentleman of sanguineous temperament, aged forty-five, complained of debility and malaise and occasional chilliness, succeeded by fever, accompanied by pain in one or several

joints, which soon began to swell and redden. The swelling relieved the pain partially. The disease did not remain stationary in the joint first attacked. It traveled from one to another until nearly every joint in the upper and lower extremities became implicated and even the cervical and spinal articulations were beset with pain of an excruciating character and almost unendurable from the slightest motion; and yet, being tortured by restlessness, he was compelled to move even if it caused the greatest suffering. The fever in this case ran very high, and the temperature was several degrees above the normal; the pulse was full and tense, but not rapid; murmurs were heard in the cardiac region, together with an audible palpitation. The respiration was considerably accelerated. A profuse, warm, acid perspiration was eliminated from the skin, which afforded no relief. The urine was scanty, and loaded with urea and uric acid, which after cooling presented a thick deposit. We have thus been particular in presenting a record of this case, because, under the influence of rightly chosen remedies, the patient recovered from the attack in less than twenty days, and has remained in perfect health for several years. The chief remedies employed in the treatment of this case were *Aconite* and *Bryonia*. The *Aconite* 3d dilution in water was given in teaspoonful doses every two hours in the first onset of the fever, and *Bryonia* 3d dilution, a few drops in half a tumbler water was given every hour or two, or three after, until the disease had finished its course. And here let it be stated that the *Bryonia* quelled the palpitation and murmurs, and the accelerated respiration. Judging from what we have observed in other cases, the *Bryonia* stayed the progress of the disease before it reached the pericardium, or brought the endocardium or valves into its range. Up to the stage depicted in the case cited above, acute rheumatism is curable with properly affiliated remedies. When improperly treated, it may linger in the system until cardiac lesions become a secondary result.

Several years ago our esteemed colleague Prof. T. S. Hoyne, had a painful attack of acute rheumatism, generally implicating his joints, with severe pain and swelling. After weeks of excruciating pain, he was relieved and radically cured by the frequent administration of *Bryonia*. Every vestige of the disease appeared to be eliminated, and for the last ten years he has not been conscious of any predisposition to another attack. This case adds to the proof that rheumatism previous to, and not complicated with any organic change can be cured.

Acute muscular rheumatism which has its seat in the muscles, tendons and other fibrous tissues is attended with burning, shooting and stinging pains in the affected muscles, sometimes worse, and at other times relieved by motion. This kind of rheumatism, under some circumstances, by injudicious treatment, and faulty medication may extend to the muscular fibres of the heart. It may occur in the muscles of the upper and lower extremities, in those of the neck, back and chest, or any other portion of the muscles, but in whatever locality, let therapeutics do its work at once. If in the lower extremities, attended with a sense of lameness, worse when at rest, and better during motion, *Rhus tox.* is in the center of the group of remedies to be consulted. Rheumatism in any of the muscles attended with synochal fever must be first treated with *Aconite*. If rheumatism has its seat in the muscles of the shoulder, *Lycopodium*; in the fingers, *Caulophyllin*. When muscular rheumatism has located itself, search for a remedy suited to the locality and symptoms.

A gentleman aged fifty, who had suffered from repeated attacks of muscular rheumatism with cardiac complications, and always recovered under homœopathic treatment, was suddenly taken off his feet by a "kink in the back," and wishing to be relieved at once he called on an old school physician, who treated him to hypodermic injections of morphine. After two weeks confinement with this kink he sent for his homœopathic physician, who gave him a dose of *Belladonna*, and the next day he was a sterling advocate of homœopathic practice, and remains so to the present time. *Phytolacca*, *Nux vom.*, *Pulsatilla*, *Calcarea carb.* and many other remedies are applicable in the cure of lumbago. The characteristic symptoms in each individual case, whether the seat of the pain be in the pectoral, intercostal, femoral, humeral, or muscles of any other locality, must guide in the selection of remedies.

With regard to the origin of heart disease from rheumatism, says Peacock, "Out of 100 cases in which a precise early history could be obtained, sixty-one occurred from rheumatism, either acute or chronic, implicating the joints or muscles, seventeen cases were secondary to indigestion without any previous rheumatic pains, four from rheumatic gout, six from scarlet fever, six from typhoid fever, five from renal disease, and in five cases the disease was evidently congenital. The estimate of Sansom is similar, varying but slightly.

In a minority of instances endocarditis is secondary to pleuritis,

pneumonia and morbus. Brightii pericarditis is more frequently secondary to arthritic inflammation. Hypertrophy of the heart generally results from valvular lesions, which result from Bright's disease. The connection between the renal lesion and the heart is obvious; for where structural disease affects the kidney the elimination of urinary solids is so greatly obstructed that their retention results in vaso-motor irritation that interrupts the passage of the blood through the capillaries, and subjects the heart to a great increase of propulsive power, and hypertrophy ensues.

Cardiac degeneration is intimately associated with hypertrophy consequent upon valvular lesions or chronic Bright's disease, inasmuch as these processes induce degenerative changes in the aorta, which lessen the activity of the circulation, and develop the same difficulty in the coronary arteries. The fact of this pathological condition being so formidable as to resist the curative effect of remedies simply argues that the antecedents did not receive early and efficient attention. It is well known that the intemperate use of intoxicating liquors causes renal lesions and albuminuria. Then let alcoholism receive due attention—enjoin abstinence when the degeneracy first seizes the patient. Let *Nux. vom.* have its remedial effect sufficiently early to successfully protect both the heart and arteries.

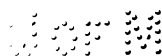
We find occasionally the initiation of heart disease from scarlet fever. An error in the treatment of this formidable disease may be the cause of sequellæ, which ripen into dropsy and Bright's disease, and are liable to operate insidiously in producing cardiac degeneration. Simple albuminuria, anasarca and local dropsies in their incipency often yield to remedial treatment, with *Apis mel.*, *Apocynum*, *Asclepias* and their analogues.

Any disease dependent on some morbid principle, whether epidemic, endemic, sporadic or contagious, which acts disastrously in the circulatory system, if not carefully eliminated may result in atheroma or thrombosis, and thence in cardiac lesions. Diphtheria and other zymotic diseases, the major exanthems, typhoid fever and pyelitis have in many instances been the antecedents of heart disease. It will be seen that idiopathic affections of the heart are rare compared with those generated by disease, at first remote from the center of the circulation. So varied are the diseases that directly or indirectly end in organic heart troubles, either from neglect or maltreatment, it would seem requisite to affiliate a correct

treatment for each in the earliest stage of its manifestation. When cardiac lesions are known to be secondary to certain specific diseases, and if these diseases are not aborted or cured prior to their extreme development, this fact alone would indicate the necessity for the most critical therapeutics in the onset of such as are liable to inaugurate a series of disturbances in the circulatory system which have a direct or indirect action on the heart. And inasmuch as any invasion of disease is expressed by symptoms which indicate the efforts of nature to eliminate from the system the *materics morbi* that has invaded and deranged the vital forces, it is manifestly plain that no other aid than the selection of remedies whose pathogenetic symptoms are similar to those presented by the disease is acceptable assistance to Nature in her struggles. The reason is the similarity existing between the pathogenesis and the symptoms of the disease, showing that the medicinal action will be in the direction of nature's struggles, and thus a positive aid to her eliminating efforts. It is impossible to estimate the good that can be accomplished by a critical adherence to that law of cure expressed in the formula, *Similia similibus curentur*. Such a course would undoubtedly prevent many diseases in the periphery of the body from encroaching on the vital domain, and ultimately with disastrous and fatal effects.

URINARY AND RENAL DISORDERS.\*—The contents of this new book, if expected to be an addition to the information already given to the profession on the subject of urinary diseases, proves disappointing. The author has, however, fortified many of his statements in his former works by the addition of the experience of other physicians and observers in this specialty. The manner of presenting the information is by topics, there being but one continuous chapter in the book. This innovation, if accompanied by a more complete index, would be commendable. The subjects written upon are normal and abnormal urine, urinary deposits, and urinary calculi and calculous disorders. In the topical divisions in very many instances the author refers to the clinical record of cases for evidence as to success in diagnosis and treatment, and he has thus designedly built up an extensive compilation of fact and theory which is valuable to the reader in having the clinical experience of others to analyze and

\*"Urinary and Renal Derangements, and Calculous Disorders," by Lionel S. Beale, M. D. P. Blakiston, Son & Co., Philadelphia, Penn.; pp. 360; 1885.





to compare with his own. The author has done a grand work in his long labors in the study of urinary diseases, and many, doubtless all, can read this book with great profit to their store of practical knowledge. The evidences of hasty editing mar the work, but there are so many pages of choice facts that this can be easily forgiven.

E. S. B.

**THE DECLINE OF MANHOOD.\***—This monograph, as carefully revised, comes from the pen of an author whose writings as well as whose judgment are of the common-sense kind. The book treats of the causes leading to a decline in the sexual power of man, the best means of preventing their effects and bringing about a restoration to health. The doctor's methods of observation, his ability to describe what he discovers to be the causes of the diseases, and his firm hold of moral truth as a guide as to what ought to be man's standard of living, make him the peculiarly fit author of a book on this delicate subject. In the hands of the laity the book would be instructive and profitable for good advice and preventive treatment. The experience of forty years as a physician to the sick, and as a teacher in the professional schools has led him to choose well the methods of cure, which he advocates plainly and impressively. As a guide in treatment, for reference and description, the book is cordially commended to the profession.

**THE NEW TREATMENT FOR HAY FEVER.†**—Owing to the careful experiments and researches instituted some years ago by Dr. Blackley, of Manchester, England, it has been conclusively demonstrated that the inhalation of the pollen of several plants stands in a causative relation to the yearly attacks of hay fever in susceptible individuals.

These experiments, satisfactory as they were from an etiological point of view, had up to the present time suggested no successful plan of treatment, and this has remained, notwithstanding our thorough knowledge of its natural history, one of the most difficult and refractory diseases to deal with.

Phœbus gives a long list of remedies that have been unsuccessfully employed to combat it, and Zuelzer in Ziemssen's *Encyclopædia*,

\***THE DECLINE OF MANHOOD.**—By A. E. SMALL, M. D. Duncan Bros., Chicago, Publishers; 3d edition; 1885.

† "Hay Fever and its Successful Treatment by Superficial Organic Alteration of the Nasal Mucous Membrane," by Charles E. Sajous, M. D., pp. 103. F. A. Davis, Att'y.

after giving a complete history and description of the disease, dismisses the consideration of its treatment with the statement that "treatment is powerless against it."

Neither does homœopathic literature record many cures, and leading writers of our school speak of this ailment with some diffidence; hence, any one coming forward with a new and successful treatment, as Dr. Sajous claims to do, ought to be warmly welcomed.

This treatment is based upon some recent discoveries in the pathology of the disease made by J. N. Mackenzie, Hack and Sajous. These discoveries were in brief, that in the nasal mucous membrane of all hay-fever patients there existed one, two or three hyperæsthetic areas which, if irritated by a probe, or other mechanical means, brought on an access, more or less complete, of the usual hay-fever symptoms, and also that all sufferers from this disease were neurasthenic.

According to this view, all the head and chest and general systemic symptoms of hay-fever are of purely reflex or nervous origin, and are induced by the pollen of plants mechanically irritating these hyper-sensitive spots in the nose, much as a hysterical paroxysm is brought on by touching one of the puncta hystérica.

The new and successful treatment, based upon these discoveries, and originated, at least in part, by Dr. Sajous, is entirely surgical, and consists in cauterizing by means of escharotic acids, or the electro-cautery, these sensitive nasal spots, and thus producing a superficial organic alteration in the mucous membrane, thereby rendering the special cause of hay-fever inoperative.

To those who have always regarded the coryza of hay-fever as simply the local expression of a general systemic disease, just as is the coryza of influenza, or the enteric lesions of continued fever, this scheme of treatment will seem inadequate; for inasmuch as the ✓ tincture of *Ambrosia artemissifolia*, the greatest enemy of hay-fever sufferers, containing no pollen, but simply the active principles of the plant in solution, will, when taken internally, produce in susceptible individuals an attack similar to hay-fever, it shows that these symptoms can be produced by absorption of the active principles of the plant into the system, without any local action upon the nasal passages whatever.

Such being the case, it seems as if no cauterizing of a certain area in the nose could prevent the entrance of the pollen into the

system through the nose and mouth, to lodge upon some mucous surface, and there give rise more slowly to the same symptoms that would have occurred immediately if it had lodged upon the uncauterized sensitive spots.

Then, again, the fact that violent irritating agents, like capsicum, veratrum, alum, or tobacco, do not produce hay-fever symptoms, but simply symptoms of nasal irritation, goes to show that the pollen which produces hay-fever must do so by virtue of some peculiar dynamic property of its own, which militates against the theory of mere mechanical irritation.

This fact, indeed, attracted Dr. Sajous' attention, but he does not attempt to explain it.

In reading of the careful localization of the area of hyperæsthesia, one cannot help reflecting that it is difficult to find an area on the nasal mucous membrane that is not sensitive. Few people can suffer even the careful introduction of a probe into the nasal passages, without lachrymation and intolerable itching, as any one who has introduced an Eustachian tube can testify.

All theoretical objections, however, must give way before a record of clinical cases, and Dr. Sajous gives a number of such, in all of which the treatment was successful. The number, however, is hardly large enough to establish its claim of being always successful.

More recently, Dr. Ingals in a paper read before the Chicago Medical Society, gave a small number of cases treated in this way, in which the results were, on the whole, favorable.

This little work, with its accurate and scientific directions and explanations, will be sure to cause a large number of experiments in this line to be made; and but a short time will be required to show us whether this clever treatise is to make an important addition to the established methods of practice, or like many other ephemeral and visionary pamphlets to be relegated to the dusty regions of an unused top-shelf.

J. B. S. K.

# Hospital Notes.

## THE WOMEN'S CLINIC.

### SERVICE OF PROF. LUDLAM.

**CARCINOPHOBIA.**—*Case 17,415*—Mrs. —, aged forty-eight, married, has had nine children, the youngest of which is now thirteen years old. The menses were regular, but were of more than normal quantity until about six months ago, when she passed four months without them. The last period came two weeks ago and continued for six or seven days with an excessive flow. She has no leucorrhœa, but at times has had an inter-menstrual discharge of a pinkish color and a slightly disagreeable odor. There is a feeling of soreness all about the abdomen, and she cannot bear any pressure upon it.

She has a great deal of severe frontal headache. She is completely out of breath on going up stairs or from walking fast, and often has palpitation of the heart.

Twenty years ago she first noticed a small blister just within the vulva, and four years ago this began to sting and burn until at times the pain has been almost unbearable. During the last four weeks she has used carbolic acid locally, which has given her some relief. Her uncle and an aunt have died of cancer; her sister now has cancer of the uterus, and she herself is a great sufferer from a dread of that disease. She is extremely nervous and low-spirited. The bowels and kidneys act normally. *Digitalis* 3 four times a day.

May 1.—The medicine greatly relieved the irregular action of the heart and the headache. A local examination reveals an old laceration of the cervix. The womb is *in situ* and is not increased in depth, but the tissue around the os-uteri is extremely friable, bleeding on the slightest touch. *Hydrastis* to be applied locally, and *Mercurius bijodat.* 3 internally.

May 15.—She failed to get the medicine at the last visit, but has still taken the *Digitalis* whenever her head has begun to ache, and it has always relieved her. The menses came two weeks ago, and she went through the period nicely. During the past week she has suffered mentally more than ever before, and is more than ever possessed with the idea that she has a cancer. A private note from a friend of hers says in substance: "Mrs. — is determined that she has a cancer, whether it is one or not, and yet if she were told that she really had one, I am afraid she would do violence to herself. Her friends think she is really losing her reason in this regard."

A careful local examination finds the parts all very sensitive and somewhat inflamed. No positive diagnosis is made, but there are

present many evidences of cancer of the uterus. Continue the *Hydrastis* locally, and give *Arsenicum iod.* 3 internally.

After the examination, the patient having been sent into the ante-room, Prof. L. said: "Before that table is rolled in again we must have a word or two upon what you have just seen and heard. Nothing is more common than for our patients to imagine that they are suffering from and will die of this or that form of incurable disease. When such an impression is fanciful and has its root in the emotions there is really very little danger that such a result will follow. Indeed, in certain cases, as where men or women imagine that they have consumption, or will become insane, clinical experience often shows that the very dread of the disease, or the determination to have it, is *prima facie* evidence of exemption from it. There is a practical limit to the power of the imagination to cause a diseased condition which shall be of a serious and really dangerous character that is not always appreciated by the physician and the gynecologist. If we exclude those cases in which from hereditary or acquired predisposition our patients are pretty certain to suffer and to die of phthisis, or rheumatism, or of cancer, the rest are much more likely to fall victims to something that they had not thought of and never imagined themselves likely to have. Fancied diseases are not fatal in their character; but when one whose family history is bad becomes thoroughly possessed and saturated with the idea that the same affection which has carried off several of her relatives has already seized upon her, the dread of it has a much more serious significance. You will need to discriminate between those cases in which your patients imagine that they are doomed to develop and to die of an incurable constitutional disease without being predisposed to it, and those in which there is a reasonable probability that sooner or later they surely will do so. What I wish to say is that fear and dread of any ordinary disease, any disease that is neither epidemic nor malignant, is not likely to induce it in those who are not predisposed to it.

"The horror that our patient has of dying of cancer is not a figment of the imagination. A fortnight ago my colleague, Prof. Bailey, recognized that the local lesions in her case were suspicious. Those lesions are not yet fully developed, but they are sufficient to show the inevitable drift of the case, and, independent of her family history, make it certain that her fears are not groundless. Her friend is quite right in supposing that she might harm herself if I should

tell her the whole truth, for she is really insane upon this one single topic. And this insanity, this unbalancing of the reason through a fear of dying from that horrible disease is what is called carcinophobia."

**LACERATION OF THE CERVIX AND PERINEUM, WITH A RECTO-VAGINAL FISTULA.**—*Case 17,423*—Mrs. M., German, aged twenty-five, has had no children, but had a miscarriage at about the fifth month three years ago. At that time her husband was drinking to such excess that she thought she would be obliged to separate from him, and, as she did not wish to have a child to support, following the advice of a neighbor, she inserted a penholder into the os-uteri as far as she could, leaving it until, to use her own words, "I had opened my womb." Following this she was quite ill for three days, when a physician was sent for, who took the foetus away with instruments. She was not off her bed for a number of weeks, but when at last she was able to walk, she went to the doctor's office and submitted to a local examination. He told her the parts were torn, and used a caustic locally. As she suffered more after the treatment, she did not continue it. She has not had a well day since the miscarriage. The menses are irregular, painful, and the flow is very scanty. She has constant neuralgia, which unfits her for work; has no strength and less ambition, and can only walk a short distance without becoming very faint and weary. The bowels are very constipated, and it is only with great difficulty that she can have a movement. Occasionally flatus and fecal matter pass through the vagina.

A local examination finds the cervix in the center of the pelvis, movable and slightly torn. The perineum is lacerated from the summit to the fourchette, but the integument is completely intact; and there is a recto-vaginal fistula large enough to admit the point of a uterine sound. *Belladonna 3.*

May 18.—The patient came to the hospital for operation. She is willing to do anything if she can only be relieved of her backache and feel strong again. After being thoroughly anæsthetized, the operation of trachelorrhaphy was first performed, catgut sutures alone being used. In order to freshen the edges and coapt the parts of the lacerated perineum and at the same time close the fistula, it was necessary to slit the integument at the median raphe. After this was done and all the cicatricial tissue removed, the parts were carefully brought together and held in position by silver wire sutures.

Surgical anæsthesia not only puts our patient into the state of absolute repose which is necessary to the performance of these delicate plastic operations, but it permits me to "improve the occasion" as we proceed with the operation. How it was possible that these tissues could have been so badly lacerated in a delivery at the fifth

month, I do not know, unless it was through some mischievous interference.

The cervical rent is not a large one, but you will observe that I take the same pains to remove every scrap of cicatricial tissue as if it were. This freshening must be freely done, and the edges of the wound carefully coapted, or the result will be a failure. Where the neck of the womb is not enlarged, the laceration is limited, and there is no sub-involution of the uterus, I sometimes depend upon coarse catgut sutures only. Under these circumstances there is little or no strain upon them; the surfaces unite before the sutures have softened and yielded; and we avoid the trouble and risk of removing them over a freshly-united perineum. But in ordinary cases the silver wire, the silk-worm gut, or the hair sutures are best.

I did intend to make Emmet's crescentic operation for this perineum, but the integument is too thin, and I therefore cut it down to the depth of the internal laceration. The foreign tissue is removed from the summit and the lateral sulci, as well as from the borders of the recto-vaginal fistula, the hæmorrhage controlled with hot water, and the wound secured with three silver sutures, two of which are hidden and one is labial. On the vaginal side I put two catgut sutures, and now the edges of the incision fit as they should—like a ball-cover.

To save time and trouble these three operations may sometimes be made at one sitting; but when this is attempted the patient's general health and surroundings must be good; the internal laceration must not be too large or severe to be trusted, almost exclusively if not entirely, to the catgut sutures; the fistula be small enough and so situated as to be included in the perineal wound; and the nursing and after-treatment should be of the most careful kind. Otherwise it would be better to make two or even three successive operations than to attempt too much at one time.

CONTRA-INDICATIONS FOR A UTERINE PESSARY.—The following hints were given after the removal of a pessary that had caused a great deal of suffering: The intelligent use of this instrument is one thing, and the ignorant abuse of it is quite another thing. The violation of a very simple and practical rule has given this patient unnecessary pain, and done her no good. The fault was with the physician who applied it, and not with the pessary. He must have

forgotten, if he ever knew, that when the pelvic tissues anywhere about the womb are or have been inflamed, the use of a pessary is contra-indicated. This woman has pelvic cellulitis, for the left broad ligament is checked up, and every little while she discharges pus by the rectum. Moreover, it is a post-~~puerperal~~ <sup>puerperal</sup> affair of some years duration. These inflamed tissues will not tolerate the mechanical pressure of a vaginal pessary. They are sufficiently traumatized by the weight and movements of the uterus itself, especially when the patient stands or walks about.

It is a most unfortunate thing that so many physicians overlook the sensitiveness of the inflamed areolar tissue within the pelvis. I have had cases of pelvic cellulitis in which relapses were directly traceable to constipation with straining at stool; and others in which vesical tenesmus had the same effect. Many of these and similar cases of relapsing cellulitis, with or without suppuration, have been unwittingly cured by Dr. Weir Mitchell's method of absolute rest, but they are not to be cured by the wearing of this or anybody's pessary. The fact is that although the pelvic cellular tissue is wonderfully elastic, undergoing the most remarkable changes during pregnancy, parturition, and puerperality, it acquires a morbid delicacy when it is inflamed, and is especially intolerant of mechanical pressure or injury of any kind.

Therefore I would advise you always to inquire very carefully into the clinical history of the case before you fit a pessary for the cure of a uterine displacement. You should be on the lookout for a latent cellulitis, or pelvic peritonitis, or the remains of an old hematocoele, or of a retro-uterine abscess, and if any of these conditions are present, you should remember that a pessary will do more harm than good.

It is a safe rule to be as careful in applying a pessary as you would in introducing a sponge tent, or in dilating the cervix mechanically by the use of instruments, neither of which expedients would be proper in case of peri-uterine inflammation, or abscess.

---



## Miscellaneous Items.

Our bi-monthly portrait affords an excellent likeness of GEORGE F. SHEARS, M. D., Associate Professor of the Principles and Practice of Surgery in the Hahnemann Medical College and Hospital, of Chicago.—Bro. Hoyne, editor of the *Medical Visitor*, is on a fishing excursion in Wisconsin.—Dr. C. C. Brace, Class '75, has been elected Mayor of Boulder City, Colo.—Dr. Alice K. Brown reports having obtained prompt relief in a case of acute peritonitis from painting the surface of the abdomen with a 4 per cent solution of the muriate of cocaine.—We have pleasure in recording the marriage of Dr. E. J. Abell, Class '81, May 13, to Miss Kate Sander-son, of Chicago, and of Dr. J. D. Cole, '82, to Miss Adda E. Gar-ri-son, of Ontario.—Since our last issue death has robbed us of two of our local physicians: Dr. James S. Beach, who came to Chicago in 1838, and had practiced his profession since 1854; and Dr. John L. Atwater, Class '80, who died May 28, æt. fifty-eight. Both of them were greatly respected.—There are 300 homœopathic physi-cians in Wisconsin.—Our friend Miessler has translated and pub-lished a portion of Duncan's book on the diseases of children.—“The Diseases of the Nares, Larynx and Trachea in Childhood,” by Dr. Thomas Nichol, of Montreal, has been issued by the A. L. Chatter-ton Co., of New York. It is really a valuable and creditable work, one of a kind that, for the sake of all concerned, should multiply and increase.—“Bodily Posture in Gynecology,” by Dr. S. J. Donald-son, of New York, is a reprint from the *American Journal of Obstet-rics*, etc.; and “The Treatment of Diphtheria and Croup”, by Dr. Marc Jousset, comes from J. B. Bailliere et Fils, Paris.—The Clinical Society continues regularly to hold its monthly meetings at the Grand Pacific Hotel. The last, June 6, was its 100th session.—Our friend, Dr. G. E. Smith, Class '80, being pressed for a stethoscope, away off in the country, was sharp enough to try an inverted wine-glass, and found it to answer a very good purpose.—The next meeting of the American Institute will be held in Saratoga.—Dr. Smith's gold mine is booming.—The editor of THE CLINIQUE has recently had a very interesting visit from Dr. C. F. Fisher, of Sid-ney, Australia.

# THE CLINIQUE.

---

VOL. VI.]

CHICAGO, JULY 15, 1885.

[No. 7.]

---

## Original Lectures.

### *A FIBROID IN THE BLADDER.*

A CLINICAL LECTURE, BY PROF. LUDLAM, DELIVERED IN THE  
HAHNEMANN HOSPITAL, OF CHICAGO.

*Case 17,465.*—Mrs. —, æt. twenty-four, is married and has had two children. Her first labor was a breech presentation, and was long and painful; but she made a good recovery. The second delivery was a very easy one. When about twelve years old she began to have dysuria, which was not constant, and did not appear to be connected with any external circumstances, but came at more or less irregular intervals. She has no knowledge of ever having received a fall or an injury.

After the birth of her first child the difficulty in urinating increased, and she consulted several physicians in reference to it.

One told her that it was due to a misplaced uterus, but treatment upon that theory brought no relief; another that she had gravel, and sweet spirits of nitre, buchu, and other diuretics were taken without benefit. The urine has been analyzed, and found to contain no abnormal products, but at times she has noticed a cloudiness in it, and again, after great pain and severe straining, a few drops of blood have passed. Occasionally it has been of a deep yellow color. If she retains the water after the first inclination to void it, when she at last endeavors to do so she cannot pass any, but instead has severe labor-like pains. Hot applications, sitz-baths, etc., have never given her any relief. The menses have always been pretty regular, normal and painless. Her feet and ankles often swell, and occasionally there is a noticeable enlargement of the abdomen. The bowels are regular. A local examination finds the uterus in position, and of normal depth. The cervix is slightly lacerated.

Surgeons sometimes operate first, and make a diagnosis afterward. In abdominal surgery especially, this is sometimes our only resource. It is not unusual for physicians to make a very thorough diagnosis after an autopsy; nor is it an unheard-of thing for them to be unable to tell, even then, what has been the disease in question.

First, we will examine the uterus. The size, shape, and position of the cervix are normal. Upon drawing the organ into view, you observe a slight laceration and erosion. There is no anchorage of it. The sound passes readily, and indicates a depth of three inches. We must therefore excuse the womb from any serious complicity in the morbid condition.

This narrows our search to the bladder. If the urinary trouble in this case was merely functional, it could not have continued for so many years; and, if it was organic, you will say the quality of the urine should be greatly changed. So it should, and this is the puzzle in the case. With a stone, or almost any kind of a tumor in the bladder, the urine would have been bloody, or purulent, with an admixture of mucus. If the bladder was paralyzed the urine would be offensive from alkaline decomposition, as it was in some of the cases of cystocele that I have shown you. Chronic cystitis with suppuration would have its characteristic secretion; but here, as you see, the urine is clear, amber-colored, and natural in quality.

Shall we therefore, conclude that our patient's symptoms are imaginary, and that she is a fit subject for the "mind-cure?" By no means. Wonderful as its effects are in producing certain kinds of disease, the imagination could not have caused the vesical tenesmus that has tortured this poor woman almost incessantly ever since she was a child. There must have been some local and constantly-acting source of irritation in this case, and the only way of finding it is to explore the cavity of the bladder.

Now looking into the bladder through an endoscope is one of the refinements of physical diagnosis that are worth very little practically. I pass the sound, and after careful manipulation fail to find anything abnormal. There is no click from a calculus, nor can we discern the projection of any tumor, or the presence of any abnormal growths within the bladder. I want to apply the "touch" without which the diagnosis will not be complete. But how can we examine the interior of the bladder with the index finger? Either by first making an incision by the scalpel or with the thermo-cautery through

the vesico-vaginal septum, or by dilating the urethra. The former of these methods is especially adapted to cases in which the urine is of a very bad quality, and where the bladder needs to be drained and irrigated, a condition of things which is not present in this case. Dilatation has its disadvantages, but when it is rapidly, and at the same time carefully performed, it is safer and quite as satisfactory.

Having first stretched the urethra with these long, narrow forceps, I pass a Hunter's uterine dilator without the rubber attachments, and expand the blades in the direction of the patient's hips, or transversely with the vagina. It is better that the meatus should tear a little than to nick it beforehand, as some operators have done. On withdrawing the instrument we apply the hard-rubber blades, and reintroduce it. This must be carefully done or mischief will result, for, although the modern method of rapid dilatation is safer than the old way of doing it with sponge tents, still it is a ticklish expedient.

I will now withdraw the dilator at the risk of letting one or both of the rubbers slip into the bladder (an accident that happened in one of my operations two years ago), and afterward push my finger into the cavity. Now I am ready for a digital palpation of the bladder. My index is upon the vesical trigone, which is normal, and now it has passed over the whole of the *bas-fond*, in which I find no foreign body, nor anything wrong. In the fundus of the organ, however, there is something that should not be there. By the conjoined touch I find it to be a round, smooth, hard, rather thin body, that is firmly set in the wall of the bladder. It has exactly the feel of a small interstitial fibroid of the uterus. It is not a stone, nor is there any roughness upon its mucous surface.

There is some hemorrhage, and we will therefore inject the bladder with hot calendula water, and afterward put the patient quietly to bed, where she will be given *Aconite* 3, and *Arnica* 3, in hourly alternation.

Wednesday, July 1.—After the operation on Monday I promised to say something more of our patient and her condition in my clinic to-day. Happily she is doing well, and thus far has experienced no bad effects from the operation. There naturally was some pain during the first few hours, and the first night she had very little sleep; but last night she slept well. There has been no involuntary urination, and now she retains the urine for six or eight hours;

indeed, did not urinate through the whole of last night. This affords another illustration that the rapid dilatation of the female urethra is not necessarily followed by a more or less tedious incontinence. In the last six cases in which I have practiced it there has been no trouble of the kind afterward.

But what of the tumor that has been the cause of so much suffering? If you will carefully observe the anatomical relations of the bladder, which are so clearly shown in this model, you will see how easily and certainly the growth that we found would excite a strong vesical tenesmus, and force the poor woman to try to urinate whenever a slight accumulation took place in that organ. It acts in the same way as pressure from an anteverted uterus, an ante-uterine tumor, an ovarian cyst, or from a stone in the bladder. This is why one physician said that the uterus had fallen forward, and why others claimed that she certainly had stone.

Dieulafoy has shown that *pollakiurie*, as he styles it, or a great frequency of urination, may be of recent origin, or the opposite, painful or painless, and may occur exclusively during the day or the night. In recent cases, as when it accompanies menstruation, or the beginning or the end of pregnancy, or follows the eating of certain kinds of fruit or fish, or certain drinks or medicines, it has no clinical significance. But of chronic cases Péan says:

"An old case of *pollakiurie* often depends upon disease of the genito-urinary organs, more especially of the urethra and of the bladder. In men it is incident to hypospadias, epispadias, urethritis, affections of the prostate, as well as varicosis, tuberculosis and cystitis. In women, besides urethritis and cystitis, it may be induced mechanically by uterine, ovarian and pelvic tumors, chronic pelvi-peritonitis, and by a floating kidney. Finally, in both sexes it may arise from affections of the rectum, thread-worms, hemorrhoids, stricture; or of the kidney, and more especially from albuminous nephritis. In the latter case its significance is very great, both in the onset and in the fully developed form of Bright's disease, for it anticipates the other symptoms and may put the physician in the way of its recognition. This is the point of view that Dieulafoy has studied most carefully."\*

It is possible that the tumor which I certainly felt in the fundus of the bladder in this case is the result of a limited sclerosis from inflammation of the areolar tissue. But it seemed too round and

\* *Diagnostic et traitement des tumeurs de l'abdomen et du bassin*, par J. Péan, etc., tome II. p 62, Paris, 1885.

smooth to the touch. For the same reason, and because it did not project either beneath the peritoneum or into the cavity of the bladder, it is not likely to be schirrhous. That it is not a soft cancer of any kind is shown as well by the character of the urine as by my failing to find any roughness or vegetative sprouts upon the vesical mucous membrane. Moreover, the slow growth of this tumor is pretty good evidence of its benign character.

I have felt of so many uterine fibroids that the recognition of a fibrous growth almost anywhere within the pelvis is no longer very difficult. There is no cachexia in the case, for in other respects the woman is well, and in good flesh and spirits.

But, under the promise of a friend who was operated upon and cured in this clinic, that she, too, should be benefitted, she has come a long way for relief. What can we do for her? The maxim of Abernethy which held that a case that is well diagnosed (we say diagnosticated now-a-days) is half cured, is as true as it was fifty years ago; but, if we can help it, we must not be satisfied with doing things by halves.

After recovering from the anæsthesia she was disappointed because I had not ventured upon an operation while she was in an unconscious state and when I had found the tumor. But you know that that would not have been either good or safe practice. That growth can not be taken from the inside of the organ until it has become larger and more decidedly developed in that direction; nor from its outer surface without cutting through the fundus of the bladder. It is possible, but not probable, that in the future it may so change its form, size and relations as to render it expedient to operate for its removal, either by the curette or by the knife. But now we must desist. And not only must we refrain from cutting in this case, but it is incumbent upon us to decide whether any form of local treatment could be of service. My judgment is that it would almost certainly do more harm than good; for the effect of injecting her bladder frequently or habitually with any medicated preparation would be to change the quality of the urine and to cause a degree of local irritation that could not fail to be mischievous. I would rather depend upon constitutional remedies, and the regulation of the diet and the habits of the patient than upon any local treatment whatever.

There is one practical way of prescribing, of which I am per-

suaded we shall do well to avail ourselves in this case. That method consists in arranging similar or parallel cases into clinical groups. This intra-mural growth belongs to a class of tumors that are constantly under our care. Fibroids of the bladder are as rare as those of the ovary; but, wherever they are found, these growths have their own clinical history and significance. They constitute a group of cases which are as interesting and as important as are those which in general practice are styled rheumatic, scrofulous, calculous, etc., for they, too, represent a kind of diathesis.

Their seat and their symptoms may vary the same as in articular and cardiac rheumatism, in renal and hepatic colic from the lodgment of calculi, but their rational and successful treatment involves a recognition of their common characteristics. If the fibroid that our patient has in the fundus of the bladder was located in the wall of her womb, she would almost certainly have had a copious menstruation. As it is, she has had nothing of the kind.

Fibroids are usually of very slow growth, at least until they begin to undergo some form of degeneration; but the frequent changes in the vascularity of the uterus during menstruation and pregnancy are very apt to promote their development, and also to increase their number when they are attached to that organ. There is no such physiological stimulus to the growth of a vesical fibroid, and no good reason why she might not possibly continue to enjoy an immunity from the increased size of this tumor as time goes on.

But it is not enough that we may sometimes arrange our cases into clinical groups, or that we may find physiological reasons why certain tumors should not continue to grow at a dangerous pace. We must not only clear up the diagnosis, but must cure our patient whenever it is possible. After thinking the matter over very carefully, I have concluded to prescribe *Ergot* 3 for this case, not only because it can sometimes be depended upon to cut off the nutrition and to jugulate these fibrous growths in an incipient stage of their development, but also because its pathogenesis has a lot of urinary symptoms that are closely related to it. When she has taken it in the third potency for a time it may be best to change to the second or the first, or perhaps to select a higher dilution.

---

## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

### JULY MEETING, 1885.

The one hundred and first session of the Clinical Society occurred on Saturday evening, July 11, at the Grand Pacific Hotel, Dr. C. T. Canfield, vice-president, in the chair. In due course the Society heard and adopted

#### *THE REPORT OF THE COMMITTEE ON THE PRESIDENT'S ADDRESS,*

which read as follows: The committee is of the unanimous opinion that the suggestions offered by the president, Dr. H. B. Fellows, in his inaugural address, if acted upon, would tend to improve and render more profitable and interesting the work of the Society, therefore, in strict accordance with these suggestions, the committee recommends:

That the chairman of each bureau choose anew the members belonging to same, with special reference to their ability and willingness to do work and prepare papers on topics in his particular branch of clinical work.

Also that the chairman of each bureau not only select the topic for his report sufficient time in advance of the meeting at which the report has to be made to allow the members to be notified, but also apportion the topic into such sections that the bureau members shall each have a share to subscribe to the report

The committee also commends to the notice of the members of the Society generally the advice that they take proper cognizance of the topic to be brought before the succeeding meeting, so that each and every one shall be the better prepared to discuss the same with greater freedom and more point.

And, lastly, that all active, associate and corresponding members of this Society, bear in mind the need of presenting pathological specimens as frequently as it comes within their power to do, because it is in the direct line of the work of the Clinical Society, and always does good by adding to our knowledge.



## THE REPORT OF THE BUREAU OF CLINICAL HYGIENE.

J. E. GILMAN, M. D., CHAIRMAN.

THE SANITARY CONDITION OF THE CITY OF CHICAGO—BY J. E. GILMAN, M. D., PROFESSOR OF SANITARY SCIENCE IN THE HAHNEMANN MEDICAL COLLEGE.—The city of Chicago, despite its natural disadvantages of location, has gained within the last few years an enviable position in the list of cities, by reason of its continually improving mortuary reports. From being a place where disease was rife and deadly in effect, it has gradually emerged into the front rank and leader of all the large cities in the world, with the lowest death record per thousand. And we may say that it stands to-day with a small average death rate, that is unequaled by any place of 100,000 inhabitants, or over. Scarcely is there a New England country village that has such a low percentage of deaths as this great city. The greater the aggregation of human beings in a community, the more densely settled and crowded together a population is, the higher may we expect the ratio of death losses to become. Yet, while Chicago has been filling up her vacant lots with buildings, and thus closing up one breathing place after another, and adding thousands to her population, still the death rate has steadily diminished; and the object of this paper is to point out the method by which this has been accomplished, and to make known the sanitary measures planned and carried out by the commissioner of health, to still further improve the condition of our citizens. First, then, let us consider briefly the disadvantages to be overcome: Chicago is built upon ground but slightly elevated above the level of the lake. The soil is underlaid and saturated with water, and the difficulties in the way of sewerage and drainage are very great. In the spring time many sections of the city are subject to inundation, and the water covers all the surface of these sections for weeks at a time; filling excavations, cellars, and openings under buildings, and leaving damp walls and pools of water far into the summer months. The city has grown very rapidly, and, like a boy that fast increases in stature finds its outfit too scant for the necessities of the occasion, consequently we find long lines of streets destitute of sewers and proper drainage, without pavements, dependent upon vaults for excreta; and considerable

areas are built and filled up with inhabitants in an inconceivably short period. In the year 1884 there were erected sixteen miles of three-story buildings in the city of Chicago, and square after square of structures are thus raised, leaving these other matters to be finished at some future period. Then there is a very large foreign element of the working class, who have very little regard for sanitary observances, and less knowledge of what is needed to prevent disease. In fact many resent the efforts to improve the condition of their habitations as an inroad upon their vested rights. There are large numbers of manufactories of all sorts, distilleries and brewing houses, in and about the city, which have, in various ways, had an injurious influence on the public health. Then with the immense slaughtering houses, and business of the stock yards, and the carrying trade of meat in transit to the Eastern and Middle States, we have a traffic that causes Chicago to become the rendering establishment for the world. There is scarcely a town or hamlet on the globe where American canned, pickled or preserved meats may not be found, and the aggregate quantities shipped reach stupendous figures. As an illustration of this, two houses alone sent from Chicago 21,500,000 pounds of meats for the use of the British Army in the Soudan campaign, besides supplying the immense orders of their regular business. And all the waste and refuse of this vast industry passes through the rendering and fertilizing establishments, to be worked over into substances for other uses. And this constitutes a formidable problem for sanitary solution. Having these elements with which to contend, and the business and monetary interests which conflict with the sanitarians plans and efforts, the task of regulating the hygienic welfare of Chicago is a herculean one. The health department, under the command of Dr. Oscar DeWolf have conquered and controled the great rendering establishments and have succeeded in making them comparatively harmless, in fact now, instead of antagonizing, they adopt his plans and aid his efforts. But it was a long and arduous task. The stench that was a constant nightly visitant, the odors which were a reproach and by-word when the name of Chicago was pronounced, are, at the present time, almost a thing of the past. If through the carelessness of some employes an occasional fetor renders the night burdensome, the health officers ride it down, discover its origin, and the offender is punished accordingly. So these offensive odors come but seldom, when but a short time ago they were constant. This

done, the improvement of the sanitary condition of the factories and tenement houses was taken up and accomplished.

The real work of renovating and regulating the workshops and homes of the working people, began systematically some five years ago, and has been organized into a system so perfect that England sends her representatives here to study our methods, and such men as Dr. Carpenter and Henry Burdett move their adoption in that country, and men of science show their sense of the value of the plan by making Dr. DeWolf, our Health Commissioner, a member of the British Society for the advancement of science for his labors in this direction, while from other cities and foreign lands come requests for the printed forms and order of work, as instituted here. England is credited with being fifty years in advance of this country in sanitary matters, but in this respect Chicago is in advance of the world, and the improvements effected in factories and tenement houses have greatly added to the comfort and increased the longevity of the inmates. Under the direction of Mr. Zenung, the chief of the tenement house and factory inspectors, there are a corps of practical men who make systematic visits to 10,000 tenement buildings and factories. These inspectors have a knowledge of plumbing, and are well versed in all the defects of ventilation and drainage. Our laws give the health commissioner more than police power, for he is ordered to enforce the ordinances, and to do this "is empowered to enter any house, store, stable or other building from the rising to the setting sun; cause the floors to be raised if he shall deem it necessary, in order to a thorough examination," and if there are defects in any respect that in his judgment endanger the health of the occupants, he may, if the same are not speedily altered to conform with the rigid rules of the department, order the house vacated, and enforce his order, too, by actual police ejectment. There are fines and penalties for neglect to heed the warning notices of defects in the sanitary condition of the buildings, and the courts impose the fines speedily on complaint, so that experience has taught the lesson that when an inspector makes a complaint and gives his notice of the imperfection, the house owner or agent can not well avoid giving it immediate attention. The following blank marked A gives the form in which an inspector makes his report of the tenement house, factory or workshop; while the forms, B, and C, exhibit the thorough manner in which the inspection is carried on. Now this has been done as I

(A)  
COMPLAINT.

## HEALTH DEPARTMENT.

Page.....

Tenement and Factory Inspector's **SPECIAL** Report to Commissioner of Health.

Chicago.....

188

Location.....

Ward.....

Owner or Agent of Premises.....

Description of Building.....

## TENEMENT REPORT.

## FACTORY AND WORKSHOP REPORT.

| Floors. | Rooms. | Fam-<br>ilies. | Occu-<br>pants. | Fe-<br>males | Boys<br>under 16. | Girls<br>under 16. | Name of<br>Employer. | Kind of<br>Business. | Factory | Store. | Miscel-<br>laneous. | Total<br>Emp'd. | Males | Fe-<br>males | Boys<br>under 16. | Girls<br>under 16. |
|---------|--------|----------------|-----------------|--------------|-------------------|--------------------|----------------------|----------------------|---------|--------|---------------------|-----------------|-------|--------------|-------------------|--------------------|
| Bas't.  |        |                |                 |              |                   |                    |                      |                      |         |        |                     |                 |       |              |                   |                    |
| 1st.    |        |                |                 |              |                   |                    |                      |                      |         |        |                     |                 |       |              |                   |                    |
| 2d.     |        |                |                 |              |                   |                    |                      |                      |         |        |                     |                 |       |              |                   |                    |
| 3d.     |        |                |                 |              |                   |                    |                      |                      |         |        |                     |                 |       |              |                   |                    |
| Total.  |        |                |                 |              |                   |                    |                      |                      |         |        |                     |                 |       |              |                   |                    |

Ventilation.....

Plumbing.....

Drainage.....

Privies, W. Closets and Urinals.....

Means of Egress and Safety.....

Violations of Ordinances.....

Action.....

Remarks.....

Inspector.....

stated during the last five years, and in that time, ordinance after ordinance, and statutory enactments have been formulated and become laws, that absolutely prohibit the people from dwelling in unsanitary surroundings, and what was a chaotic jumble of unsatisfactory and inoperative regulations, has under the present regime, become crystallized into a definite form, and the health office is run systematically to enforce the wise sanitary rules it has been instrumental in instituting.

The work of reforming the tenement houses and factories, however, great as it has been, is but the advance column of the work. Ignorance or greed has caused the construction of large numbers of buildings great and small, that have been built in direct violation to sanitary laws. Good plumbing costs much more than poor, and when a builder of the Buddensiek type constructs dwellings, inferior work is put in and covered up, until the building is disposed of, and not until the foul odors creeping through puttied joints and dislocated pipe connections, reveal the condition, is there any chance of the wrong being righted. The health department has created a healthy sentiment of fear of sewer gas, and faulty drainage in the public mind, among the more intelligent class of people, and the average citizen looks more closely into these matters than formerly. Dread of avoidable disease, dislike of pain, and the doctor's bills, to say nothing of the darker possibilities urge a careful study, so far as the householder's knowledge extends, of the condition of his house, and if sickness happens of frequent occurrence, he will call upon the health office to investigate his premises, for a possible solution of its cause. In a desultory way this inspection has been done, until quite recently. But in view of the likelihood of the advent of cholera, the department has been enabled to carry out the plans of the commissioner, for the investigation of all the dwelling houses in the city of Chicago. There are about 97,000 buildings in the city, and there are registered as inspected, with a full description of the structure, its character and surroundings, in short a perfect pen portrait of its sanitary condition, already somewhere in the neighborhood of 16,000, and by the last of August, there will have been 50,000 domiciles canvassed, so that if a complaint is entered, a reference to the book will at once give the condition of the premises at such a date. This will, in the near future, be a very valuable thing to the tenant class, for when about to select a house which one desires to rent, he can by a call at the

(B)

DEPARTMENT OF HEALTH.

## INSPECTOR'S REPORT

TO THE

# COMMISSIONER OF HEALTH,

## CITY OF CHICAGO.

1. Date.....188 . Location.....Ward.....
2. Owner or Agent.....Address .....
3. Description of Building (stories, size, material).....
4. Number of families in building.....Rooms.....Persons.....  
Male.....Female.....Boys.....Girls.....
5. Is there a store.....workshop.....factory.....on these premises? Where?.....
6. Kind of business.....Employer.....
7. No of Employés.....Males....Females....Boys.....Girls....
8. Are there any dark.....damp.....filthy.....or unventilated rooms?.....
9. Are the water-closet rooms clean?...and properly ventilated?....
10. Description of out-houses.....barns.....How used?.....
11. Is surface of lot below street level?.....How much?.....
12. Are the plumbing works in good repair?...and well trapped?....
13. Are the buildings.....and yard.....properly connected with sewer?.....
14. Is the cellar well ventilated?.....Clean?.....And dry?.....
15. What part of premises need limewashing?.....
16. Sanitary condition of space under building.....Yard.....  
Alley.....Street gutter.....Corner catch-basins...Vicinity....
17. Number and location of catch-basins.....Water closets.....  
Privies.....
18. Sanitary condition of such C. B.....W. C.....P.....
19. Nuisances—State of what they consist.....
20. Is the water supply adequate?.....On each story?.....
21. Violation of ordinance.....Action.....
22. Remarks:.....  
.....  
.....Inspector.

health office, learn officially its whole history as it appears to the eye of a practical sanitarian. It seems to me that when the inspectors have finished the whole circuit, and catalogued every house in the manner in which they are now doing, that no volume of records could have such a practical interest to the citizens of Chicago, and if it were generally known that this information was open to all, the month of April would find the health department rooms thronged with enquiries for safe houses to rent. For the immediate emergency the commissioner selected the sections of the city where the population was most crowded, and the defects more likely to prove disastrous to the larger number of people, and as in these localities, the residents were not as apt to notice or endeavor to improve their surroundings, it was deemed advisable to make the beginning here. So with a route designated, the corps of inspectors are day after day making a careful study of every house in a given district, taking the houses in consecutive order, making their report on the form herein given, and when there are defects in plumbing, in ventilation, in cleanliness, in removal of excretion or garbage, and the numerous violation of common law and common sense, that are so frequent in houses, notice is at once given for abatement and reform, and it is the duty of the inspector to see that this is done, so he visits and revisits until it is accomplished. The little paragraph which probably is passed over or read without thought, as to what it means in the Sunday papers, if you analyze it, is a record of good work, worthy of the reward due to those who benefit their fellow men.

Here is a paragraph from the *Times* of June 21: "The tenement inspectors made last week examinations of 1,016 houses, and 141 special examinations; abated 525 nuisances, and served 565 notices to abate. There were eleven suits brought for violation of the health ordinance." This week there were 525 plague spots and centering places for disease germs to occupy, removed, and the premises made safe for human occupancy. Again, June 28, under the heading of "Minor Mention," the tenement house inspectors report that during the past week they "examined 1,050 houses, abated 520 nuisances, caused 286 privy vaults to be cleaned, white-washed 187 rooms and ordered sundry repairs to defective drains." The magnitude of the work to the careless reader is entirely unknown. and it is doubtful if there were many readers of the papers who had the faintest idea of how much they were directly interested in the

(c)

## DEPARTMENT OF HEALTH.

*Inspector's Report to Commissioner of Health for the week ending*.....188

## HOUSE REPORT.

| WARD. | Special<br>*Examination | Houses<br>Examined. | Rooms. | Families. | Persons. | Males. | Females. | Boys<br>Under 15. | Girls<br>Under 15. | Notices. | Abate-<br>ments |
|-------|-------------------------|---------------------|--------|-----------|----------|--------|----------|-------------------|--------------------|----------|-----------------|
|       |                         |                     |        |           |          |        |          |                   |                    |          |                 |
|       |                         |                     |        |           |          |        |          |                   |                    |          |                 |
|       |                         |                     |        |           |          |        |          |                   |                    |          |                 |
|       |                         |                     |        |           |          |        |          |                   |                    |          |                 |
|       |                         |                     |        |           |          |        |          |                   |                    |          |                 |
|       |                         |                     |        |           |          |        |          |                   |                    |          |                 |
|       |                         |                     |        |           |          |        |          |                   |                    |          |                 |
|       |                         |                     |        |           |          |        |          |                   |                    |          |                 |
|       |                         |                     |        |           |          |        |          |                   |                    |          |                 |

Abate-ments include:—Defective plumbing repaired.....; traps applied.....; ventilation applied to waste and soil pipes.....; ditto living rooms.....; ditto workshops.....; ditto water closets.....; defective sewers and drains repaired.....; new sewers constructed and connections made.....; catch basins built.....; ditto cleaned.....; ditto repaired.....; privy vaults cleaned.....; ditto constructed.....; water closets constructed.....; rooms hlewashed.....; leaky roofs repaired.....; machinery (pss) protected.....; filthy bedding destroyed (entire beds).....; ditto renovated.....; uninhabitable basements cleared of occupants.....; miscellaneous.....; new buildings examined (in course of construction).....

## FACTORY REPORT.

| WARD. | Special<br>*Examination | Factories. | Stores. | Miscellaneous. | Total. | Total<br>Employed. | Males. | Females. | Boys<br>Under 15. | Girls<br>Under 15. | Notices. | Abate-<br>ments |
|-------|-------------------------|------------|---------|----------------|--------|--------------------|--------|----------|-------------------|--------------------|----------|-----------------|
|       |                         |            |         |                |        |                    |        |          |                   |                    |          |                 |
|       |                         |            |         |                |        |                    |        |          |                   |                    |          |                 |
|       |                         |            |         |                |        |                    |        |          |                   |                    |          |                 |
|       |                         |            |         |                |        |                    |        |          |                   |                    |          |                 |
|       |                         |            |         |                |        |                    |        |          |                   |                    |          |                 |
|       |                         |            |         |                |        |                    |        |          |                   |                    |          |                 |
|       |                         |            |         |                |        |                    |        |          |                   |                    |          |                 |
|       |                         |            |         |                |        |                    |        |          |                   |                    |          |                 |
|       |                         |            |         |                |        |                    |        |          |                   |                    |          |                 |

\*On complaint of owner or occupant.

†Pursuant to State law.

Inspector.



results achieved in these weeks' works. The common council having now increased the appropriation for the use of the health department, the commissioner has been able in the last week to increase his working force to eighty men, and the results will be correspondingly greater than the reports given above. So day after day this work is going on which promises to make Chicago plague-proof. Filth and damp do not generate zymotic disease, but where these are found if the germs of cholera, typhoid, diphtheria, or similar epidemic disorders come in contact with them, it is the touch of fire to gunpowder, and disaster follows. The grains of wheat that fell upon stony ground failed to germinate, while those that were sown upon fertile soil produced a hundred fold, and the germs of these diseases reaching the renovated dwellings of our city find but stony ground and fail to spread. If infective diseases make a lodgment in a locality, with the work which the health department is now doing, well done, it is a much less difficult task to stamp it out, and prevent its spread just as the removal of tinder-box houses and magazines of combustible substances, and the substitution of stone and brick structures simplifies the labor of the fire department. An epidemic starts in a similar manner to a great conflagration. There would be no great fires if there were no collections of inflammable materials. There would be no great epidemics of the disorders classed under the head of filth diseases, if there were no such places as the health department is now engaged in removing. Daily each inspector hands in a detailed report of the work done. One man can examine from five or six, to ten or twelve ordinary dwellings in a day if he works steadily, and these reports are condensed in a book kept for that purpose, and the report placed on file where it can be readily reached if a reference to the detailed report is desired. This is the labor the health officer is doing to repair violation of health laws in house construction in those buildings already erected. But the city is growing mightily, and the health authorities have succeeded in securing a safeguard against any future infractions of the laws of sanitation in the new buildings that are added to the city's number. Before any structure can be erected, the architect or builder is obliged to present his plans and specifications to the health commissioner for examination, and "approval or rejection as to proposed plans for the ventilation of rooms, light and air shafts, windows, ventilation of

## D) DEPARTMENT OF HEALTH.

## Inspector's Report of Ventilation, Light, Drainage and Plumbing in New Buildings.

Date.....188 . Plan No.....  
 Location.....No. of Buildings.....  
 No. of Stories.....Exclusive of Cellar, Basement, Attic.  
 Size of each Building.....Size of Lot.....  
 How is the Basement occupied?.....  
 Is the First Floor occupied as a Store?.....  
 Or for Families?.....Or both?.....

|                                 | BASEMENT. | 1st. | 2d. | 3d. |
|---------------------------------|-----------|------|-----|-----|
| Height of Ceilings,             |           |      |     |     |
| Inside Rooms, No. on each floor |           |      |     |     |
| “ “ How Lighted,                |           |      |     |     |
| “ “ How Ventilated,             |           |      |     |     |

Total No. of Rooms (each Building).....Total No. of Families.....  
 Halls, how lighted and ventilated?.....  
 Will each living room communicate with external air?.....  
 Will each bedroom have a window opening to external air?.....  
 Will all the soil and waste pipes extend above the roof?.....  
 Will all the catch basins be placed outside the Building?.....  
 Size of windows opening on light and air shafts?.....  
 Size of fanlights over all doors?.....  
 Skylights, No. of.....Size.....  
 Where located?.....  
 What additional structure, if any, will be on the lot?.....  
 How occupied?.....Dimensions.....  
 No. and location of W. C.....  
 Dimensions of shaft for W. C.....  
 No. and location of privies.....  
 Name of Architect.....  
 Name of Owner.....  
 Remarks.....

.....Inspector.

water-closets, drainage and plumbing," and until approval, no work can be done; and before any of the plumbing work is covered up in the building, or on the premises, it must be seen and approved by the inspector of the health department. There are heavy penalties for violation of these ordinances. The laws are explicit as to what may and what may not be done, and demands for each occupant of building his fair share of air and light, and provides for speedy and safe removal of excretions and waste. It would transcend the limits of this paper to even epitomize these laws further than I have done; but no building may be reared in the city limits without the health department first satisfying themselves that the plan is in full accordance with the law, and the copy of the plan placed on file for reference in the future. There are thousands of plans now deposited in the great safes of the health department open to public inspection.

In the future when the architects and the owners' plans have been lost, and new men are in possession, it may be very desirable to find the location and plan of the plumbing and drains, and this department will possess the record. I give here the form used for the inspector's first inquiry and last inspection of new buildings (D and E). A perusal of these forms will show how thoroughly the sanitary interests are cared for of the tenants of those later structures in our city. Chicago possesses two inestimable blessings; factors that give an advantage over many places. Situated upon a broad prairie, her streets and alleys are swept out daily by the healthful breezes; pure air we receive in plentiful supply, and the exhalations from animal life and the emanations from city refuse are diluted and removed constantly. There are no physical obstructions to this free inrush of air; this dilution of urban effluvia and rapid removal of noxious vapors, and one dangerous element of ordinary city life, we thus avoid. The other factor is pure water in abundance. With so grand a reservoir as Lake Michigan from which to draw our supplies, and the ample distribution of the same, there remains no necessity for the excavation of wells, and there exists, I am told, but one well in Chicago from which any water supply is taken. With the exception of a limited period in the early spring, when a combination of circumstances have flooded the country, flushed our river, reversed its current, and driven the flow far into the lake, the water furnished to the citizens of Chicago is unexcelled by the water supply of any other city; and even in this period we are favored by having

(E)

## HEALTH DEPARTMENT.

**Inspectors' Report on Light, Ventilation, Plumbing and Drainage of New Buildings, to Commissioner of Health, Chicago.**

Date.....188 , No. of Houses..... Ward.....  
 Location.....Description.....  
 Owner or Agent.....Address.....  
 Architect or Builder.....Address.....  
 No. of Rooms.....No. of Families.....  
 How many inside rooms?.....Where located?.....  
 How are they lighted?.....  
 How are they ventilated?.....  
 Are the halls properly lighted?.....and ventilated?.....  
 Will each living room communicate with the external air?.....  
 Will each bedroom have a window opening to external air?.....  
 Are all the light and ventilating shafts of proper dimensions?.....  
 How are the shafts arranged at top to secure ventilation?.....  
 Are all of the windows opening on them properly located and of sufficient size?.....  
 Are the water closet rooms sufficiently lighted?.....and vent'd?.....  
 Are the water closet and habitable rooms separately ventilated?.....  
 No.....and location of water closets.....  
 Are they provided with cisterns for flushing?.....  
 No.....and location of privies.....  
 Are they properly connected with house drain?.....  
 House Drain: Is it properly constructed?.....material.....  
 Is it trapped at curb?.....Has it a fresh air inlet?.....  
 Is each soil and waste pipe properly connected with drain?.....  
 Is each of proper size?.....and material?.....  
 Are they properly trapped?.....and ventilated above roof?.....  
 Are all joints made?.....  
 Trap vent Pipes: Are they adequate and properly constructed?.....  
 Do the leaders connect with house drain?.....or privy?.....  
 Are they trapped?.....Are the grease catch basins outside bldg?.....  
 Is the cellar properly drained?.....and ventilated?.....  
 Of what material is the cellar floor?.....  
 Are the yards and areas properly drained?.....  
 Is proper cold air duct provided for heating apparatus?.....  
 General: Quality of material.....and workmanship.....  
 Violations.....  
 Action.....Remarks.....  
 .....Inspector.

it occur during the time when it can affect us the least. Still there exists a danger of the contamination of the water inlet, and it is to be hoped that the near future will give us an intercepting conduit that shall receive the sewerage, conveying it far out of the city limits for utilization as a fertilizer, thus freeing the river from the pollution which should no longer be allowed to reach it. Then, with the work of house to house inspection continued, and the rigid enforcement of our sanitary regulations throughout the city—with the aid of the moral force of public opinion favoring those efforts for the public benefit—we may eventually hope to reach the ideal death ratio only, and preserve our homes from the invasion of zymotic diseases.

**POISONING BY CARBONIC ACID GAS.**—BY JOSEPH P. COBB, M. D.—May 31, 1885. At 5 A. M. Mr. D. called for my assistance, stating that his whole family were sick.

His family consisted of his wife, boy *æt.* twelve, girl *æt.* six, baby *æt.* two years, and a servant. They all went to bed the night before feeling as well as usual. About midnight the little girl and baby grew sick and vomited; though drowsy, they continued retching at short intervals, the girl complaining of pain all through the top of her head. About two hours later, the boy was awakened from sleep, to find that he had vomited profusely. He complained of headache, but was too sleepy to say much about it.

At 4 A. M., Mrs. D. felt tired, sleepy and dizzy; she thought nothing of it at first, supposing it due to her long vigil; she soon became faint however, then vomiting, retching, and a very distressing headache ensued.

Soon after returning from out of doors, Mr. D. complained of a dizzy feeling, and an inclination to vomit; this soon passed off, and was followed by a very copious, loose, *fæcal* evacuation.

The servant was not affected until she had been called into the sleeping-rooms a number of times, and then only slightly.

On first entering the rooms I noticed that they were very close, that the air seemed heavy, that there was a faint, though peculiar odor present. I did not at first, however, connect the general distress with this circumstance, thinking that it was simply due to the exhalations of so many individuals retained all night in closed rooms. Yet I opened widely a window in each of these connecting rooms as I entered them, to examine the different patients.

They volunteered the opinion, that the trouble was due to something that they had eaten, and were inclined to put the burden upon some home-made ice-cream, of which all had indulged at least twice the previous day. I thought this quite possible, and was to a certain extent, influenced by it.

In each case the substance first ejected from the stomach seemed to be partially digested food; this was followed by frequent spells of retching and gagging, with the result of throwing off a little glairy mucus. I ordered hot water to drink, and gave *Nux Vomica* at frequent intervals.

Not being satisfied with the alleged cause, I questioned Mr. D. more closely. He remembered that a neighbor who had dined with them on the previous day had also eaten of the cream. A messenger sent to inquire after her, reported that she was feeling perfectly well, and had passed a comfortable night. The servant also acknowledged to having absorbed a fair share of the cream.

Further inquiry elicited the following: On the day before, Mr. D. had built a fire in the furnace; at noon he had thrown on the now smouldering fire a quantity of rubbish, barrel staves, butter tubs, etc.; at night he had closed the furnace drafts without looking inside.

On examining the furnace we found that the last fuel had not been consumed, but was smouldering away, unburnt on top, a mass of embers below. It now seemed evident that the imperfect combustion had generated carbonic oxide gas (C. O.) which had permeated the house and vitiated the air. To strengthen the conclusion was the fact that the servant occupied a room shut off from the remainder of the house, and furnished with no connection with the furnace. Mr. D. and the two younger children were ready for breakfast, and suffered no further inconvenience; the boy had no appetite during the day, and complained of a bad feeling in the head. It was fully three days before Mrs. D. regained her normal condition. We noticed that the younger members of the family suffered first; that the older were slower in coming under the influence, but with the exception of Mr. D., were more severely affected, while Mrs. D., worn out by her long watch with the children, was by far the sickest.

Mr. D.'s immunity I attribute to the fact that he took a walk out of doors before he was overcome, and soon after his return the air in the room was changed.

The furnace in this house is furnished with a cold air box lead-

ing directly out of doors. The fire chamber has no apparent communication with the hot air supply for the house; the masonry and general setting of the furnace and pipes seemed to be unusually good work.

The question arises, is it possible to keep from the house all gases generated in the fire pot?

DISCUSSION.—Dr. J. E. GILMAN.—In answer to Dr. Cobbs' question the fire part of a furnace is a cylinder with a pipe leading to the chimney for the conveyance of the gases generated by combustion. For the sake of conserving the heat and regulating the draft, this is supplied with a damper which, if closed too tightly, will shut off the proper outlet and the gases will find their way into the air chamber and so be distributed over the house. The construction of a furnace is simply a stove with a jacket of sheet iron about it. The air reaches the heated surface and is warmed and passes through the register pipes to the different rooms. If the draft pipe to the chimney is unobstructed so the gas can escape, there would be no danger of gas reaching the air chamber in a furnace of good construction, but when the draft in the direction of the proper outlet is obstructed, there is great danger from carbonic oxide. I recall the case of a wholesale poisoning from this cause. A gentleman was awakened at night by a feeling of oppression and nausea, and divining at once the reason, endeavored to rise and secure fresh air, when to his horror, he found himself unable to move. It is a curious effect of carbonic oxide that it leaves the consciousness unimpaired, but paralyzes motion. He told me that he summoned all his will power to gain the window, and he never struggled so hard in his life to do anything, as he did this. He had not the strength to raise the sash, but succeeded in breaking the window and so saved the lives of the other members of the family (five in number) who were affected in a very similar manner to himself. The same general symptoms as given in Dr. Cobbs' paper, were present in this case. The cause in this instance was the turning of the damper in the chimney pipe so far as to prevent the gas from the night's coal escaping through its proper channel.

✓ ZIZYGIUM JAMBOLÆNUM IN DIABETES. BY W. H. BURT, M. D., CHICAGO.—I wish to bring to the notice of this Society a remedy recently obtained from the East Indies which promises to be

of the utmost value in the treatment of diabetes. Having noticed a reference to this drug in the *Medical Record*, I advised a patient of mine in the city to get some of it and try it. This gentleman was a pronounced diabetic subject, and had tried everything he possibly could for relief, and had passed through many prominent physicians' hands, both in this country and in Europe, without benefit. He possessed the most precise and best authenticated history of his condition, covering the longest consecutive period of time of any case of diabetes that has ever come under my care. His urine has been examined qualitatively and quantitatively every week for two and a-half years past. The specific gravity has ranged from 1037 to 1052, and sugar has been present constantly and in considerable proportion, averaging fifteen per cent. The endeavor was made to procure some of the *Zizygium* when I recommended its trial, but no pharmacist in this country had any. Consequently we had to wait until it could be sent on from the Indies. Eventually ten small sacks of the berries arrived, and here is a sample for your inspection: They are shorter and thicker than a date-seed, are of a grayish black color, quite hard, and possess a slightly aromatic flavor. A decoction was prepared from these berries, and my patient took tablespoonful doses three times a day. Marvelous as it may seem, in three days' time the quantity of urine passed in twenty-four hours was lessened one-half, and for the first time in two-and-a-half years not a trace of sugar was discoverable. Up to the time this gentleman left for a trip to Europe, a week ago, there was no recurrence of the excessive quantity nor of the glucose in his urine.

It appears to be a perfect and most remarkable cure, and I would urge the members of the society to test the remedy on cases of diabetes and furnish a report of the results as soon as possible. The only reference to this drug in Homœopathic literature that I have noticed is a report by Dr. Dudgeon, of London, of a case of diabetes cured by the *Zizygium*, I.

DISCUSSION.—DR. J. E. GILMAN.—In reference to the *Zizygium Jambolanum* I would state that I learned of the instance spoken of by Dr. Burt and began to look the matter up. I secured a bottle of the decoction from Mr. Sargent, and gave to a case of diabetes under my charge. This is a boy who has been suffering from a pronounced form of diabetes; the quantity of urine passed



averaging two gallons daily, of a specific gravity of 1026 to 1034, and a 5 to 6.5 per cent of sugar. At the time he began using it, for two weeks it had not fallen below 5.5 per cent sugar. Under the use of the decoction it fell to 4.5 per cent, but did not lessen materially the quantity of the water. I am not wholly satisfied with the experiment for some reasons, and propose to continue it, for the wonderful effect detailed to me by Mr. C., warrants a better acquaintance with the drug.

I would say I have been making a proving of the drug on a perfectly healthy prover, and am happy to state that the pulverized seeds promptly produced a marked increase in the urine, and he reported to me within three days sugar in the discharge, and said he was afraid he was getting diabetes. The prover was entirely ignorant of what he was taking, and only knew that I wished him to especially notice the urinary symptoms, making frequent analyses of the same.

It will be of interest to read the letter sent me by Mr. C., which is as follows: "I am very glad to give you my experience with this remarkable drug, *Zizygium jambolanum*, of the order of myrtaceæ. I saw it mentioned first in the number of August 5, 1884, of the *London Lancet*, and at once set about to find the plant. I got the seeds from Thomas Charity & Co., of London, only two weeks ago, and have been taking the infusion, two ounces of seeds to one pint of water, prepared by Mr. Lemars, of Sargents. It is now eight days that I have taken the medicine, and the result is very remarkable. From eight pints up to that time I now pass but three and a half. From four calls during the night I now do not get up, and only pass, say, one-half pint in the morning. From 12 per cent sugar Dr. C. E. Clacius now finds none. Sugar has never been absent during the last three years, although during that time for four months I lived entirely upon skim milk, and another time upon skim milk and gluten bread. Sometimes the sugar has gone down from 5 to 7 per cent but, much of the time 12 per cent. Now the change came within twenty hours. A clearing of the head, an entire change of everything. The astringent seeds seem to be the active part."

I had understood that he at one time took more than was desirable, and inquired what symptoms led him to think he was taking too much. Mr. C. goes on to answer this question as follows: "I judged that my dose was large from the increased activity of the heart. I took

about twenty grains three times each day, and probably five to eight is quite enough to produce same results. It will reduce the quantity of the water at once. I write in great haste. If you only have a subject you can at once confirm all that I have said, and do something in the cause of humanity. I wish all who suffer from this trouble knew of this simple yet complete remedy. It may not be a complete remedy. It is certainly a great relief for the time being, even if it should not be permanent in its results,—Yours truly, etc."

I will report at the next meeting the proving and the further action of the remedy in the case in which I am using it.

DR. BURT.—In about three weeks from now Mr. Sargent expects to receive a fresh consignment of the berries, when he will be able to supply the decoction to those who want it, and I would advise Dr. Gilman to give the remedy a renewed trial then, because I believe that I am correct in stating that the decoction he has used so far has been prepared from the bark, and not from the berries. The same thing occurred in my patient's case, and, as with Dr. Gilman, without any marked benefit until the berries were resorted to.

---

ITEMS.—Prof. Ludlam's course on the Puerperal Diseases will be given to the students of the Hahnemann Medical College and Hospital, of this city, during the coming winter free of extra charge. —Under Prof. Hall's supervision, the Surgical Department of the Hahnemann Hospital is being thoroughly renovated and refitted. —Our present issue has failed, unfortunately, to furnish a clinical lecture by Prof. Fellows. —By reason of the new law in Illinois, dissecting material will be not only abundant but *free*, at the "old Hahnemann," henceforth. —The McIntosh Galvanic & Faradic Battery Company, whose card has held the same place in the *Clinique* for the past five years, and which merits frequent reading, has captured the gold medal over foreign and home competition at the World's Exhibition in New Orleans. —Prof. Gilman's report on the sanitary condition of this city is certain to attract the professional attention.

---

## Hospital Notes.

### PHYSICAL DIAGNOSIS CLINIC.

SERVICE OF PROF. CRAWFORD.

**ENLARGED THYMUS.**—*Case 19096.*—Boy, aged two and a half years, is brought to this clinic by Dr. A—— for examination.

Last summer the child had a very severe attack of cholera infantum. There was no sign of his present trouble prior to this illness. At times he complains of great difficulty of breathing. He perspires very readily, especially at night, and coughs a little, but there is no fever nor expectoration. He is the possessor of a fair complexion, flaxen hair, large head and soft flesh.

The chest presents a very pronounced malformation commonly called *chicken-breast*. The sternum, particularly the upper part, bulges prominently forward, and there is, consequently, flattening of the lateral chest walls. Besides this there is a sinking in of the ribs transversely from the ensiform cartilage, like gutters running into the axillary regions. Corresponding with the prominence of the chest there is a compensating anterior spinal curvature, sufficient to almost obliterate the lowest cervical and upper dorsal spinous processes.

There is normal puerile respiration over both lungs, but over the trachea at its division into the bronchi the breathing is somewhat intensified, and the expiration noticeably obstructed. A slight hæmic murmur is heard over the pulmonic orifice.

The development of chicken-breast is usually ascribed to a partial emphysema of the lung tissue immediately beneath the costal projection. But this instance lacks the signs of emphysema, while it gives very fair evidence of enlargement of the thymus gland. The signs elicited can all be readily laid to pressure at the root of the lung. The boy is just at the age when the thymus attains its maximum development, and being of a strumous diathesis, and having suffered a severe check in nutrition, it is neither wonderful that a gland should abnormally enlarge, nor that bone softening should ensue.

The lad's general condition has seemed to improve under Dr. A——'s prescription of *Calc. carb.*, and it was advised that the same remedy be continued in the twelfth trituration.

**ANÆMIA.**—*Case 19101.*—This girl, seventeen years of age, is referred to this clinic by Prof. Ludlam for an examination of the chest. You see she is poor in flesh, anæmic, stoops a great deal,

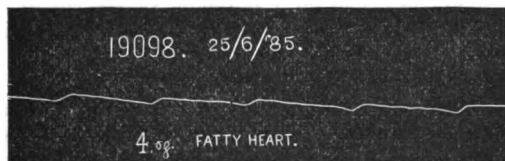
and she tells us that she caught cold six weeks ago, and since then has expectorated considerable bloody serum. She complains of the cough hurting her in the left clavicular region.

The fear is that she may already be in an advanced stage of phthisis; but, on exposing the chest, there is seen to be free and full thoracic expansion, no increased femitus, no dullness under the percussion hammer, nor are there any pulmonary rales. The heart's action is rapid and irritable, and a hæmic murmur is heard over the root of the pulmonary artery. The patient is told to return to the Women's clinic for treatment, and a card given her designating the diagnosis anæmia.

**POST-DIPHTHERITIC BRONCHITIS.**—*Case 19,100*—Her mother tells us that this little girl, aged seven years, has had a very bad cough for six months past, and brings up a good deal of phlegm. The child is very nervous, and her hearing is becoming very much impaired. Her troubles date from an attack of diptheria which she had last winter. The bases of both lungs emit sub-mucous rales, and occasionally dry rhonchi. The heart is normal.

After being on *Argentum nitricum*, 30, one week, the child appeared again at the clinic a rather repulsive sight. All about the mouth and chin an eruption had broken out, which had scabbed in an almost unbroken plaque, and under and between her toes the same condition existed. Her cough had improved, meantime, she had expectorated much less, her eyes had brightened up, and she was apparently mending, so the same remedy was continued.

**FATTY DEGENERATION OF THE HEART.**—*Case 19,098.*—A large, fleshy German, forty-one years of age, accompanied by his physician, Dr. J., is anxious to know what the matter is. The doctor tells us that three months ago his patient took cold from getting his feet wet, following which he had a run of malarial fever. After



getting better of that his liver enlarged, and bloating of the whole body set in, or rather the anasarca extended from his face to his knees. There was also considerable ascitic accumulation, which, as well as the general oedema, has varied in degree at different times. For a while the pulse was very slow and weak.

The symptomatic remedy has been hunted for arduously by the

doctor; on one occasion he found some seventy symptoms of *Sulphur*, but neither the finding of the symptoms nor the giving of the remedy to correspond has cured the patient.

Examination of the urine gave negative results; no albumen, no sugar. Looking over the cardiac region the apex impulse is not discernable either by inspection or palpation. There is no increased area of dullness over the heart, and on applying the stethoscope no murmurs are heard. So far the examination of the heart is also negative. But upon closer scrutiny of the character of the cardiac sounds they are found to be materially at fault. The first sound lacks entirely the boom, the throb of normal ventricular systole. And the clear click of the second sound catches the ear much more readily than the first. The sphygmographic tracing of the radial pulse shows a miserably weak circulation, possessing neither cardiac nor arterial tension.

There is no doubt but that fatty degeneration of the heart exists, and to a very grave extent. Such a patient might drop dead at any moment; consequently to preserve life for any time, the total absence of excitement or exposure, or anything which would tax the heart, must be secured beyond a peradventure. As a remedy *Phosphorus* 30, was recommended to be given continuously, and should signs of cardiac failure appear at any time, to give *Digitalis* in tr. or 1 x. in conjunction with the inhalation of ammonia and the imbibition of spirits until the attack should pass off. He was also advised to follow Dr. Ebstein's method of dieting for corpulent persons.

**ACUTE PNEUMONIC PHTHISIS—Case 19075.**—This little mulatto girl came to our clinic the middle of March last. She is thirteen years of age, her eyes are lustrous, and she is much emaciated. She told us that three months prior to her coming to this Hospital she took a severe cold, had a great deal of pain in her chest, shortness of breath and a cough. She had fever and night sweats, and expectorated a good deal, but the exact character of the latter was difficult to learn from her. It seems most likely that she had at that time an attack of broncho-pneumonia.

She still has a bad cough, and expectorates much of a blackish character, but says there are no night sweats now. Dark sputum is not an uncommon symptom in the city, where there is so much coal smoke in the atmosphere.

Physical examination brings to light the following points: A narrow and depressed chest; the shoulders project forward; the respirations are shallow and frequent; the upper portions of the chest give resonant percussion notes, but the lower two-thirds are dull, increasing toward the bases to almost complete flatness. The right lung is the most implicated. It gives forth roughened bronchial

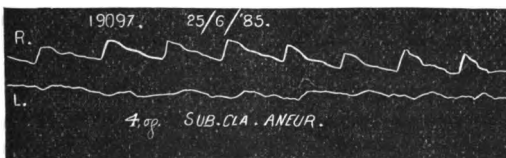
breathing, mucous rales, and bronchophony at the base. The left is less moist, and more sonorous and sibilant in character.

The heart beats violently and rapidly, numbering 128 strokes to the minute, and the temperature is  $101\frac{1}{2}^{\circ}$ .

This is a case, then, which began as an acute pulmonic inflammation, and which stopped short of resolution. The exudation thus remaining unabsorbed in the lung tissue is dealt with by nature in one of two ways, either purulent transformation takes place rapidly, or the more slow process of caseous degeneration ensues. The latter has been the course in this instance, consequently we have a case of galloping consumption, or acute phthisis, growing directly out of a pneumonic inflammation. The three months of homœopathic treatment to which the patient has been subjected has certainly done something toward alleviating her condition, and, no doubt, of prolonging her life. Although the pulse still runs high, and the temperature, each time it has been taken, has been from  $100^{\circ}$  to  $101^{\circ}$ , and slight hemorrhages have appeared, and persisted for some time, the consolidation has lessened very markedly, the cough has not been nearly so bad of late, and the sputa are neither so abundant nor so frequently bloody as they were. But notwithstanding these favorable signs, as the girl belongs to a consumptive family, the outlook is not encouraging.

The first remedy prescribed was *Sulphur*, 30, following which she had *Calc. hypophos.*, 3, and recently she has been put on *Bryonia* 3 and *Tartar emet.* 3 in alternation.

**ANEURISM OF THE LEFT SUBCLAVIAN ARTERY.**—*Case 19097*  
—Mrs. —, æt. thirty, complains of a dry cough, which she says she has every spring. It has been troubling her now for six weeks. When tired, the cough is worse. She has been losing flesh recently. She states there is a great deal of lung trouble in the family, but she has never spat up blood.



No sounds nor signs of disease of the heart or lungs are to be found. But in the left supra-clavicular region the heart's rhythm is heard distinctly, and a blowing murmur and an impulse accompany the systole. No such sound is to be heard on the right side. The

left radial pulse is found to be retarded, and the sphygmographic tracing of the right and left wrist pulses taken on the same paper, exhibits at once the marked difference between the two. The left is seen to consist solely of an uneven, tremulous wave, the cardiac energy having been wasted in an aneurismal enlargement under the clavicle. Pellets saturated with *Digitalis* tincture were prescribed, four doses daily.

**CHRONIC BRONCHITIS.**—*Case 19095*—Mrs. —, has a cough and brings up a considerable quantity of yellow phlegm. She has been subject to coughs ever since she had an attack of lung fever when she was a little girl. The apices of the lungs are in good condition. There is no percussion dulness on either side of the chest. The bronchi of the bases give evidence of clogging, and the air cells do not fill readily, excepting on forced inspiration. She was put on *Tartar emet.* 3x.

When this patient returned to the clinic she reported that her cough and sputa had improved until she caught another slight cold. Some dry rales are now heard in addition to the signs discovered before. *Bryonia* is now substituted, which she is instructed to take until the effects of the fresh cold have passed off, then she is to return to the former remedy.

**ASTHMA**—*Case 19092*.—Mrs. —, aged forty-two, suffers from an attack of asthma every night. She is wheezy, and is distressed for breath when exercising. There is no trouble in finding the physical signs in this patient's case. Sibilant, sonorous and mucous rales are abundant, and bi-lateral. She says she has great trouble with her stomach during the period of the attacks. She belches up wind constantly, and expectorates abundance of frothy mucus. *Lobelia* tr. was given the first week, but on reporting that she was slightly worse at the next Clinic, *Arsenicum* 6x was prescribed. From that date on she improved rapidly, and was soon well.

**ASTHMA ET EMPHYSEMA**—*Case 19090*.—Mrs. — says she has been ill for three years. She has frequently recurring attacks of spasmodic asthma, during which she coughs up considerable green sputum and frothy material. There is never any blood in it. She is always worse when she lies down. There is a good deal of belching of wind, which relieves her very much.

The chest presents a full and distended appearance, and the expiratory act is much lengthened. A forced inspiration shows there is but little expansion of the chest, and it develops the sinking in of the supra-clavicular and lower thoracic regions peculiar to emphysematous subjects. By auscultation, wheezing respiration, moist rales and prolonged expiration are all found.

The patient is very subject to catching cold, which exhibits itself always as a bronchitis in her case, and this in its turn aggravates and strengthens the deeper-seated affections. *Ipecac* 2 is to be taken continuously, and *Lobelia* to be held in reserve for the asthmatic attacks.

**CHRONIC PHTHISIS—Case 19088.** A laboring man, forty-five years of age, embodies a host of complaints in his history. His appetite is all gone, he has had night sweats for six weeks, and has a very harassing, loose cough; he has spat up a good deal of blood, he has lost much flesh, and his strength has so waned that he can no longer work. A year ago he suffered from rheumatism, and quite recently he has had attacks of angina pectoris. His present sickness he refers back to last winter. As well as we can make out his general health had already become impaired then, for he had been troubled with a cough coming and going for some time previous.

When stripped of his heavy woolen shirts, he presents a much emaciated appearance. The ribs are prominent, and the clavicles are more so. Breathing is labored, and the left chest moves without seeming to expand a particle. The right does much better. The left side is quite flattened, and gives pronounced dullness on percussion. The right is resonant. Through the stethoscope at the left apex whistling inspiration and expiration is heard. In the subclavicular region the sounds are harsh, interrupted and prolonged respiration, and bubbling rales. These all decrease in intensity and prevalence as the search extends toward the base. The left side is therefore advanced to the third stage of phthisis, and the right lung is fast becoming involved. His temperature is slightly elevated, being within a fraction of 100° at noonday. As the patient is too poor to go in search of a favorable clime, no hope can be held out to him.

He is more certainly doomed than if he were incarcerated by law and under sentence of death.

He is given some directions in regard to diet and living, and has prescribed for him *Veratrum viride* for his night cough, and *Calc. hypophos.* 3 x for a regular remedy.



## Miscellaneous Items.

Prof. Hawkes is vacating, and Prof. Hoyne has returned home again.—Prof. Laning has recovered his health, and is at work.—Drs. Dudley, of Philadelphia, and McClellan, of Pittsburgh, have been appointed members of the Pennsylvania State Board of Health.—Dr. H. R. Arndt has accepted the appointment of Professor of Materia Medica and Therapeutics in the Homœopathic Department of the University of Michigan.—Dr. H. G. Thole, of the Class of '78, died recently at Dwight, Ill., after a long and painful illness.—The *Hahnemannian Monthly* for July announces the death of Prof. H. N. Guernsey, of Philadelphia, but gives no particulars.—The *Medical Investigator* of the same date issues a prospectus for a treatise on the Theory and Practice, by our excellent colleague, Prof. A. E. Small, which is now in press.—The *Revista Homœopatica Catalana*, of Barcelona, Spain, for May 30, publishes a translation from the *Clinique* of Prof. Shears' lecture on Lupus.—Prof. Bailey is as busy as the clerk of a sewing-society in his correspondence with the students for next winter's session in the "old Hahnemann," and in assigning their seats in the hospital amphitheater.—Dr. W. H. Holcombe will spend the next two months at Oconomowoc, Wis., where he can be reached professionally.—The Wisconsin State Homœopathic Society has honored itself by electing Dr. H. E. Boardman, of Monroe, President for the next year.—At the next meeting of the Clinical Society, Prof. Ludlam will present the report of the bureau of Gynecology.—The Twenty-sixth annual catalogue of the Hahnemann Medical College and Hospital, of Chicago, may be had by addressing Prof. Bailey, 3034 Michigan av., this city.—The Boston University has located the Garden of Eden at the North Pole. With the thermometer at a hundred, "Oh, what would it be to be there."—The changes of location place Drs. W. D. Thomas at West Union, Ill.; W. C. Duncan, at Oakfield, Wis.; A. R. Thomas, at Columbus, Kan.; J. D. Wetmore, at Farley, Iowa; and H. W. Brown, at Coldwater, Mich.





**J. B. S. KING, M. D.**

**ADJUNCT PROFESSOR OF CHEMISTRY IN THE HAHNEMANN MEDICAL  
COLLEGE AND HOSPITAL, CHICAGO.**

# THE CLINIQUE.

---

VOL. VI.]

CHICAGO, AUG. 15, 1885.

[No. 8

---

## Original Lectures.

### *THE DISEASES OF THE ANUS AND RECTUM.*

IN TWO LECTURES, BY G. A. HALL, M. D., PROFESSOR OF THE PRINCIPLES AND PRACTICE OF SURGERY IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL.

#### LECTURE I.

In opening this lecture we feel an inability, in the brief space allotted, to express all that is important and vital to this subject. Beyond question this topic, which we are now to consider, is freighted with greater interest, both to patient and physician, than any other subject within the domain of surgery or medicine. It is peculiarly important for more reasons than one. Morbid conditions in this locality prevail at all times of life, from birth to old age; neither nationality nor sex find exemption from these peculiar afflictions, and no latitude, climate, vocation or surrounding has yet proved a shield against this van of troubles; they may also be found in the feeble and attenuated as well as in the most robust.

Diseases of the anus and rectum appear singly and as complications with many other troubles. They are sometimes primary, but more frequently secondary. The causes may be recognized as exciting and predisposing. Often they are unsuccessfully treated, and in many instances they are not treated at all, because the difficulty is referred to some other locality. Frequently they are occult, and in other cases the patient, influenced by modesty, may be barred from giving a clear description of the trouble.

When we take a survey of these troubles, and consider the anatomy of the parts, we can readily see how difficulties in this locality may, by their symptomatology, simulate other diseases, and be referable to remote organs.

The rectum being the very lowest extremity of the alimentary canal, its construction, shape, and mechanical relations with other

viscera, furnish ample excuse for its frequent diseased involvement. Tracing down the descending colon to the sigmoid flexure, and through this to the brim of the pelvis, we come to the upper portion of the rectum. From here it descends through the hollow of the sacrum and presents two curves which are exceedingly important in the study of the morbid changes here. One is the antero-posterior, and the other the lateral curve. Passing down the concavity of the sacrum, the direction of the axis is forward and downward. A short distance beyond the apex of the coccyx, the axis suddenly turns upon itself and passes backward and outward through the sphincter and anus. From the middle of the sacrum downward the rectum resembles the lower half of the letter S. The angle formed by the junction of these curves is not without importance in the function of defecation. The lateral curve is single and curves from left to right, starting at the left sacro-iliac-synchondrosis and terminating at the median line at a point opposite the third sacral vertebra. At the lower curve it is separated from the vagina in the female and from the urethra in the male, leaving a triangular space which has the perinæum as its base. These curves and flexures of the rectum are seldom found in a normal condition in adult life.

As a matter of convenience, we will divide the rectum into three portions extending from below upward. The first division begins at the anus and extends upward about one inch and a half in length and is firmly encircled by the sphincters. As before mentioned, the axis of this portion extends forward and upward toward the vagina or prostate gland. Hence, in making a digital rectal examination, the finger should always be passed forward and upward toward the sub-pubic arch and not backward toward the hollow of the sacrum. This little precaution will save your patient much suffering.

The second portion of the rectum extends from the sphincter to a point opposite the third sacral vertebra, and measures in all about three inches. This portion is convex from before backward greatly resembling the curve of the sacrum.

The third portion extends from this point and follows the lateral curve up to the left sacro-iliac-synchondrosis.

The relation which these portions of the rectum sustain to adjacent tissues and viscera is of surgical importance. We find the lower portion surrounded laterally and posteriorly by loose areolar connective tissue together with adipose deposit. Traversing this are blood vessels of minor importance. In front its relation is directly with the membranous portion of the urethra or recto-vaginal space. Its internal relationship with the urethra, in the male, is of vital importance in catheterism, for, passing the finger into the rectum, the tip of the instrument may be easily felt as it passes through the membranous part of the urethra. It also explains why, in all operations upon the vagina, or urethra, the rectum should be first thoroughly emptied thus avoiding injury to the gut. In the second portion we find laterally and posteriorly no special surgical relations.

Anteriorly, however, in normal conditions, we find this portion in contact with the vagina in the female, and in displacements of the uterus it is the point of impingement when the uterus descends into the pelvic cavity. In the male it rests in contact with the prostate gland, the base of the bladder, and vesiculæ seminales. This accounts for the urinary complications and seminal weaknesses which complicate rectal irritations. It was through this portion that the trocar was passed in the old operation of puncturing the bladder through the rectum.

The first and second divisions of the rectum have no peritoneal covering. The upper or third portion receives an investment from this membrane thus explaining the reason why it is hazardous to remove more than three and one half or four inches of the rectum. Going above this line we must of necessity open the peritoneal cavity.

When we consider the juxtaposition of the middle portion of the rectum with the vaginal walls and the axis of the uterus, we see at once the rectal complications which must follow prolapsus uteri or retro-flexion of that organ, when the uterus is crowded heavily into the sacral cavity. We wish to emphasize this point, and boldly state that in a large per cent of the cases of uterine displacement the rectum and not the uterus is the seat of suffering. The nerves which supply the rectum are received from the cerebro-spinal and the sympathetic system, which accounts for the spinal irritability and the endless sympathetic irritations caused by the mechanical pressure of the uterus upon the sacrum and rectum.

The intestine here, as elsewhere, is composed of mucous, vascular and muscular coats. In addition there is external to and surrounding it a large amount of loose cellular tissue.

The anus or outlet of the rectum is securely guarded by two circular and muscular bands, called the internal and external sphincters. It is the province of these muscles to close the outlet, and to let nothing pass through it except such substances as nature has designed. During the act of defecation, when the expulsive muscles are brought into a state of contraction, it is the duty of the sphincter to dilate and allow the fecal contents to escape. Owing to some nervous or morbid influence the act of coördination is frequently destroyed and the sphincter, instead of performing its legitimate function during the act of expulsion, not only refuses to dilate but obstinately contracts, and thus occludes the passage. This irregular action or want of coördination has been termed "stammering of the sphincter ani." It becomes a painful malady in some instances, and is no doubt the beginning of more serious trouble. It is a difficulty frequently found in children, where the sphincter ani has become sensitive through the use of the syringe or the introduction of other foreign substances. In nervous and irritable women of sedentary habits, when the bowels have become obstinately constipated, we find the sphincter congested and irritable, thereby causing painful defecation. Many times in the effort to pass the fecal contents the muscle, through the

reflex system, powerfully contracts and renders expulsion difficult. For instance, Mrs. M—, æt. thirty-eight, had for many years suffered, as she supposed, from uterine troubles, and had been treated for such by eminent physicians. In February, 1883, she came to me for treatment, and in speaking of the habits of the bowels she remarked that the act of defecation was attended with severe pain at the point of the coccyx and was followed by nausea and great prostration. She said: "When I attempt to evacuate the bowels, the greater the effort the tighter and closer the parts become." Upon examination an irritable sphincter was found and she was suffering from this disease called "stammering of the bowels." The sphincter was thoroughly paralyzed by stretching, the patient being under the influence of an anæsthetic, a compress of lint two and one-half inches in diameter saturated with calendula and smeared with cosmoline was placed in the anal opening, and allowed to remain there twenty-four hours. When removed the muscles were in a flat and flabby condition, but soon regained their tonicity, sufficient to control the action of the bowels. The act of defecation became normal and the supposed uterine difficulty disappeared and she is to-day perfectly well.

Around the border of the anus the skin begins to change in character and, being divested of epithelium, it is gradually transformed into mucous membrane as it passes the border of the external sphincter. Externally and within the corrugated folds of the anus the integument is very delicate but is covered by very fine hair in the male and there is a large number of sebaceous follicles and muciparous glands. We will announce here the morbid processes found at the border of the anus, viz.: Pruritus, erythema, eczema, fissures and ulceration.

Pruritus, or itching in the vicinity of the anus, is not a dangerous disease but an exceedingly annoying one, and often drives the sufferer to acts of desperation as for instance the tearing of the parts with sharp instruments and forcing rough bodies or pieces of broken glass within the anal orifice. It is usually a symptom of other diseases as hemorrhoids, eczema, parasites, fissures, herpes, erythema and morbid secretions. In treatment, the cause of the difficulty should first be accurately ascertained. No physician would be excusable in prescribing simply for this symptom without first making a careful examination of the parts under a strong light to ascertain the real cause. It appears in patients under all circumstances and is marked by more or less uneasiness and irritation, and the trouble is greatly augmented after the patient becomes warm in bed at night. In poorly nourished subjects of scorbutic habits we find the secretions acrid and irritating to the delicate surfaces. Again the discharge from the bowels will erode and cause erythema and inflammation of the muciparous glands. Pruritus is also frequently caused by internal hemorrhoids or a minute fistula in ano.

The presence of pin worms in children will cause the same and produce the most violent nervous manifestation resulting in chorea

and convulsions. When it is complicated with erythema in children or in fleshy people the parts should be frequently cleansed with hot water or a hot solution of "Listerine." After the parts are well dried benzoated zinc ointment or the zinc oxide should be applied. In some instances pulverized starch, slightly moistened by a one per cent solution of *Mercurius Cor.* will suffice, or the following ointment:

|                     |     |
|---------------------|-----|
| Chloral.....        | 3i  |
| Camphor Gum.....    | 3i  |
| White Vaseline..... | 3ij |

applied morning and night after the parts have been thoroughly cleansed. Or perhaps the following:

|                             |      |
|-----------------------------|------|
| Permanganate of Potash..... | grsx |
| Aqua Font.....              | 3vi  |

applied with a camel hair brush after the use of warm Castile soap-suds.

In cases of eczema cleanliness is without question the most important feature. Frequent ablutions of hot water and the use of green soap or white sulphur soap are imperative. Iodide of sulphur cerate or the acid nitrate of mercury ointment, hydrastis 2x mixed with equal parts of mercurius cor. 3x applied to the parts in the form of a powder will be of service.

In cases of fissure and ulceration the anus should be examined under a strong light by means of a reflector. Separating the parts with the thumbs on either side and instructing the patient to strain, we observe that the tissues have a whitened appearance as if they had been subjected to a solution of acid along the folds of the tissue which has become somewhat thickened by constant rubbing. Upon closer examination we find small fissures and in some instances quite large ulcers which have their long diameters in line with the folds of the tissue.

It is our custom to subject such cases to a twenty per cent solution of nitric acid or even a stronger solution where the cases are of long standing. Carbolic acid may be preferable in some instances simply touching the fissures with the pure dissolved crystals. A match or small piece of pine wood, sharpened at the end, is a convenient medium for its application. It has been authoritatively stated and it is frequently the case that a majority of these cases are of syphilitic origin. It is true that they may occur from other causes but this taint should be particularly inquired after.

When parasites cause irritation and itching, injections of strong lime water should be used and followed soon after by enemas of sweet oil. Internal remedies should be selected according to symptoms and conditions. We may find the digestion to be at fault. In such cases *Arsenicum iod.*, *Sulphur*, *Calcarea carb.*, *Mercurius* and *Rheum* are of value. When we find fissures complicated with specific taints *Nitric Acid* followed by *Mercurius*, *Kali hyd.* and *Hydrastis* have been



tried successfully. When parasites complicate the case *Viola odorata*, *Iris vers*, *Santonine*, *Sulphur* and *Phenic acid* are recommended.

In all of these troubles the diet and habits of the patient should be carefully regulated. In those who have been overfed a plain and simple diet should be established. For those who have been underfed, or who are of a scorbutic habit a good and generous diet should be recommended, and onions should constitute a liberal share. The bowel should be kept open, and the rectum should be cleansed after each passage by means of enemas of warm water.

Closely allied to, or complicated with, the foregoing troubles we have a spasmodic or irritable sphincter. It may not yet have gained the habit of stammering, but it is a source of great annoyance and pain. It occurs frequently in women, and is occasionally found in men. Sufferers from this difficulty are usually of a nervous, apprehensive or despondent temperament. Constantly dwelling upon their own troubles, they are fearful of some serious calamity. The act of defecation is very painful, and there is more or less uneasiness in the back, with pain radiating up the spinal column and through the bowels. Upon examination the anal orifice is found to be greatly contracted, scarcely admitting a No. 3 bougie. Any attempt to introduce the finger will cause the patient to shriek with pain. Coccyodynia is not an infrequent complication, and adds to the patient's suffering. Causes of this difficulty are idiopathic or traumatic. The anal fissures may, if extended within the sphincter, cause this difficulty, as well as internal hemorrhoidal congestion and ulceration. The treatment should be both constitutional and local. If the difficulty arises from torpid portal circulation, imperfect digestion, or a general neurasthenia, remedies to meet these several conditions should be employed. The diet should be bland and nutritious, and of such a character as would keep the bowels soluble. Among remedies found useful may be enumerated *Nux-vomica*, *Pulsatilla*, *Ignatia*, *Physostigma* and *Sulphur*.

The local treatment consists essentially in paralyzing the sphincter. The patient being placed under an anæsthetic, the sphincter is forcibly stretched, even unto lacerations, and retained until all muscular resistance is overcome. Hemorrhage may follow, but this will serve to relieve the hemorrhoidal congestion, and in the end will prove beneficial to the patient. The rectum should now be filled with *Calendula* or *Hamamelis* cerate. A heavy compress may be applied to the anus and maintained by a T bandage. After twenty-four hours the rectum should be thoroughly washed out with dilute Pond's Extract and warm water. The following cerate or suppositories may be used daily:

|                             |     |
|-----------------------------|-----|
| Rhatany, solid extract..... | 3ij |
| Plain cosmoline ..          | 3ij |

This is to be applied daily, and the enemas of Pond's Extract and hot water are to be continued once daily.

# Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

AUGUST MEETING, 1885.

The regular monthly session of the Clinical Society was held on Saturday evening, August 1, at the Grand Pacific Hotel, Dr. C. T. Canfield, vice-president, in the chair. Twenty-six members and visitors were present. The time of the meeting was occupied with the

## REPORT OF THE BUREAU OF GYNECOLOGY.

OF THE URINARY AFFECTIONS THAT ARE ASSOCIATED WITH UTERINE CANCER.—BY R. LUDLAM, M. D.—The following paper has been prepared in support of several distinct clinical propositions:

I. *Uraemia as a Cause of Death from Uterine Cancer.*—The most common cause of death from cancer affecting the lower segment of the womb is uraemia. The following is a case in point:

*Case*—Mrs. —, æt. fifty-six, consulted me a year and a half ago for the relief of frequent attacks of uterine hemorrhage with an intercurrent ichorous, and watery leucorrhœal flow. Her general health was so good, and her family history so free from any cancerous taint, that I saw her three times before making a final diagnosis. The usual signs of cervical cancer were, however, present, and the daughter, her only child, was apprised of the exact nature of the case. She came a few times for remedies, and then, at the solicitation of friends and with my full consent, placed herself under what is known as the "metaphysical treatment."

Being endowed with an amiable character, and of a trusting and confiding disposition, that "treatment" really seemed to have a good effect in controlling the worry, the pain, and the wakefulness that usually accompany the development of uterine cancer, especially when it follows the menopause. For the next eleven months she took no remedies whatever, and used nothing locally except warm water, for the sake of cleanliness. The hemorrhage recurred, and bits and shreds of the sloughing tissue were occasionally discharged. The leucorrhœa continued, but she suffered comparatively little pain, and ate and slept well. The cachexia developed, and the disease progressed steadily; but, although she lost flesh and strength, both she and her friends insisted that she would ultimately recover.

For several weeks toward the end of her life the urine became scanty, and at times it was entirely suppressed. She complained of a burning pain which extended from the bladder along the course of the ureters toward the kidneys. On the last day of May I was sent for, and found that she had suffered for twenty-four hours from an almost incessant vomiting, which no ordinary remedies would allay. She had occasional diarrhœic stools, with dryness of the mouth, great prostration, cold extremities, and a total suppression of the urine. Her mind was clear when aroused, but at other times she was very dull and drowsy. This condition, with slight remissions but no flow of urine, continued for three days, when she passed into a state of euthanasia, from which she did not revive. A post-mortem was not allowed.

Two reasons explain the easy involvement of the urinary function in a case of cancer of the neck of the womb: (1). The position of the ureters alongside the abdominal portion of the cervix uteri; and (2), the frequent invasion of the bladder by an extension of the disease through contiguity of structure.

That renal inadequacy and consequent uræmia may be due to a partial or complete obliteration of the ureters from a cancerous deposit about them, as illustrated in this cut (see fig. 1), seems not to have been recognized until a comparatively recent date. In 1854,\* Dr. John Beatty first called attention to it as a clinical fact in a paper, entitled: "*On a rare and hitherto unobserved form of death in cancer of the uterus.*" He reports three cases, in the remarks upon which he says:

"In the great majority of cases the induration of the coats of the bladder gives rise, first, to great irritability of the viscus and frequent desire to pass water; and, finally, ulceration having taken place, incontinence of urine is the result. But in some instances the contamination takes place more slowly, and over a broader surface, and the openings of the ureters into the bladder become blocked up by the cancerous deposit, which extends even a short way into those canals. While this process is going forward, the urine discharged from the bladder gradually diminishes in quantity, and at last is totally suppressed. The catheter may be passed through the urethra, but the bladder will be found empty. The kidneys, however, have not ceased to perform their function; the urine is still secreted, and finding no exit into the bladder, it accumulates in the ureters, distending these canals and the pelvis of the kidneys to an enormous extent. The well known consequences of such an obstruction now begin to develop themselves. Symptoms of uræmic poisoning appear, coma supervenes, and the patient dies. This is the most merciful

\*Trans. of the Pathological Society, Dublin *Medical Journal*, 1854; and also in his *Contributions to Medicine and Midwifery*, Dublin, 1866, p. 263.

manner in which the life of the unfortunate victim of this incurable disease can be brought to a close; and when it so happens, it is a subject for much thankfulness. But too often ulceration proceeds at a rate too rapid to permit of this easy and unconscious descent into

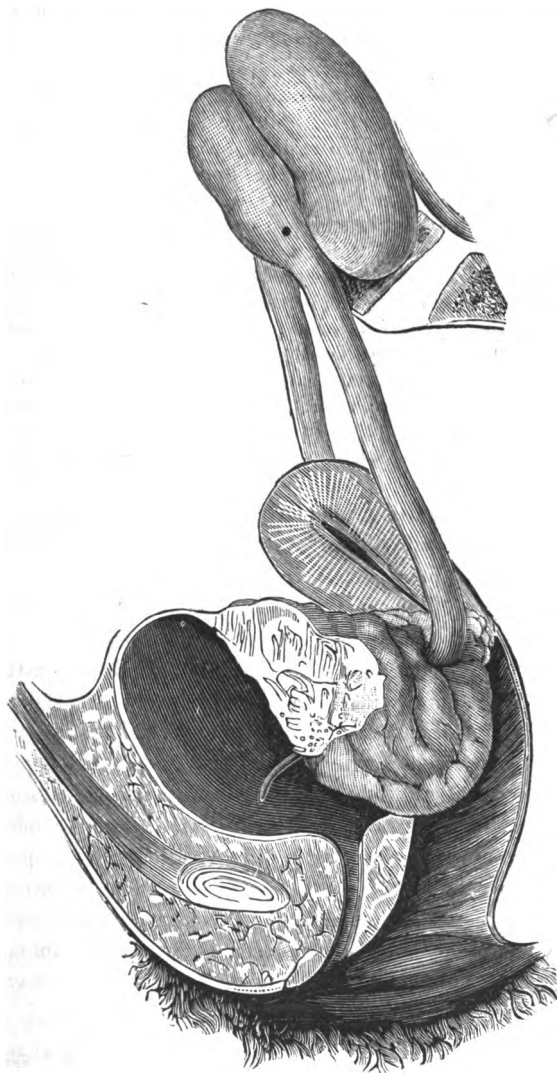


FIG. 1. CANCER OF THE CERVIX UTERI WITH OBSTRUCTION AND DILATATION OF THE URETERS, AND HYDRONEPHROSIS.

the grave; one or both of the blocked-up ureters are opened by the spreading ulceration, a sudden rush of urine takes place through the vagina, the coma gradually clears away, and the patient awakens up to undergo the longer and more distressing career of decay and death that are now before her."

Aran tells us very graphically how he stumbled upon a verification of the clinical conditions under review : \*

"This fact, which I believe is incontestable, came to my notice in the following manner: A woman was brought to my clinic in a comatose and convulsive state. She died without having recovered consciousness. The urine contained no albumen. What was my astonishment to find nothing in the brain, but on the contrary, to discover a uterine cancer in a very advanced stage, with a hydronephrosis that was so developed as to have changed the kidney into a mere membranous shell! From that moment in the case of women with cancer and who are seized with brain troubles, even if the urine is non-albuminous, I have not hesitated to insist that they must have hydronephrosis. In exceptional cases, however, it is possible that albuminous nephritis may coexist with uterine cancer; consequently if the urine is highly albuminous, we may find it to be a case of coincident Bright's disease. These convulsive and comatose symptoms are not invariably mortal, for, as in some cases of albuminous nephritis, they may disappear for a time and the patient continue to drag out a miserable existence."

Among other writers who have given us a practical application of this phase of their clinical experience are Seyfert & Saexinger,† Lusk,‡ Charcot, Fournier, Rayer, West and Lionville & Carpentier-Mericourt in their reports to the Anatomical Society of Paris in 1873-74; Péan in the second volume of his great work on abdominal and pelvic tumors, page 648, and Fordyce Barker in the Transactions of the New York Academy of Medicine, for 1870.

The form of uræmia that is most frequent in uterine cancer is the chronic form, in which the resorption of urine (urinæmia), or of urea is more or less constant. With the gradual obliteration of one or both ureters the obstruction is neither sudden nor complete. The general system accommodates itself to the imperfect depuration of the blood by opening other avenues of escape for the excess of urea in the circulation. A compensatory excretion goes on from the alimentary and other mucous surfaces, and the uræmic intoxication is toned down. This condition of smouldering uræmia may possibly

\* *Leçons cliniques sur les Maladies des Femmes, etc.*, Paris, 1858, p. 968.

† *Prager Viertel Jahrschrift*, Prague, January, 1867.

‡ *Uræmia as a common cause of death in uterine cancer*. New York Medical Journal Vol. V, p. 205.

continue for weeks or months; but there comes a time when both the natural and the unnatural outlets are inadequate, and a fatal poisoning is the result.

As in the case which I have reported, death may happen from uræmia without the occurrence of convulsions. Because of the chronic nature of the urinary complication, and especially, as Charcot has said, because of the vicarious elimination of the urea by the gastro-intestinal mucous membrane, as shown in the vomiting and purging, the cerebral and other lesions may be developed without shock or eclampsia. The coma and convulsions are present, however, in about one-third of the cases.

"In 1853 I several times saw, with the late Dr. Henry G. Cox, a patient in whom the cancerous deposit had extended from the uterus to the vesico-vaginal and the recto-vaginal walls. As I lived much nearer to the patient than Dr. Cox, I was called in the night to see her on account of an attack of convulsions, and found that no urine had been passed for nearly forty-eight hours. I introduced the catheter, but found no urine in the bladder. During the night she had five convulsions. The tendency to convulsions seemed to be overcome by chloroform, and the next day the excretion of urine became abundant, and she lived more than a year after this occurrence."—FORDYCE BARKER.

According to Wambrucq and Laségue death sometimes happens from closure of the ureters, and a total retention of urine, before the cancerous cachexia has developed. The forms of renal disease which are referable to occlusion of the ureters by the cancerous deposit and degeneration are chronic desquamative nephritis, with thinness and dilatation of the walls of the ureters (which are sometimes as large as one's thumb, or even as large as a sausage), and hydronephrosis, the kidney being distended nearly to the point of bursting. The lesions that follow are cerebral anæmia, œdema of the brain and the lungs, tubercles or cancer, and fatty and cystic degeneration of the kidneys.

Before death from uterine cancer with uræmic complication there is very apt to be decided evidence of cardiac insufficiency. This is shown in a lowering of the cardiac tension, that is so necessary to the proper circulation of the blood through the kidneys. In addition to this, as the twin lesions progress, the digestion becomes fagged and imperfect, and the blood is more and more impure until death, which, as the inevitable result, follows.

II. *Urinary affections and the early diagnosis of Uterine Cancer.*—Enlargements of the uterine cervix, with anchorage of its abdominal portion, are almost certain to be cancerous, if the urine is habitually scanty or suppressed.

The early recognition of any form of uterine cancer is difficult, but it is especially so when it involves the more substantial structure of the neck of the organ and the parametric tissues. If, however, the lesion is seated in the vaginal cervix it is accessible, and, whether it begin on the mucous surface as an epithelioma or not, the question of its nature is more readily determined. But when that portion of the uterine neck which lies above the roof of the vagina is enlarged, with anchorage of the womb and frequent involvement of the urinary function, we have reason to suspect the existence of a form of uterine cancer.

In anterior displacements of the womb, the bladder is the seat of suffering, and the passage of the urine is more or less interfered with. There is a characteristic inclination to void it frequently, and an intolerance of more than a very slight accumulation. What is passed is natural in quality, or nearly so, and in quantity also, if the total amount is measured. But when the ureters are blocked by the cancerous deposit about and within them, the case is very different. Partial obliteration of these tubes is equivalent to a scanty secretion of urine, and if this state of things is to continue and increase as the local disease develops, a serious condition of the kidneys with uræmia must certainly follow. I have known cases of cancer of the abdominal cervix to be treated for anterior displacement of the womb, under the mistaken idea that the fixity of the organ was due to peritoneal adhesions, and the urinary symptoms to a direct pressure upon the fundus of the bladder.

When the womb deviates forward, backward, or laterally, the ureters have sufficient latitude of motion to prevent their being seriously implicated. It is only when they are included in the abnormal deposit, and their calibre is either choked or closed that the urinary symptoms become significant and alarming.

For safety in prognosis and for certainty in practice it is desirable that this class of cases should be recognized as early as possible. It certainly would not be best to decide hastily, or to declare too positively that hypertrophy, with anchorage of the supra-vaginal cervix and scantiness or suppression of the urine, was pathognomonic of

uterine cancer. Some of these symptoms might be due to the pressure of a uterine fibroid; to the entailed lesions of pelvic cellulitis or peritonitis; to an old hematocle; or to tuberculous infiltration. But the smaller fibroids are seldom glued to the surrounding organs or fixed in their position; the sequelæ of pelvic cellulitis are of a suppurative kind, with a marked tendency to recurrent abscesses; pelvic peritonitis, in the chronic form, with persistent adhesions and relapsing attacks, is almost always tuberculous; an antecedent hematocle would be allied to the hemorrhagic, or to the hemorrhoidal diathesis; while pelvic tuberculosis is always accompanied by marked evidences of this peculiar diathesis.

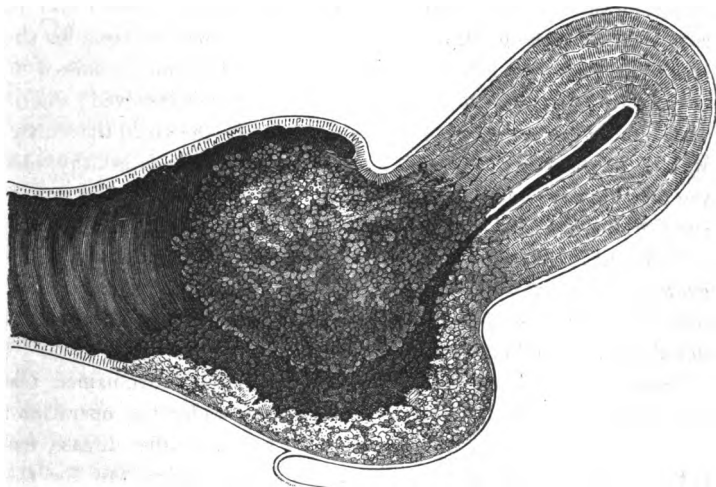


FIG. 2. A SLOUGHING EPITHELIOMA OF THE CERVIX UTERI.

In a given case, therefore, we should have to exclude all these conditions before we could determine the existence of cancer of the neck of the womb. Fortunately they are not liable to be accompanied by an insufficient depuration of the blood by the kidneys. It is only when they are complicated with one of the forms of Bright's disease, pyelitis, hydronephrosis, or hæmaturia that they are likely to be confounded with cervical cancer. Given the urinary symptoms in a marked and decided manner, with the local lesions about the neck of the womb, as already described, and the probabilities are greatly in favor of the existence of incipient cancer of the neck of the womb.



When the lining membrane of the cervix is the seat of malignant degeneration, there is no renal and vesical mischief until the disease has finally invaded the neighboring organs through continuity of tissue. (See Fig. 2.) But this type of the disease may change into the medullary form, and then the rule will fail.

III. *Urinary Affections and Hysterotomy for Cancer.*—Another reason why the early diagnosis of uterine cancer is of the utmost importance is that it helps to settle the question of the propriety of surgical interference. If the disease is ever localized; if there is a pre-cancerous period in which the morbid growth may be removed before the general system is tainted, that is the time for the operation. If we can find a case in which the lesion is limited to the cervix uteri, and the perimetric tissues are not involved; one in which the uterus is mobile and might easily be drawn to the vulva; where the cellular tissue at the vault of the vagina is healthy, and the pelvic nerves and lymphatics have escaped infection, the way is clear. But how shall we be certain that these favorable conditions are present? If the infra-vaginal cervix is the seat of a suspicious growth, the microscope will furnish its collateral evidence, for the part that is involved is readily accessible; but not so with whatever lies above the vaginal roof.

Cases that were apparently suitable by the above-named test have been found to be fearfully complicated under the operation; the deposit could not be thoroughly removed, the disease has returned, and the patient has died. This old clinical test for the expediency of the extirpation of the womb is not, therefore, sufficient and satisfactory in all cases. It is impossible to say when the adjacent tissues are free and when they are not. The case is the counterpart of amputation of the breast for mammary cancer. If the surgeon persists in removing the axillary and cervical glands along with the tumor, because they are implicated and because he can get at them, he does not suppose that his patient will survive more than a few weeks, or months at the farthest. He has no expectation of a radical cure. The same is true if the gynecologist performs hysterotomy in an old and complicated case of uterine cancer.

Now a serious involvement of the urinary system is to uterine cancer what the infiltration and enlargement of the axillary and

cervical glands is to cancer of the breast, *id. est*, a tangible and certain evidence that a radical operation is out of the question. I propose this rule as applicable to all those cases of cancer which involve the portion of the womb that lies above the vagina, and in which it is very difficult, if not impossible, to determine whether the neighboring tissues are involved or not. And I am satisfied, not alone upon theoretical grounds, but also from experience, that if this idea and safeguard had been seriously entertained, there would have been fewer operations for the removal of the uterus, and perhaps better results when it was done.

*Discussion.*—DR. LEAVITT said that the Society was under deep obligation to Dr. Ludlam for the preparation of so admirable a paper on so interesting a subject. He regretted his inability to add any very important testimony, but he wished to allude to two cases which presented symptoms corresponding, in a measure, to those detailed in the report.

The first was that of a woman suffering from carcinoma of the cervix, who came under his care some three or four years previously, in the later stages of the disease. The vaginal walls had become involved to such an extent that to the finger, when introduced, they presented the roughness and friability which characterized the ulcerative stage. During the last two or three days of her life, there was an almost total suppression of the urine, and also a comatose state, deepening into coma. The second case was that of a woman suffering with carcinoma of the cervix, of the epithelial variety, who for a number of days, at intervals, voided but little urine, and developed alarming symptoms. The lower extremities became greatly cedematous, the cardiac action extremely irregular and feeble, and the intellect somewhat clouded. Under the use of suitable remedies the flow of urine was started, and the foregoing symptoms in a measure alleviated. Subsequently the case passed out of his hands, and the woman now lay at the point of death, if she has not already passed away.

DR. H. B. FELLOWS.—In my reading recently, I noticed that in certain cases of glycosuria in women, the cause was said to be disease of the uterine appendages, and that the removal of these cured the diabetes.

DR. J. E. GILMAN.—In this connection I remember well a case of hepatic carcinoma, in which there was nothing special to indicate involvement of the liver, but on the contrary all the symptoms pointed to renal trouble. The autopsy did not show any reason for the marked urinary symptoms. Both kidneys were normal in appearance—slight adhesion of the capsule in spots, but nothing wrong with the structure. Yet the indications during life were that the beginning of the trouble was abscess of the kidney, and as the case progressed I was more and more inclined to the belief that there was renal cancer. Four days before death the urine was entirely suppressed, and the lady succumbed under uræmia. It may be that this urinary implication goes with cancer of any of the abdominal organs.

DR. A. E. SMALL.—As Dr. Ludlam progressed with the reading of his paper, several cases came to mind confirmatory of the statements he has made. One instance was that of a lady at the climacteric, who was afflicted with a serious cancerous difficulty. Although it was not less than twenty years ago, I remember well what trouble it gave me to try and obtain some relief for her. She finally died of uræmic poisoning. Dr. Ludlam quite likely remembers the patient, for he saw her with me. Another case was that of a lady past the climacteric, who suffered intensely with a cancer of the womb. The pain was so terrible that she accustomed herself to take *Morphia* to assuage the suffering. The habit so grew that she took eventually an ounce of the morphine in less than a week. She retained her mental faculties clear until very near the end, but the latter part of her life was marked by suppression of urine. This I supposed at the time to have been the result of the massive doses taken of the narcotic. When she died, no urine had been passed for nearly a week.

DR. R. LUDLAM thanked the members present for their evident interest in his paper, and begged to remind them that the subject was not a new one. Authors on the diseases of women had mentioned uræmia as one of the causes of death in uterine cancer, but had said little or nothing of its special connection with cancer of the cervix. The subject was suggestive, especially in its relation to the early recognition of that disease, and also to the question of the extirpation of the womb, whether by the abdominal or the vaginal

method. If the urinary complication of uterine cancer stands in the same relation to the removal of the uterus that axillary and cervical involvement confessedly does to amputation of the breast, the fact should be known and acted upon. Whether a quantitative analysis of the urine for urea will tell us if an abdominal tumor is or is not malignant, as Thiriar has proposed, is a question that farther experience will help to decide.

**HYSTERO-EPILEPSY WITH PSEUDO-PARALYSIS AT THE CLIMACTERIC**—BY MRS. C. T. CANFIELD, M. D.—The following case is not presented on account of any peculiarity of disease or treatment. Similar cases are daily presenting themselves in the practice of physicians. Our resources are sometimes taxed to the utmost, especially when called upon to treat a disease which exists almost entirely in the mind of the sufferer. Still none the less does our duty require us to attempt to restore our patient to a normal condition, mentally and physically. Our endeavors should be in the direction of "exciting those mental conditions, which shall act beneficially" in a given case. The "confidence of our patient must border upon a certainty of the probable good effect" of the treatment pursued. Their hopes must be aroused, their expectations excited, and thus their anticipations of a cure will be realized. This fact is the secret of the so-called "faith cure," and the peculiar strength of the "metaphysical" miracles. That hope, expectation and imagination are potent factors in the cure of the neuroses is an irrefutable fact. This subject is one worthy of study by all conscientious physicians. The assistance we may render in the treatment of these annoying conditions merits the effort it may cost, and thereby we are enabled to devote to our own use the entire armament of these "miracle workers." At the same time no one can better respond to the interrogatory: "Who can minister to a mind diseased?" than the physician who subscribes to and adheres to the "law of similia." Thus doubly-armed and skilled in the use of our weapons, we may boldly confront disease, whether of a physical or psychical nature, so far as human power can avert a chronic and protracted invalidism, or delay the approach of our common enemy.

*Case.*—Mrs. H., aged forty, American, has been married twenty years. Has one child aged eighteen. Was formerly an active, hard-working woman, having for many years had the entire charge of a large boarding-house. For a year or more she had been under the

professional care of various physicians of the old school, and obtaining no relief, finally became discouraged. It was only at the earnest solicitations of her friends that she consented to see another doctor. At my first visit she informed me that she had no faith in medicine or physicians. I found her a complete wreck, mentally and physically, her body emaciated, and of an anæmic appearance. She had been unable to walk for half a year, and confined to her bed for three months. She insisted that she could not sustain herself upon her feet, and had no power to place one foot before the other. Notwithstanding her assertion I observed that occasionally she moved her limbs in bed.

She talked incessantly in a peculiar whining, peevish tone of voice, and while speaking was continually wringing and twisting her hands. Occasionally I detected a furtive glance of the eye in my direction. She "knows that every one is tired of her," and when her husband endeavors to assure her to the contrary, she becomes greatly excited, as she usually does at the slightest contradiction. Is inordinately fond of company, in fact, will not be alone night or day, and insists upon having her room as light as it can be made.

She fancies she has heart disease, is positive "the heart has fallen from its proper position," and that at times "it stops beating." Again, "It is too large and nearly chokes her." In short, her vagaries are innumerable.

She had been troubled for more than a year with "poor spells" or "spasms," as they are termed by her friends. She becomes apparently insensible. There is a rolling of the eyes, a tonic contraction of the muscles of the extremities, and sometimes a frothing at the mouth. These attacks usually precede the menses, which appear every three weeks, and are gradually decreasing in quantity. She sleeps very little, and the appetite and digestion are poor.

Upon a thorough examination I could detect no organic disease whatever.

*Treatment.*—From my introductory remarks you will infer, that my first aim was to gain my patient's confidence. In a few days I had the satisfaction of feeling assured that I had accomplished that desired result. My first prescription was *Stramonium* 30, "indicated by the prominent mental symptoms. One week later, she informed me she was "improving." She has more appetite, sleeps better, is less desponding, and inquires, "What have you been doing to me?" *Stramonium* continued.

For several weeks there was a gradual gain. She was induced to leave her bed at intervals, and occasionally stood upon her feet. Six weeks subsequent to my first visit, I was hastily summoned with the message that "Mrs. H. was dying." I found her apparently insensible, with the eye-balls rolled upward, and the body rigid, with cold extremities. She soon began weeping and moaning, sighing often, and insisting that she was "going to die." *Aconite* soon

quieted her, and in an hour or so I left her sleeping. This was the first and last spasm she had while under my care. *Arsenicum* was now indicated, and in a week she was sitting up and with my assistance walked a few steps.

At the next menstrual nixus, I found her despairing and disposed to find fault with all her friends, especially her husband. At the same time she was afraid that he would weary of her. She "did not think he would lose much if she should die." *Lachesis* 30 was now given with excellent results. She became cheerful and happy and slowly regained the use of her limbs. She passed through the climacteric, and although several years have since elapsed, she has had no return of the pseudo-paralysis or spasms.

In the above case, although I am confident that my remedies were closely affiliated, I am positive I should not have cured my patient so easily and completely, had I not combined "psycho-therapeutics" with other remedial measures.

**OVARIOTOMY.**—Dr. Ludlam said that out of a number of cases in which he had made this operation during the spring and summer months two of them were, he thought, worthy of especial mention. He then gave a verbal report of the following :

*Case 1.*—*Ovariectomy; weight of tumor forty-eight pounds; death on the twentieth day*, was that of a young, unmarried lady of seventeen, a patient of Dr. A. O. Pitcher, of Mt. Pleasant, Iowa. She had suffered from scanty and infrequent menstruation, and had always had a rapid and weak pulse. She was highly educated, and had formerly been plump and of full habit, but since her illness had become very pale and considerably emaciated. Dr. P. was called to her January 3, 1885, for a sub-acute ovarian peritonitis of the right side. The attack was induced by a hurried walk to the train, while carrying a heavy satchel. The peritonitis soon became diffuse; the pain subsided under treatment, but the distention increased, and on the 15th of March she was tapped, and about twelve quarts of a brownish viscid fluid, containing shreds of pus, were drawn off. Seven weeks later a second tapping was practiced, and about the same quantity of the same dark-brown fluid was removed.

With the assistance of Drs. Pitcher and G. E. Smith, of Mt. Pleasant, and Dr. B. L. Reynolds, of Chicago, I made the operation at the patient's home May 21, 1885. There was nothing peculiar about the circumstances except that on account of the extreme distention and weight of the tumor the patient had not been able to lie upon the back more than a very few minutes at a time without suffocation. This necessitated the giving of the anæsthetic while she was lying upon her side, a rapid section of the abdominal walls and the immediate tapping of the parent cyst. We had also to give

repeated hypodermic injections of whisky to keep her alive meanwhile. The tumor was multilocular; the adhesions were bad enough; the pedicle was ligated and dropped back again; the peritoneal cavity was thoroughly cleansed, drainage provided for and the wound closed.

She reacted well, and under the kind and skillful and persevering attention of the physician who has furnished me the daily record of her case, did as well as the average patient after so serious an operation. The range of her temperature was but slightly above the normal, but the pulse continued frequent, as it was before the operation. She had no vomiting, but an increasing appetite, slept well and had little or no pain. The urine was free, the skin healthy, the color improved, and the bowels were regular. At first the serum was freely drained from the abdomen, and the wound and the cavity carefully and thoroughly cleansed antiseptically. She was bright and hopeful, and everybody expected her to recover. On the sixteenth day the record reads "still improving."

17th day. Is not so well; had a slight chill at midnight. Pulse 130, temperature 103°. The discharge is the same in kind, but less in quantity. *Aconite* and *Arsenicum Alb.*, and two grains of quinine at 6 A. M. In the evening is feeling better, but has broken out with sudamina.

18th day. Better in the morning, but worse in the evening, when the pulse was 130, temperature 105°, with some sickness at the stomach, and an uneasy sensation in the region of the liver.

19th day. Was much better all day. Pulse 120, temperature 100°. She rested well all night and is very cheerful.

20th day. She slept well throughout the night, and ate a good breakfast. Is cheerful and boasts of her gaining strength. Only about half a teaspoonful of healthy pus was discharged from the lower angle of the wound. She laughed and chatted freely with her family and the nurse, and after being dressed expressed a desire to sleep. She slept well for an hour and a half, and then called for a drink of water; said she felt sick at the stomach, raised a mouthful of foetid pus and died in a very few minutes. There was a large quantity of pus discharged from the mouth after death.

*Case 2.—Double Ovariectomy—Recovery.*—Miss —, æt. fifty-four, was the patient of Dr. Alice K. Brown, of Topeka, Kan. She had been in poor health for several years, but the tumor had not been recognized until within about two years. Early in April, 1885, it had attained such dimensions as to distress her very much, and indeed to occasion great dyspnoea, with gastric uneasiness, intolerance of food, and anasarca of the lower extremities. Being detained with other work in my specialty just then, it was impossible to go at once to her relief, and I advised tapping as a temporary resource, and to give her a respite from her suffering. This was safely accomplished, without any mishap, and in a few days she was able to ride out. The

abdomen was soon as large as ever, and all of her bad symptoms returned.

I went to Topeka, and on May 4th, with the help of Drs. A. K. Brown and George Dick, and Drs. Mulvaine, of Topeka, and Dr. B. L. Reynolds, of Chicago, made the operation. The day was a very warm one, the temperature being 82° F. out of doors. We operated, therefore, with open windows. As soon as the section of the abdominal parietes was made and the sac exposed, it burst and flooded everything. When this rotten shell was separated from its visceral adhesions, a second and a third were drawn forward to the incision, and both were equally unsound. The pedicle being carefully ligated, the opposite ovary was found to be the seat of another tumor consisting of two cysts lying one above the other. The upper cyst was almost free, but the lower one was retro-uterine, and was bound all around by adhesions which anchored it in the Douglas space. These attachments were broken up, and the second pedicle was ligated. The abdomen was flushed three times in succession with carbolyzed water, mopped out until it was dry and perfectly clean, and then closed with careful arrangements for subsequent drainage.

Dr. Brown watched this patient day and night; she had excellent nursing and care, and the surroundings were all that could be desired. Her highest temperature was 101½, which was on the evening of the third day, and the highest pulse recorded was 115. She made an uninterrupted recovery, and is now in good health.

**PUERPERAL CELLULITIS WITH ABSCESS.**—BY J. E. GILMAN, M. D.—*Case.*—Mrs. P. was confined May 11, 1885. After the uterine cervix was dilated, the labor was completed with only two or three pains. During the labor the temperature was 101.5°. She had complained of soreness in the abdominal parietes during the latter months. The high temperature caused me to apprehend the advent of puerperal convulsions, but the labor was concluded without any untoward symptoms, although the temperature did not fall. Then for several days I had a fear of septic fever on account of the continuance of a temperature of 101° to 103°, but within a week with the aid of vaginal irrigation and proper medication the fever subsided. The patient was of a portly physique, the abdominal walls were thick and their soreness prevented such manipulation as was necessary to detect any local lesions that might exist. I was uncertain of the existence of an abscess, but became satisfied of it when it discharged into the bladder and emptied what must have been quite a large gathering, judging from its fluid contents. This was followed by a period of improvement, but the milk refused to appear in the breasts, except in limited quantities, and methods that heretofore had not failed to bring it, were of little effect. I soon was able to determine why, for the outlines of a tumor could be distinctly



made out occupying the lower left portion of the abdomen. This gradually increased in size so that in the last days of July it had gained a size equal to the sixth month in pregnancy, and was accompanied by bowel disturbances which interfered seriously with the proper feeding of the patient, and by severe pains occurring at irregular intervals, mostly in the night. There was but little rise in temperature with this abscess, no chills, and no symptoms of absorption into the blood. The disturbance of temperature seemed to be due to the local inflammation of surrounding parts. Peritoneal inflammation threatened, but was controlled. There was, however, considerable weakness and prostration. July 25, Dr. R. Ludlam was called in consultation, and again July 29, when about four ounces of thick creamy pus was removed by aspiration, the puncture being made per vagina, and a final operation for the removal of the remainder on the 5th of August, when a still larger quantity was taken in the same manner. The patient at date is doing well, regaining strength and health. There was in addition to the abdominal abscess one formed in the ear causing much temporary difficulty in hearing. The peculiarity in this case seemed to be the formation of an undetected abscess during the latter portion of the parturient period—a lesion that must have been there from its subsequent course and history.

*Discussion.*—DR. LUDLAM said that this case was worthy of being reported because the pelvic inflammation had begun before the delivery; because the traumatism of a rapid labor had probably hastened the suppurative process; because, to have discharged itself through the bladder, the first abscess must have formed in front of the uterus, while the second one was retro-uterine, and was tapped through the posterior cul-de-sac; and because lactation was interrupted. It also illustrates the practical value of the clinical thermometer as an ante-partum indicator of latent inflammation and mischief; as well as of the aspirator as a means of discharging these pelvic abscesses.

ENDO CERVICITIS, DYSPEPSIA AND ANGINA GRANULOSA.—BY W. O. CHESEMAN, M. D., JOLIET, ILL.—*Case.*—Mrs. Mary B., age twenty-six, married, has had one child. Five years ago she commenced to have trouble with her stomach. Appetite capricious. Her food digests with difficulty. Sense of weight and fulness in the epigastrium. Occasionally she has heartburn and belches up wind. Pain and soreness at the pit of the stomach during digestion. Tongue clean. Bowels inclined to be constipated. Urine scanty and high colored or very pale. Drowsiness after meals. Wakefulness at night. Epigastric region tender on pressure. Occasional headaches. Her memory is defective and she is very nervous. She has to be very careful about her diet. Has had a creamy viscid leucorrhœa for the past two years. She is worse as soon as she moves about in

the morning. Has bearing down pains. She also complains of pains in the back with sensitive points on the lumbar vertebrae and a dragging sensation about the hips. Whenever the leucorrhœa is profuse these symptoms are aggravated. She cannot walk but a short distance at a time; tires out easily. The eyes are weak; she cannot see very well. The menses are regular as to time, but scanty. The leucorrhœa seems to be worse after the menstrual flow.

When this patient came to me she desired me to reintroduce a hard rubber pessary which she had been wearing. After getting the above symptoms I had no difficulty in persuading her that the pessary was injurious and uncalled for. On making an examination I found the uterus slightly prolapsed, the cervix swollen, the os tender and its mucous membrane everted. She has had throat trouble for the past year. On examining the throat the pharyngeal wall of the fauces was found covered with little roundish elevated spots extending from above downward. The mucous membrane was dry and glistening. She complains of an occasional sense of irritation and cough. The throat feels raw and dry. And there is an accumulation of phlegm, which is hard to get up.

*Treatment.*—Commencing with the throat I gave for the angina *Causticum*, 3x, and to the cervix uteri applications were made of glycerine and hydrastis.

January 13.—The throat trouble has disappeared, and the leucorrhœa is not so profuse. *Carbo veg.*, 3x, was prescribed, and applications of glycerine and hydrastis continued.

January 24.—Not so much belching up of wind. Food digests better. She is stronger on her feet. The stomach is not so sensitive. No change in the treatment.

February 4.—She has just passed the menstrual period. The flow was natural as to quantity, with less pain than she has had for a long time. The leucorrhœa is still troublesome. Continued the same remedy and application.

February 18.—Improvement of all the stomach symptoms is noted. The leucorrhœa is about the same. On the symptom "leucorrhœa flowing down like warm water" I prescribed *Borax* 3x with intra-uterine pencils of muriate of hydrastis.

March 7.—She is better. Stronger on her feet, and the leucorrhœa is not so profuse. Again gave *Borax* 3x and the muriate of hydrastis pencils.

March 14.—She is still improving, and the same treatment is continued.

March 21.—The leucorrhœa is still troublesome. She has occasional spells of vertigo. Cold damp feet, and much perspiration on the head and upper part of the body. Prescribed *Cal. carb.* 3 and 200.

April 4.—The leucorrhœa is better, with general improvement. This time I gave her *Cal. carb.* 200 and *Sac. lac.*

April 18.—She is better than she has been for years. Shortly after this the patient went to St. Louis. May 24 I received a letter from her saying that she was still improving, and was comparatively well. The leucorrhœa had entirely disappeared. This patient had been under the treatment of nine physicians before she came to me. Two of them had made a diagnosis of prolapsus uteri. The angina, which I cured in one week with *Causticum 3x*, had been sprayed and washed by all of the remedies known to our Allopathic brethren.

RECTAL FISTULA.—BY A. M. LINN, M. D., OF DES MOINES, IOWA.—*Case*.—Mr. P. æt. forty years, slender, light complexion, lymphatic temperament, called me to attend him June 8, 1884. I had treated him six months before for a severe chronic diarrhœa, with which he had suffered at times for several years, and almost constantly during the preceding eight months. He usually had from three to five movements by 10 A. M. Other symptoms corresponding, I prescribed *Sulphur 30*, with marked benefit.

He now complained of a severe throbbing, pulsating pain in the rectum, almost unbearable during efforts at stool. Pains radiated into the abdomen and outward over the left hip. Movements were frequent, diarrhœic, dark-colored, offensive and at times slightly streaked with blood. He suffered much from flatus and distension of the abdomen, with large amounts of gas. His appetite was poor, and he was nervous, restless, sleepless and apprehensive. There was marked prostration, some fever and thirst also.

Digital examination revealed a developing abscess in the anterior walls of the rectum from one and a half to two inches above the anal orifice.

Also he complained much of a swollen, sensitive, discolored spot in the left inguinal region over the sigmoid flexure of the colon. This induration was so persistent and painful as to warrant the diagnosis of a developing abscess. I may observe that two of my Allopathic brethren subsequently diagnosed a malignant growth of some type. The abscess (as it proved to be) developed, discharged and disappeared. The patient claimed he had been inoculated with syphilis through impure vaccine virus a few years before. A statement which is, as shown subsequently in this paper, somewhat at variance with accepted facts. *Hepar Sulph.*, *Thuya*, *Merc. Sol.*, *Nit. Ac.*, and *Silicia* were given as indicated. I could do little but exhibit remedies and wait. Waiting was not satisfactory, and I was discharged.

October 1st I was recalled to the case. I found the threatened abscess in the rectal walls had developed into a complete fistula, and the fistula, like the Nile, becoming ambitious to have several outlets, had formed two additional openings through the perineum anterior to the anal orifice.

The first was just anterior to the anus; the second, two inches forward, and an inch to the left of the raphe; the third, an inch anterior to the second and nearer the raphe. They had developed in the order named.

A swollen, discolored, sensitive point showed the probable site of another opening. In truth the perineum, as operation afterward proved, was pretty thoroughly plowed and seamed with fistulous sinuses. Preceding the discharge of the rectal abscess a catheter was necessary to draw the urine; pain, swelling and discoloration of the perineum were present; all diagnostic of the coming trouble. Yet the condition was not recognized until the fistula formed, and then the tracts were not kept free to prevent further burrowing.

When I was recalled, the patient was able to be about the house. An operation promised but little, yet it held out the only hope of relief. He was kept on a nourishing diet, the tracts kept freely discharging to prevent further burrowing. November 15th I operated with the bistoury, opened the fistulous tracts and scraped them thoroughly with a sharp scoop.

The large wound was then packed with oakum saturated with *calendula*. Little loss of blood occurred, and there was no secondary hemorrhage. Granulation began promptly, and a favorable result promised.

During his entire sickness he had used morphine freely to allay the pain. This habit he still persisted in against my earnest protest and with full knowledge of its unpleasant effects. Ten days after the operation, a violent attack of vomiting occurred, lasting several days. It was connected with an inflamed condition of the entire intestinal tract. The tongue was dry, very red, and covered with apthous patches, there was much soreness of the mouth and throat, the stomach retained but little nourishment, the alvine dejections became very frequent, offensive, liquid, and at times seemed chiefly muco-purulent. There was considerable thirst, and from two to four degrees rise of temperature. Rapid prostration followed, although the rectal wound continued to heal kindly and, at the time of his death, three weeks later, it was but a small point.

He had, in fact, regained entire control of the sphincter, and the slight point not yet cicatrized gave him no pain or inconvenience.

This case presents several interesting points for our consideration:

- 1st, the question of syphilitic infection from vaccination;
- 2d, the repair of wounds after a prolonged use of morphia;
- 3d, the repair of wound and constitutional dyscrasia, *i. e.* tuberculosis;
- 4th, tuberculosis intestinalis;
- 5th, multiple fistulæ and their surgical treatment.

## THERMOMETRIC RECORD OF PHTHISIS UNDER PHENIC ACID.—

By A. K. CRAWFORD, M. D.—*Case.*—A lady, fifty-five years of age suffered a very severe attack of pleuritis a year ago, which progressed rapidly to effusion, almost filling the left chest. Of course, while this lasted, the chest was distended, immobile, gave perfect flatness on percussion, and no pulmonary sounds were audible. Hemoptysis occurred several times, both the temperature and pulse kept elevated, and profuse sweats were oft repeated. It seemed pretty certain that the fluid contents of the pleural cavity were becoming purulent, and it was debated whether paracentesis should not be performed. But soon the signs showed that absorption was taking place, and the lung resuming gradually something of its old-time function. But the general health of the patient did not grow in a ratio corresponding with the decrease of the physical signs of empyema. After regaining her feet, she remained weak, pale, and decidedly cachetic looking. The cough which had persisted from the moment of the onset of the pleurisy, became dry, hacking, and tormenting, and not long thereafter, there was accompanying it a heavy greenish tinted sputum. The belief that the pleural inflammation had been of tubercular origin, was now being confirmed, inasmuch as the signs denoted rapidly progressing tubercular degeneration of the lung substance of the same side.

Nothing that was prescribed or done stayed the course of the malady a particle, nor was there any hope held out to the relatives that it would. Neither is it for the purpose of detailing the steps in the march of so universally fatal a disease that this brief report is made. But having instituted the phenic acid treatment in so advanced a case, and having noted one or two direct effects from it, I desire to place a record of the same before this Society. For weeks prior to beginning this treatment, the patient's temperature ranged from 101° to 103° F., and there was no remission to it. Whether taken in the morning, afternoon, or at night, the thermometer indicated the heat to be in the neighborhood of 102 and a fraction. Moreover, the condition of the digestive tract was ever becoming less capable of performing its functions. The bowels were torpid beyond recall seemingly, and the stomach refused absolutely to take food enough to preserve an infant's life. Days would go by, and only a few lumps of fecal matter, hard as baked pottery, would pass. The tissues through which such scybala passed must have been as dry as

though the body of the patient were already undergoing incineration. *Lycopod.*, *Bryonia*, *Nux.*, *Opium*, *Arsenicum*, drinking hot water and Hunyadi, giving enemata, as well as other remedies and means, were all tried in vain.

This then was the condition of our patient when the phenic acid was given a trial. The left lung was totally useless and perforated with cavities, the right apex was infiltrated and softening, and the morning on which the first dose was administered the pulse was 100, respirations 38 to the minute, and temperature  $102\frac{1}{2}^{\circ}$ . The iodo-phenique was used hypodermically, and the nascent phenique *per oram*; of the former, a full barrel of the D  clat syringe (80 m.), and of the latter three tablespoonfuls, were given each day, and this was continued without interruption for thirty-four days.

But for the professional aid tendered by Mr. Chris. Bollen, the arduous task of attending thus to a patient living at a considerable distance from the office, could not have been done by me with the promptitude, regularity and care which every detail received at his hands, nor could I have brought to this meeting this chart which has lined on it the daily record taken by him of the pulse, the temperature and the respiration.

In three days' time the morning temperature had dropped from  $102\frac{1}{2}^{\circ}$  to  $99\frac{1}{2}^{\circ}$ , and on the sixth morning it was normal, at which point it remained until the nineteenth day of the treatment. The evening temperature during this period ranged from  $100^{\circ}$  to  $100\frac{3}{4}^{\circ}$ , so that there was established a regular diurnal variation in the heat line. The continuous high temperature that had existed previously, was completely broken in upon, and the beneficial effect on the patient was quickly observed. The bowels resumed their normal duty, stools passed easily and were of good consistence. The stomach evidenced regained tone, and an appetite and relish for food was the result. The patient was without doubt looking better, feeling better and gaining strength.

What the Acid Phenique did not do was this: It did not lower the number of heart beats nor respirations. The one continued in the nineties, the other about 40 to 42 a minute. The fact is simply enough adduced, that while some functional improvement had taken place, the pathological condition remained unaltered.

Another apparent outcome of the continuance of the Phenique treatment, was, that from the nineteenth day on to the twenty-sixth,

a tertian element was developed in the fever. Each alternate day there was an exacerbation of the fever, and when the twenty-sixth day arrived, a decided chill was experienced, and the temperature rose to  $103^{\circ}$ , the pulse to 120, and the respiration to 48.

Without either a profuse sweat, a diarrhoea, or a discharge of pus anywhere, this septic flash subsided. But when toward the thirty-fourth day the same symptoms were threatening, it was deemed advisable to discontinue the acid entirely. Several weeks have passed since then and there has been no repetition of the chill, nor any need to return to the hypodermic, for the good dame seemingly still holds on to the benefit which accrued to her from its continued use before.

There is no doubt in my mind that the application of the phenic acid to this patient's case, gave her great relief from bodily suffering and prolonged her days.

*Discussion.*—DR. G. F. SHEARS.—In my experience with the use of phenic acid in various diseased states, other than phthisis, I have noticed the peculiarity of its action in regulating the bowels, just as the doctor tells us happened in the case given. It was particularly remarked in a lady patient who was slowly dying of recurrent sarcoma. The bowels were in a wretched dried-up state, and the phenic acid was used simply to see what it would do. The only benefit was the alleviation afforded them by securing perfectly healthy movements.

**THE DEATH OF PROF. H. N. GUERNSEY.**—Appropriate resolutions having been presented by a committee appointed for the purpose, DR. A. E. SMALL spoke as follows:

Forty-five years ago I first made the acquaintance of Henry Newel Guernsey, then engaged in teaching one of the public grammar schools of Delaware County, near Philadelphia. The following year he became a member of my family, and for several succeeding years was an intimate acquaintance of my household. He was a native of Rochester, Vt., and received his academic education at Royalton Academy in the same State. From thence he came into Pennsylvania, where for several years he was highly respected as a teacher. He applied himself closely to this honorable, useful calling; was industrious and self-sacrificing in the discharge of his duties; and won for himself an enviable reputation, as an efficient laborer in the cause of education. He was esteemed as a high-minded Christian gentleman, always exemplary, conscientious and faithful.

He commenced the study of medicine even before he had fully retired from his labors as a teacher. He made creditable progress in his medical studies, and after diligent and faithful study for more than a year, matured as a student in the Medical Department of Pennsylvania College, and by faithful attendance on a full course of instruction in this institution, he won the confidence and esteem of the various professors. His second course of lectures was taken in the Medical Department of the University of New York, and here honorable mention was made of his attainments by some of the distinguished professors. After a final and plenary examination, he received the doctorate from this college and returned to Pennsylvania. Soon after he settled in Frankford, near Philadelphia.

By some persons, Dr. Guernsey was regarded as extremely credulous. It is believed that this view of his character was far from being correct. He was gifted with a quick perception of truth, and when once it was enthroned on his convictions, he believed and practiced it with all his heart. When he read Hahnemann's Organon and became familiar with its doctrines, his assent was unreservedly in their favor. He regarded them in the light of a special revelation for the relief of suffering humanity, and as a matter of course, he was honestly and from the sincerest conviction, a strict Hahnemannian through life. His culture of therapeutics by constant association with Hering, Lippe, Williamson, and other members of the Homœopathic School in Philadelphia, inspired him with unlimited confidence in this branch of the healing art. His manifest sincerity and faith in the prescriptions which he made, inspired his patrons with confidence, and secured for him a large and lucrative practice. He was a member of the New Church (Swedenborgian) in Philadelphia, his pastor, the Rev. Chauncy Giles. His life was exemplary as a Christian physician, who believed that a strict devotion to religion could only be exemplified by faithfulness in his calling. Soon after he settled in Frankford, he was married to Miss Stalira Colborn, of Boston, with whom he lived as a useful and faithful helpmate, until she became a widow. One daughter, and two sons: Dr. J. C. Guernsey, of Philadelphia, and H. M. Guernsey, Esq., of New York, are left to sympathize with their widowed mother in her affliction, and it is eminently proper that we, of the Clinical Society of Hahnemann Hospital, should sympathize with them in their affliction.

After some further remarks by Dr. R. Ludlam, the resolutions were adopted and ordered to be placed on record by the secretary.



## Hospital Notes.

### THE SURGICAL CLINIC.

#### SERVICE OF PROF. SHEARS.

**ANCIENT SUBGLENOID DISLOCATION OF THE HEAD OF THE HUMERUS.**—This woman complains of pain in the right shoulder, loss of strength in the hand, and an inability to raise the arm, and only partial ability to move the arm forward and backward. Fifteen months ago she fell while cleaning windows, and struck upon the shoulder and elbow. Having pain in both shoulder and elbow she went to a dispensary, and was given a liniment for her bruises. Three weeks later, no improvement having taken place, she returned, and upon examination the arm was declared to have been broken, and splints were applied. No benefit was obtained, and now, after fifteen months of uselessness, she presents herself at this clinic.

Whatever may have been the difficulty of making a diagnosis of this injury in the past, there can be none at this stage in its progress. As the patient stands before you, the most careless eye will note the points of difference between the sound and injured shoulder, and draw therefrom the inevitable conclusion. Upon the sound side the deltoid region forms a perfect curve from above to the insertion of the deltoid muscle, the tuberosity of the humerus standing out beyond the acromion, so that this sharp process is not distinguishable from the tissues around it. On the other side the shoulder is abrupt and angular. The acromion stands out as a blunt prominence, beneath which is a prominent depression. As the patient sits before you the arm of the affected side stands out obliquely from the body instead of dropping in a straight line with the body, as is seen upon the opposite side. From the appearance alone—the cavity beneath the acromion, and the changed axis of the bone—we should judge the head of the humerus to be absent from its natural cavity, but this supposition is made a certainty as the fingers are thrust underneath the acromion process and there is no bone, and in the axilla is found a hard, round ball.

That this ball is the caput humeri is proven as we pass the fingers in a continuous unbroken line along the bone, from the condyles of the humerus to the globular mass in the axilla. Upon attempting to rotate while the head does not rotate, the transmitted force is readily felt. There is without a doubt a subglenoid dislocation of the head of the humerus, and while it is possible it might have been accompanied by fracture of the neck of the humerus, there is at present no evidence of such an injury having taken place. The responsibility then,

of changing this active self-supporting laboring woman into a helpless dependent rests upon him who made a false diagnosis.

At this late day, when all active inflammation has subsided, when the muscles have become atrophied and bony prominence marked, a non-recognition of the actual condition of affairs would seem impossible, but it must be remembered that at the time of injury many of the most marked symptoms are more or less masked by the swelling which so rapidly follows an accident to a joint.

Several of the diagnostic signs of this dislocation have been given in the review of the case before you, but it may be well to group them together, and add those which it has not been necessary to cite in this plain case. (1) A depression, or at least a flattening, of the shoulder below the acromion, with a prominence of the acromion process. (2) The head of the bone is found in the axilla. (3) The arm, measuring from the acromion to the condyle, is lengthened. (4) The elbow is held obliquely outward. (5) A rule laid on the arm from the condyle to the acromion touches both points. (6) When the hand is placed over the sound shoulder the elbow cannot be made to touch the breast. (7) There is no crepitus. (8) When reduced, the bone remains in position. What can be done for this woman? It is a commonly stated surgical precept, that after three months' reduction by ordinary means is usually hopeless. Successful results have been obtained within five or six months, and even later.

In this case, the patient now tells me that some six months after the injury, she visited one of our neighboring colleges, was given ether and the professor made an unsuccessful attempt to set the arm, probably to reduce it. With this history of non success and the amount of induration about the joint, simply extension and counter-extension, would probably be unavailing. There is great danger of rupturing the axillary vessels by making violent extension in old luxations at the shoulder. Several fatal terminations have followed this accident when force was applied. Under antiseptic precautions, the ligaments may be divided, the adhesions broken up and the head of the humerus returned to its proper position with a moderate amount of risk and a fair probability of making a useful arm. This is the treatment recommended. If nothing is done, what will be the result? In a majority of cases the ankylosis becomes perfect, and although the motion of the arm is restricted, it does not become entirely useless. Under normal conditions, there is a considerable amount of movement of the scapula and clavicle upon the trunk. In case of fixation of the head of the humerus, the motion becomes increased until in rare instances it seems almost impossible that there is ankylosis of the joint. In this patient's case, although the arm has considerable motion, you notice it is the result of the movement of the scapula and not due to the rotation of the head of the humerus.

**MYXOMA, MUCOUS POLYPUS OF THE NOSE.**—For some time, this young woman has been troubled by some obstruction in the nostrils which makes breathing through the nose a matter of great difficulty. She does not know exactly when this condition first commenced. For several years she has had a hyper-secretion of mucous, a constant sensation of fullness in the nose and more or less frontal headache. Of late, these symptoms have become more pronounced, the breathing through the nose being almost wholly obstructed. Her sense of smell is not as acute as formerly, and her friends note a peculiar nasal intonation to her voice. She takes cold readily, the slightest exposure being followed by a fit of sneezing and increased catarrh.

The symptoms in this case all point to nasal polypus, and a careful examination shows a dingy, bluish white mass, which fills the nostrils and proves an effectual barrier to the ingress and exit of air. From its color and translucent appearance, it can only be a mucous polypus or myxoma. As the probe is swept around the right nostril, the tumor seems attached to the superior turbinated bone, and examination of the left nostril shows a condition very similar. Of the various methods of treatment recommended, that by evulsion is as simple, and in most cases as effectual as any. The tumor is seized near its base with a pair of curved polypus forceps and twisted until torn out. The same treatment is successful in removing the remaining masses, and the patient is now able to breathe easily through the nose. The masses removed are clear and jelly like in appearance, having little or no blood supply. There is a tendency to a reproduction of these tumors in all cases, no matter how carefully the operation may be performed, and which only the destruction of the bone implicated will radically cure.

**EPITHELIOMA OF THE LOWER LIP.**—James A., aged sixty-one years. Three months ago this gentleman first noticed a slight thickening of the lower lip a little to the left of the median line, giving to the lip a pouting appearance, and to him a sensation of fullness. This thickening was very superficial, and was most noticeable at the junction of the skin and mucous membrane. In about a month the surface of the most protuberant portion ulcerated. Simultaneously the lip became the seat of sharp, lancinating pains. The induration gradually increased until the disease reached the mucous membrane. The patient has never had syphilis.

This disease is what is known as epithelioma or epithelial cancer, one of the malignant variety of tumors. Many authorities are inclined to believe that these growths are due to the irritation produced by smoking. The patient in this case is an inveterate smoker and says that he commonly holds his pipe on the left side; indeed his attention was first called to the swelling when pressing his lip upon the stem of his pipe. How much effect the habit of smoking

has upon the production of cancer it is difficult to determine, but it is an interesting fact in this connection that cancer of the lip in women is a great rarity.

There is only one form of treatment to be advised in this case, and that is immediate excision. At present there is no perceptible glandular enlargement, and it is probable that the submaxillary, which is the one most frequently effected, is not as yet implicated. This makes the chance of a cure much greater. Even if there was no hope of a cure, the same treatment would be advised, for statistics prove that the removal of the primary growth is always followed by an increase of life as well as relief from pain and distress. No other form of cancer is so frequently benefited by removal as the epithelioma, and especially the epithelioma of the lip.

An incision through the entire thickness of the lip is made on each side of the tumor extending from the prolabial margin toward the chin, where they meet at an acute angle, removing a V shaped piece which includes the tumor. The raw surfaces are held in exact apposition by three hair-lip pins. The restored lip is an improvement on its immediate predecessor, and when union takes place, will exhibit little or no evidence of an operation having been made. The pins will be removed on the third day. One week from the operation the union was complete.

**AMPUTATION OF FINGERS—TETANUS.**—*Case.*—German, aged fifty years. Three weeks ago he caught the little, ring and middle fingers in the cog-wheels at a mill, and sustained a severe, lacerated and contused wound. An effort was made by his physician to save the fingers, but without success, as you may see. The soft tissues are gangrenous, the bones splintered and necrosed. The fingers cannot be saved. Amputation is made through the second phalanx of each finger.

One week later the patient was in the clinic and the little and ring fingers were firm, the surfaces of the flap having healed by first intention. The middle finger was healing by granulation. On the eleventh day in the morning, the house surgeon was notified that the man was sick and could not come to the hospital. As the patient was reported as having convulsions, an immediate visit was made and the patient was found to be suffering from tetanus and almost moribund. He died in half an hour. The wound presented the usual appearance of a healthy wound. The union in the little and ring fingers was complete.

The history of the patient from the afternoon of the eighth day when seen in the clinic, at which time he was perfectly well, was given by his son as follows: The night of the ninth was excessively warm during the early part and the old man slept by the open window. During the night there was a pronounced change in the temperature and the patient became thoroughly chilled. In the morning he com-

plained of a stiff neck, and later on of a stiff jaw. During the evening he began to have convulsions, but as it was then night and he lived a long distance from the clinic, the son thought it best to wait until morning before sending for the doctor. Word therefore was not received until 10 o'clock the next morning, and by noon the patient was dead. The cause of the unfortunate complication is as in most cases of tetanus only problematical. It seems probable that the sudden variation of temperature and the consequent chilling of the patient was the exciting cause, but that it may have been due to some other condition cannot be denied. All authorities admit the important part which cold, and especially sudden variations in temperature, plays in the production of this disease, and many cases have been recorded in which tetanus has followed exposure.

**HYDROCELE, PHIMOSIS.**—*Case.*—James A., aged sixteen months. This child has, so the mother informs us, a rupture which has never been returned. She first noticed it about six months ago, at which time it was about the size of a hickory nut. Since that time it has about doubled in size. The tumor has never caused the child any pain nor is it sensitive to the touch. Upon examination a tumor, oval in form and about the size of a small hen's egg, is found, extending from the external ring downward. It is above the testicle, which can be readily felt at the bottom of the scrotum and entirely separate from this tumor, but if moved transmits an impulse to it. In feel it is tense, elastic and circumscribed. It is partially translucent.

This tumor is not the result of a hernia or rupture. There is no intestine contained in this enlargement. If it should be opened it would be found to contain a watery-like fluid. It is an encysted hydrocele of the cord. There are a variety of troubles in this locality, all of which have their distinctive characteristics, and yet which under certain circumstances may occasion some difficulty in making a diagnosis. Encysted hydrocele of the cord may be distinguished from simple hydrocele, congenital hydrocele, varicocele, cysts of the testes, and inguinal hernia. From inguinal hernia, which was in this case suspected, it is distinguished by its firm, tense feel, its translucency, its irreducibility, its lack of intestinal embarrassment, its union to the testicle, and its absence from the inguinal canal. The fact that it is irreducible is not of itself an objection to its being a hernia, but the fact that it has never been reduced, and that there is no history of pain, inflammation or intestinal embarrassment, in connection with its being irreducible, is evidence in favor of the character we give it.

Beside the hydrocele in this child's case, there is pronounced phimosis. In examining a case of hydrocele, or rupture, in a child, I always look to see if this condition be present, and in a large proportion of the cases that have come under my observation, accompanying the hydrocele or rupture, there is congenital phimosis. I am unable to say whether the irritation and straining during urination is the cause

of the hydrocele or hernia, or whether the two are associated as the result of non-development. The same causes which arrest the opening of the preputial orifice may prevent the perfect closure of the inguinal ring. At least non-development in one locality is frequently associated with non-development in another. I believe in this case the phimosis was the exciting cause of the hydrocele, the parts being congenitally weak. If the phimosis be overcome and the fluid be taken away from the hydrocele, there is little probability of its returning.

The fluid of the hydrocele was withdrawn by the aspirator, and the phimosis treated by circumcision. *Apis* 3. One month later the hydrocele showed no signs of refilling and the cure of the phimosis was complete.

**FISTULA OF THE ANUS.**—For many years this gentleman has suffered from constipation and hemorrhoides. Two years ago he began to have more pain than usual in the region of the perinæum, with a sense of fullness. Sometimes by pressing against the perinæum the uneasiness could be relieved. After exposure to cold, he had a hard chill. The region about the anus became very hard, inflamed and painful. A large abscess formed three-quarters of an inch from the anus, which eventually discharged. Defecation became painful, and at each movement of the bowels more or less fecal matter passed through the fistula. Sometimes it did not pass completely through, but lodged in the fistula. This condition caused great pain, and if the offending material was not removed at once, active inflammation supervened. More or less pus was constantly secreted and discharged, necessitating the wearing of a compress in order to protect the clothing. Upon examination an opening was found about three-quarters of an inch from the anus on the right side. Upon introducing the probe it was, with difficulty, made to follow the curve of the fistula and enter the bowel, at a point about one and one-half inches above the anus.

A director was made to follow the probe. A curved bistury was passed along the grooved director, until the point of the knife came in contact with the finger of the left hand, which was in the bowel. The knife was then made to cut its way into the bowel, the intestine being protected by the finger. The track was examined to ascertain if any sinuses lead from it, but none were found. The adventitious membranes along the edge were pared away with the scissors, and a thin tent, smeared with iodoform, inserted into the wound, and carried some distance into the bowel. A compress and a T bandage completed the dressing. In this case, although the sphincter muscle has been divided, there will probably be little trouble from paralysis of its action. The dressing was renewed daily until the wound filled up by granulation. In two weeks a cure had resulted.

## Miscellaneous Items.

Those who wish to know what a good chemist looks like will be gratified with the portrait of our colleague, Dr. J. B. S. King, Adjunct Professor of Chemistry and Toxicology, which heads this issue. —Correspondents will please remember that this is a clinical and not a controversial publication. —Seventeen hundred volumes have already been donated to the medical department of the Chicago Public Library. —Part II of the British Gynæcological Journal for July, 1885, is received. —For good locations for married doctors who are worth having, apply (with stamp enclosed) to Dr. G. E. Blackburn, Shreveport, La. —Dr. Thomas has located at Hadley, Minn., and is prosperous; do. Drs. A. G. Smith at Louisville, Ky.; L. W. Menzel at Horicon, Wis.; Geo. Fellows at Waukesha, Wis.; and J. L. Short at Rossville, Kan. —Dr. Clarence Munn, of Antigo, Wis., was recently married to Miss Adelaide E. Merrick. —The correspondent of the *Medical World* who wishes to know how to use bryonia in croup, will find what he wants in Teste's *Materia Medica*, and also in his work on Diseases of Children, both of which were printed about thirty years ago. —One of our colleges, with nearly forty teachers, men, women and children, still lacks a professor of Culinary Medicine. —Dr. G. E. Bushnell, House Physician of the Hahnemann Hospital, is off on a merited vacation. —Beside lecturing on the Principles of Homœopathy in the "Old Hahnemann" next winter, Prof. Small will give a course on Medical Jurisprudence. —"Last, but not least," the announcement and catalogue for the twenty-sixth annual term, 1885-86, in the Hahnemann Medical College and Hospital is out and ready for distribution. Copies of this very important document can be had by addressing the Registrar, Prof. E. S. Bailey, 3034 Michigan Avenue, Chicago. —Mrs. Dr. J. N. Wilkins has returned to Chicago and resumed practice at 199 N. La Salle Street. —*Homœopathy and its relation to the Germ Theory*, by Prof. R. N. Tooker, being the President's Address before the Illinois Homœopathic Medical Association, is a beautiful reprint from our neighbor the *Medical Era*. —Whoever loses his own address may consult the *Medical Visitor* for September. —Having passed the climacteric, the old N. A. Quarterly will come around every month in the future.

# THE CLINIQUE.

VOL. VI.]

CHICAGO, SEPT. 15, 1885.

[No. 9

## Original Lectures.

### *THE DISEASES OF THE ANUS AND RECTUM.*

BY G. A. HALL, M. D., PROFESSOR OF THE PRINCIPLES AND PRACTICE OF SURGERY IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL.

#### LECTURE II.

In continuing the discussion of the diseases of the rectum I shall take the liberty to make a few preliminary remarks, referring to some general rules to be observed in making a physical examination.

The first and most important duty on the part of the patient will be to have the bowels thoroughly evacuated. If they have been long constipated, and the time for examination is at your option, I deem it advisable to administer, twelve or eighteen hours prior to the examination, a mild but efficient cathartic, one which will cause the upper bowel to be emptied as well as relieve the rectum of its faecal contents. This being accomplished, a good and free enema of tepid castile soap suds should be administered just prior to the examination, and this should be followed by a slight enema of cold water.

The patient should be carefully catechised regarding the difficulty before you enter upon the examination. Question closely relative to the general habit of the bowels and the character and form of the stools. Learn whether they are large or small, round or flattened, oblong or nebulous, whether they are covered externally with mucous, blood or muco-purulent matter, and whether they have been addicted to discharges from the bowels varying from the natural excreta. Ascertain also the amount as well as the character of suffering; whether there is pain before, during or after defecation; whether there is much tenesmus or straining; whether there is a protrusion of the mucous membrane, or of any fleshy mass through the sphincter during the act of defecation, and, if so, is it vascular or sensitive to touch. If the



patient is intelligent and communicative it is best to allow him or her to make his or her own statement, or to give, in their own language, a history of the case before you proceed with the above interrogatives.

An examination of women is often difficult to obtain. Through fear or modesty they may fail to make a full confession of their symptoms, or they may not seek relief until their sufferings have become so great as to attract the attention of their friends. In extremely sensitive and delicate subjects I deem the use of anæsthetics proper, and in some instances imperative.

How shall we now proceed to make our examination? First, see that you have at your command the necessary instruments and appliances. Above all other things a good firm bed or table and a strong light are a necessity. I have used Archer's gynæcological chair, and have found it exceedingly satisfactory. It is about the right height when open, has stirrups for the maintenance of the feet, is solid and firm, and being placed upon castors is easily moved into any position desired. The light may be natural or artificial. Then we must have some small, soft surgeon's sponges with sponge holders, brushes with flexible handles, a rectal speculum, of which there are a great variety, and among which I would specially recommend Kelsey's and Helmuth's, a hard, three-cornered rubber pus pan, a fountain syringe or Kelsey's irrigator, a bottle of castor oil or cosmoline, a bowl of clear, warm water, and two competent assistants. The patient should be placed upon the table on the left side, with the body turned so as to rest upon the chest, with the right thigh flexed strongly upon the body, and the hip elevated at an angle of  $30^{\circ}$ .

If the sphincter is at all sensitive or rebellious, it should be thoroughly paralyzed before the introduction of the speculum. A digital examination should be first made, which, if conducted in a proper manner, will give little or no pain. If it is not properly performed, or if the finger is coarse and large, the suffering on the part of the patient is unbearable. See that the hand is well cleansed from all foreign matter, that the nail on the fore-finger is closely trimmed and the finger smeared with cosmoline or oil. Place the tip of the finger upon the anus and instruct the patient to bear down or strain, which they will not hesitate to do if the bowel has been thoroughly evacuated. During the act of straining, press the finger gently backwards and it passes through the sphincter upwards and forwards in the axis of the lower segment of the rectum. When through the sphincter its course changes backwards and upwards to the center of the sacrum. To the educated touch, a digital examination will reveal the true pathology of the rectum. It requires an extensive experience and frequent practice to enable one to "see" with the end of the finger, and to become familiar with the normal condition of the lower part of the bowel.

*Proctitis*, or inflammation of the rectum, is probably one of the most frequent maladies of the rectum. It may be idiopathic or traumatic and is frequently caused by the too free use of drastic cathartics containing aloes, gamboge and other irritants, or it may be caused by sitting upon the damp earth, stone steps or frosted timber. Frequently it is excited by constipation and impaction of the bowels, displacements of the uterus, the abuse of enemas, and the introduction of ice cold lotions. It is also caused by parasites, sudden colds, suppression of the menses and the introduction of foreign substances.

The symptoms announcing the presence of proctitis vary in accordance with the degree and extent of the trouble, As it is frequently a complication with other difficulties, so may the symptoms become complicated. If it is acute, we may have a sense of heat, weight, or a burning pressure, a feeling of dragging in the loin, a general uneasiness, febrile excitement, and in some rapid cases it is announced with a chill followed by dysuria or stranguria. Evacuation of the bowels is attended with tenesmus, and the stools are mixed with mucous or muco-purulent matter. A profuse leucorrhœal discharge which sometimes accompanies this trouble may mislead unless both passages are examined.

In chronic forms of this disease, the symptoms are less marked, and this condition may last for years. Diarrhœa may be alternated with constipation and there may be some heat or local pain with moderate tenesmus at times. In this form we are liable to have some constitutional disturbances. Digestion is impaired, the stomach is at times irritable, a dull frontal pain is felt in the head, there is vertigo and dizziness with pressure on the top of the head, there is a general malaise and a weak, "gone" feeling in the back, the urine is at times scanty and high colored, the patient becomes irascible and notional, and hypochondriasis may become a complication. In short, I have known patients suffering from this chronic malady to become entirely incapacitated for business, and a total wreck so far as happiness or enjoyment were concerned.

The following case is a good example of the disease: Mr. B., a farmer, æt. 45, while in the army in 1864, suffered from a severe diarrhœa, which was brought on by improper diet and exposure. He was treated with powerful astringents and opiates. Receiving his discharge, he returned home, where he slowly recovered from the severity of the symptoms, but there still remained chronic proctitis. Ten years later I was called to see him, and although he was a man of large frame and powerful physique, he had become a mere infant in mind on account of this protracted rectal trouble. He was full of apprehensions, and so irritable that he demanded the attention of his entire household to minister to his wants. An examination of the rectum revealed a thickened and turgescient state of the mucous membrane, which was covered with mucous extending up to the sigmoid flexure. There was some tenderness externally along the line

of the descending colon, and it was evident that this part of the canal was involved. Wiping off the surface of the rectum with cotton blood would ooze through, exposing a very friable state of the blood vessels, and during this maneuver he complained of pain and chills running up the back. His habits had become very sedentary, and for two years prior to my visit he had only walked once to the barn and back, a distance of about eight rods.

In the treatment of this case we found that the most difficult feature was to overcome his apprehensive state of mind, to inspire him with confidence in regard to his recovery, and to impress upon him the importance of making an effort to get out of such a rut. We insisted upon his going out every day, and, although reluctant at first, he soon began to enjoy riding about his farm and taking daily short walks. Fortunately his mind soon became engrossed with the importance of caring for some blooded stock which he possessed, and thus his mind was relieved of the burden of thinking of himself. The local treatment consisted in mopping out the entire rectal cavity with a five per cent solution of nitro-muriatic acid or nitric acid and muriatic acid mixed (equal parts), of which a five per cent solution was made. This was followed with enemas of warm flax-seed tea introduced through a long rectal tube. In four days we repeated the application of nitro-muriatic acid, following with enemas as before, and in ten days we found a large portion of the surface healed, but there were patches above the sphincter and on the posterior part of the rectum, which presented a red, irritable and granulated ulceration. A solution of permanganate of potash—one grain to four ounces of water—was applied to these surfaces once daily. Injections of flax-seed and hydrastis, morning and evening, were continued for one month. The surfaces appeared to be healed, but the mucous membrane was thickened, flabby, sodden and disposed to prolapse if the action of the bowels was in the least constipated. A decoction of rhatany root was used with the flax-seed tea once daily, filling the rectum and allowing it to remain. In a short time this had restored the tonicity of the gut so as to present nearly a normal appearance. The remedies used internally were *Sulphur*, *Mercurius cor.*, *Calcaria carb.*, *Aloes* and *Rhatany*.

Mrs. H.—, æt. thirty-four. Married ten years, and for three years an invalid. She had been treated for uterine affection, rheumatism and various other ailments. She was pale, wore an anxious look, suffered with constant backache and pain in the sacral region, extending down the thighs. Her bowels were usually constipated, but about every two weeks she would be taken with violent diarrhoea, with tenesmus. This would continue three or four days, and the bowels would relapse into a constipated state, and would continue so for nine or ten days without motion unless aided by enemas. Cathartics seemed to have lost their effect. She was melancholy and certain that she would never be any better. Upon examination we found

the uterus ante-verted, and the cervix resting heavily upon the sacrum; there was cellulitis and chronic proctitis; the sphincter ani was very irritable, and the mucous membrane of the rectum was dark red and sensitive to the touch. Introducing the finger into the vagina and pressing posteriorly the rectum felt like a large roll. Passing the bougie up the rectum we found the canal constricted about the middle of the lateral curve. The uterus was restored to its position and a stem pessary introduced to relieve the pressure upon the rectum. Under the influence of an anæsthetic the sphincter was carefully dilated sufficient to admit the hand, which was carried up to the point of stricture, and the canal was cautiously opened. The whole surface was then wiped out with glycophenic acid, and the rectum was packed with cotton saturated with Pond's Extract, four ounces, and fluid extract of Rhatany, half an ounce. After twenty-four hours this was removed, and with a rectal tube the parts were thoroughly irrigated with warm castile soap suds. This process was repeated daily for three days, when the packing was discontinued, the rectum was washed out with warm water and mild astringent lotions were employed regularly. Suppositories of hamamelis and rhatany were crowded up into the rectum every night. These were followed in the morning with a hot douche and a mild astringent enema. Under this treatment she rapidly improved, and at the end of six weeks her headache had disappeared, and in all respects she was much better.

*Inflammation of the rectum in children.*—I was called in the month of February, 1880, to see the family of Mr. J. I found his four little girls (the oldest eleven and the youngest four years) in bed, and the mother gave the following history: The morning previous they appeared at the table without appetite and complained of slight nausea and a feeling "so very tired." They made feeble attempts to play, but before 2 o'clock all had gone to bed with a chill, which was followed with high fever and pain in the back and loins extending down the limbs. She gave them aconite, and at midnight the fever subsided moderately. The following morning they were suffering with dysuria and a desire to go to stool often. The discharges were at first diarrhœic, but gradually became bloody and slimy. The front passage became violently inflamed and the leucorrhœal discharge copious, with a creamy consistency and an acrid character. The external parts, including the perinæum and anus, were covered with erythema, attended with a smarting and burning sensation. This was their condition three days after I first saw them. I ascertained that two days previous to their illness during the afternoon—the day being very warm—they were allowed to go into the backyard to play. Becoming heated and tired they sat down upon a stone horse-block for some time and partook of refreshments. To this act of imprudence we attributed the cause of the local trouble.

In the general treatment of such cases I have found it necessary

to use topical applications as well as internal remedies. Hot douches and bland or mucilagenous injections are of great value. The bowels should be kept soluble and open daily. Out-door exercise should be regularly taken, but protracted walks avoided.

*Abscesses and fistulæ.*—We have superficial and deep abscesses. The simple or superficial form involves only the integument at first, as the irritation starts from the friction of the clothes or the stoppage of the sebaceous glands. They resemble in their course a furuncle. A small inflamed point, which enlarges indefinitely will, if the patient continues to ride horse-back, or in any way increase the irritation, become very large, extend over the whole perineal surface, and dip down into the cellular tissue. When, from cause, there is rapid inflammation, suppuration is more active and pus burrows throughout the whole perineal surface, and then there are deep or diffused perineal abscesses.

When they remain simple or superficial, and their duration is limited, they are more sensitive and somewhat painful. However, a few days' rest on the part of the patient, a small linseed poultice applied locally, and *Belladonna* given internally, they will point, and then a free incision should be made. They should always be opened, for there is a probability, if allowed to open naturally, that they will become deep and diffused, and will have a fistulous track.

The deep variety differs from those just described in location, extent and gravity. The inflammation may begin primarily in the subcutaneous cellular tissue, or in the pelvi-rectal space, the recto vesical out-de-sac in males, or in the ischio-rectal fossa in either male or female. The causes of deep abscesses may be traumatism, a bruise from a fall, the passage of the foetal head, foreign bodies in the rectum, from extravasated urine in cases of rupture of the urethra, from hemorrhoidal irritation, or from obstinate constipation. They may arise from exposure, by sitting upon the ground or a stone when the patient is heated. They may be idiopathic from causes unknown.

The symptoms are those usual in acute or chronic inflammation. If the result of a blow, a fall, or a kick, there will be local pain and tenderness, painful defecation, headache and backache, and a rise of temperature. The symptoms will be acute or subacute according to the grade of inflammation. When the inflammation is caused by rectal irritation, foreign bodies, hemorrhoids, etc., the symptoms will be subacute. There will be a sense of heaviness of the parts, pressure and dull pain extending up the loins and down the thighs, dull headache, languor and depression and an inability to stand long at a time. A digital rectal examination will cause pain, and there will be increased tenderness and fulness in the region of the abscess, or where the abscess is forming. When the result of extravasated urine there will be the history of stricture or other urinary trouble. The patient may have a severe chill, followed by chilliness, alternated with fever, local pain, etc.

The diagnosis in these cases is generally not difficult if the physician will be particular and make a careful local examination. The prognosis will depend upon the accuracy of the diagnosis and the subsequent treatment.

The treatment must vary according to the cause, location and standing of the trouble. The supposed cause should be removed if possible, the inflammation should be controlled, the process of supuration limited, and an early and free outlet for the pus should be made. The risk and danger from these abscesses are greatly increased by delays, and the want of proper surgical attention after pus has formed.

Superficial abscesses should be evacuated early and thoroughly, thus preventing the deep burrowing of pus, which becomes the source of great annoyance and protracts the case indefinitely.

*Case.*—Miss O., æt twenty-one. During girlhood, she was always troubled with constipation and hemorrhoids, the external tumors being often very troublesome. After a protracted equestrian exercise, when she became very much heated, several little pustules appeared upon the surface of the perinæum and over the lower part of the labia. They went on to supuration and formed small superficial abscesses, which opened spontaneously. After these had disappeared a second inflammatory point made its appearance on the left side—anterior and internal to the tuber ischii. It dipped down and involved the deeper structure. Owing to her modesty she would not permit professional examination, but received treatment through the medium of her mother, who went to a physician and described the case. The pus burrowed in every direction, forming a diffused abscess, and after weeks of great suffering it was evacuated externally about one inch to the left of the inferior commissure. This gave her relief, but she was continually troubled with the offensive discharge, which had continued for five years up to the time of my examination in April, 1880.

I found an oblong opening nearly an inch in length and sinuses running from this in different directions, varying in size from two to four inches in length. One extended back to the ischio rectal fossa. The patient was etherized, and the opening enlarged sufficient to admit the finger. The walls or partitions were broken down, and with the curette the pyogenic surface was thoroughly scraped out, after which it was wiped out with a twenty per cent solution of carbolic acid. A five per cent solution of carbolic acid was used daily as an injection, and this was followed by a solution of rhatany, fluid extract, one drachm to four ounces of water. Her appetite and general condition improved rapidly. She received one dose of *Sulphur* internally daily, and the following remedies were also used at different times: Arsenicum alb., Mercurius, China, and Nitric Acid. At the end of eight weeks granulation had filled the cavities, but I found great difficulty in obtaining the proper external cicatricial formation on ac-

count of the friction of the parts in the act of walking. After four weeks of useless experiment, I found the obstinate and unhealthy granulations continued. I then made an oval incision on either side, embracing the entire length of the opening, and extending a line or more into healthy tissue. This left a clean, healthy and open wound. The sides were approximated and united with interrupted wire suture, it was dressed with the antiseptic dressing, and the patient was placed upon her back for ten days. At the end of fourteen days the parts were solid and firm, and the patient resumed her ordinary vocation. This case illustrates, *first*, the mischief which may be accomplished when we neglect what appears at first to be a superficial abscess; *second*, the necessity of removing all pyogenic surfaces the entire length of every sinus; *third*, the importance of establishing perfect drainage and healthy granulation; *fourth*, the difficulty which sometimes arises in obtaining cicatricial formation in this locality, where the parts are subjected to friction in the act of walking; *fifth*, the wisdom of converting such unhealthy granulating openings into an open and healthy wound and uniting the surfaces for the purpose of obtaining union by first intention.

The following is a case of deep abscess in the superior pelvic region: Mrs. S., æt. thirty-nine, of a combined scrofulous and bilious temperament, with dark complexion, black hair, deep-sunken grey eyes, heavy eye-brows and long eye-lashes, high cheek bones and thick lips, large head and small neck, five and one-half feet tall and weight 115 pounds. For years she had been troubled with constipation, and at times suffered with hemorrhoids. When about thirty-six years of age, as the result of a severe cold, she had catarrhal and enteric fever. From this she recovered slowly, and her rectal trouble was greatly increased. She used powerful cathartics and repeated enemas in order to sustain any regularity of the bowels. In a few months she was conscious of a heaviness and weight in the sacro-lumbar region. This would extend down the thighs, especially when subjected to the standing position for any length of time. Her digestion became impaired and there was a general depreciation of her health. These symptoms gradually increased in severity for two years, and were accompanied with a sense of fullness and tenderness in the rectum.

On one occasion during a warm day in September (the bowels having been unusually constipated for several days) she was obliged to walk and to be upon her feet for a number of hours in succession, when the pain became unbearable, and she was seized with a violent chill and excessive sacral and pelvic pain. After two weeks confinement to her bed she insisted upon her physician making an examination, when there was discovered a large and brawny swelling in the region of the right tuber-ischii. The whole ischial space and perineal surface of that side were distended, and there was discoloration at the acuminate point. A surgeon was called and the abscess was

opened, when there was a copious discharge of very offensive pus. This continued for some time, but her attending physician consoled her with the statement that it was a saving clause in her case, and that the pulmonary tendency which existed in her family would be averted so long as this abscess continued to discharge. Under this delusion she suffered this immoderate drainage up to the time of my examination in June following. I found her pale and emaciated, with hectic fever, stooped in form, the walls of the chest collapsed, a sepulchral voice and a nasty hacking cough, accompanied with slight expectoration. This condition of the lungs had made its appearance since the abscess was opened, previous to my examination. I found the abscess discharging two or three ounces of offensive pus daily. Her appetite was much impaired, and her bowels were alternately loose and constipated.

A probe, entered through the fistulous opening, was passed up by the side of the gut into the pelvic cavity, a distance of eight inches. With a double-bulbed syringe we injected eight ounces of carbolized water, showing the enormous extent of the cavity. The opening was enlarged sufficiently to admit an inch-glass vaginal speculum. Through this the cavity was filled with fine table salt, a tampon was placed in the outlet and allowed to remain twenty-four hours. This excited pain and inflammation, but it was effectual in destroying the pyogenic surface, which came away in shreds and a flocculent discharge. The parts were thoroughly irrigated with warm carbolized water and a solution of rhatany was used daily. Constitutional treatment was administered, and at the end of ten weeks our patient was pronounced convalescent. She began immediately to take on flesh, and at the end of six months had gained forty pounds. Her cough had disappeared, her form became erect, and she is to-day (eighteen years after our first acquaintance) a healthy and robust woman.

From the above cases you clearly observe that there is great latitude in the symptoms of abscesses as well as in the causes and their location. These are too numerous to mention; suffice to say that the symptoms are unusually pronounced, and no mistake should be made in their recognition.

Abscesses may give rise to fistulous openings, and this is frequently the case when they form in the ischio-rectal or the pelvi-rectal spaces. The opening is made artificially by passing a knife through the integument upward, external to and along the side of the gut a distance of two or four inches as may be necessary to strike the pocket of pus. This outlet will become fistulous, and its treatment should be a radical and free opening in order to obtain perfect access to the cavity, which should be thoroughly relieved of all pyogenic surface, and then packed with a four per cent solution of carbolized glycerine. After granulation is fully established I would use marine lint (picked up very fine) or absorbent cotton saturated with boroglyceride. This is to be removed daily, and the parts irrigated



with glycophenic acid solution or listerine diluted. In some cases where the granulation is inclined to be unhealthy, we have used permanganate of potash one grain to four ounces of water, or chloral hydrate ten grains to the ounce with good results. Calendula, Hydrastis, Rhatany, quarranna fluid extracts or Pond's extract will be found serviceable when there is a tendency to undue inflammatory action. These should be diluted with glycerine and water about one to twenty parts.

The patient should be perfectly nourished and the bowels should be regulated. Internally, remedies may be used according to their several indications: *Silicea*, *Sulphur*, *Hepar. sulphur*, *Arsenicum*. Mercurious and mineral acids are valuable.

Since the introduction of nascent phenic acid I have found it more serviceable, when administered internally and hypodermically, than any or all other remedies for restoring healthy granulation and limiting ulceration.

The different forms of fistulas, which appear primarily as such are of three varieties: the complete, the internal incomplete and external incomplete.

The external incomplete begins with a small inflamed spot in the cellulo-adipose tissue. When suppuration is established the pus burrows toward the surface and usually points at the margin of the external sphincter, or it may point anywhere upon the surface of the perineum. If opened or allowed to open spontaneously, pus will be discharged moderately, and a probe may be passed upward a distance of one or two inches. In these cases the opening should be made early and freely. If it is of long standing the same line of procedure is carried out, being careful to have the granulation begin at the base and work outward. If it is allowed to close externally at first, a second abscess will occur.

The internal incomplete fistula is excited by some foreign substance lodged upon the mucous membrane or upon the upper surface of the internal sphincter; as for instance, a small fish-bone or an apple-seed. This excites inflammation and suppuration. The first intrusion may be thrown off, but a second foreign substance is lodged in the same place and drills the hole a little deeper, and so a succession of local irritants may be received at this point until the ulceration has passed through the mucous membrane. The pus having now passed through into the cellular-adipose tissue, it is called an internal incomplete fistula. The great majority of these cases will after a time pass down through the loose texture and form an external opening and a complete fistula is the result. In other instances the fistula remains incomplete for a long time.

The symptoms which indicate this form of fistula, are local pain and tenderness in the vicinity of the sphincter which are worse at times.

While an abscess, caused by the presence of foreign substances,

is in progress, the parts are exceedingly painful and swollen, and the act of defecation is very troublesome, with a feeling as if the anus was blocked up. There will be a heaviness and dragging in the loins and sacral region, together with many other symptoms similar to proctitis. Whenever the bowels are moved, especially if they are very loose, the internal cavity or pocket becomes filled and very painful until, by the process of suppuration, the contents are thrown out.

Passing the finger through the sphincter when the abscess is full, we feel a semi-elastic nodule at the point. If the abscess has just been evacuated, we feel simply a soft, patulous and velvety spot at the internal opening. After they have drilled half way or more down to the external surface, an opening should be made externally to communicate with the internal cavity, thus converting the internal incomplete into a complete fistula. A probe bent in the form of a shepherd's crook passed through the sphincter into the gut, may be hooked into the cavity and its depth measured. It will also serve as a guide where to plunge the bistoury when an operation is necessary.

Complete fistulas, when the fecal contents or gas pass through (as they frequently do, and often as freely as through the natural outlet), become a source of great annoyance, though not so painful as the internal incomplete. Barring all discussion in regard to various theories and methods given for treating these sinuses, I wish to speak emphatically in favor of the open and free incision with the knife as the best, shortest and surest mode of treatment.

Operations have been performed which did not result in a cure; but this, we believe, is attributable to the fact that the pus had burrowed up alongside of the gut above the opening into the gut. In passing the probe through the sinus directly into the gut, it leaves a chamber above, which is not reached.

A probe should be first passed up through into the bowel, and with one finger inside of the gut you will recognize the opening into the gut, while a second probe should be passed up to the extreme upper end of the cavity outside of the gut, which will be felt by the finger inside, and the distance can be estimated from the extreme upper end of the cavity down to the opening into the gut. This distance may vary from half an inch to one inch or more.

In such cases the grooved director should be passed up the sinus as far as possible outside of the gut, and entrusted to an assistant. The long, curved, sharp-pointed bistoury is now passed up the director to its extreme point. The bistoury is then pushed through the gut until it is distinctly felt by the finger inside. The tip of the finger should be placed on the back of the point of the bistoury, and both should be brought down and out, thus making a clean cut throughout all intervening tissue. The line of incision should be as nearly as possible at a right angle with the sphincter, and it should pass through the fistulous opening in the gut. The old fistulous tract

should either be dissected out, or thoroughly scraped out. Then wipe it out with a forty per cent solution of glycerine and carbolic acid. Plegets of lint, saturated with calendulated glycerine, should be packed in the bottom for the entire length of the incision. Hemorrhage is sometimes copious, which will be controlled by this packing. This dressing may remain thirty-six or forty-eight hours, after which it should be removed daily, and the parts washed out.

The point desired is to obtain union by granulation, which should begin at the bottom of the wound and fill outward.

---

COCAINE IN PAINFUL DENTITION.—Dr. Kate I. Graves, clerk to Prof. Ludlam's Clinic, reports the following cases in illustration of the value of the new local anæsthetic in allaying the pain, and in relieving the reflex disorders of teething :

*Case 1.*—Boy, æt. ten months, had no teeth through, but the gums in front on both jaws were much swollen, very red and painful. The child was very restless, refusing to eat, letting go the nipple almost as soon as it was taken into his mouth, feverish, and having from ten to twelve stools a day, which were "green as grass," undigested, but not odorous. Internal remedies alone were given for two days with relief of some of the symptoms, but the diarrhœa was unaltered. I then directed the mother to bathe the gums twice, having an interval of one-half hour between the applications, with a four per cent solution of cocaine. After the second application the swelling was reduced, and the child was able to nurse. Six hours later the cocaine was again used freely. The next morning the report was that the child had passed a quiet night, the bowels were regulated and all the inflammation and swelling of the gums had disappeared.

*Case 2.*—Child æt. twelve months, the gums very much inflamed, sleepless, fretful, and having frequent undigested stools, attended with much colicky pain.

A four per cent solution of cocaine was directed to be applied to the gums by means of absorbent cotton. Four applications were made in a day. No internal remedy was given. A few days later the mother reported the child was perfectly well. The diarrhœa was cured, and the restlessness relieved, and this from the local applications alone.

# Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

SEPTEMBER MEETING, 1885.

The Society convened this month as usual at the Grand Pacific Hotel, Dr. C. T. Canfield, vice-president, in the chair. After the disposal of the preliminary business, the chair announced the Society's readiness to receive reports.

## A CLINICAL ANALYSIS OF ENURESIS.

BY C. E. LANING, M. D.

To fully comprehend the pathological conditions arising in any organ or tissue, necessitates a previous knowledge of the physiology of such structures. We will therefore glance over the physiology of the bladder so far as the immediate act of micturition is concerned.

*Physiology of micturition.*—This is an act which under normal conditions is more or less modified by the action of the will, yet nevertheless is capable of taking place without calling forth any cerebration. In the lumbar medulla is located a center exclusively automatic in its action, the so-called center of micturition. From this center to the bladder pass motor paths, to it, from the bladder, sensory ones. A sufficient quantity of urine having accumulated in the bladder to give rise to the desire to evacuate it, an impulse is transmitted through the afferent sensory nerves to the lumbar center, and from there through the efferent motor nerves is sent out an impulse which relaxes the sphincter vesicae and causes the detrusor urinae to contract and thus expell the contents of the bladder.

This then explains the function of the center of micturition so far as mere automatic action is concerned. Passing from this center to the brain, is a nerve-path through which the sensation known as the desire to urinate, is transmitted. This sensation having reached the brain, urination may at once take place, or, through an effort of the will, an inhibitory impulse may be sent down through certain afferent fibres of the cord, which prevents the center in the lumbar medulla from responding to the stimulus received from the bladder. This mechanism, while comparatively simple, may nevertheless become deranged in such a manner as to make the pathological conditions resulting at times quite obscure.

*Enuresis* is a symptom which while of frequent occurrence, is but little understood as regards its lesions and pathology. True, it

is an affection which in most cases assumes no greater gravity than that which arises from the oftentimes extreme annoyance attendant upon it. Yet its pathology is quite intricate, and its treatment often a difficult matter. By studying carefully each case or class of cases, no matter how simple they may be considered, we not only gain an insight into them, but become possessed of facts which help materially in the elucidation of more difficult and important medical problems.

*Its pathological factors.*— Let us first familiarize ourselves with the organs or structures which are involved in the production of the symptom, enuresis, for it can certainly be called nothing more than a symptom.

These are the *bladder, kidneys, spinal cord, brain, stomach and rectum.*

Next let us study the general character of the lesions affecting these structures in such a manner as to produce enuresis. The lesions of the bladder which may and often do give rise to it are *atony, hypertrophy, catarrh, acute or chronic.* The peripheral nerve lesions are *hyperæsthesia of the nerves distributed to the region of the trigonum vesicæ, hyperæsthesia of the nerves of the fundus, paresis of the motor nerves of the sphincter vesicæ, paresis of the motor nerves of the detrusor vesicæ.*

Central nerve lesions coming more properly under the head of the brain or spinal cord will be mentioned under those headings. First, then, let us study the manner in which the pathological conditions above mentioned give rise to the special symptom under discussion.

*Atony of the bladder* causes an involuntary evacuation of urine for the following reasons: The contractile power of the detrusor being almost or entirely abolished, the urine accumulates in the bladder until the resistance of its walls to further distension, is greater than is the resistance of the sphincter vesicæ. At this moment the sphincter relaxes, and a small amount of urine is voided. It is to be remembered, however, that the detrusor takes little or no part in this evacuation, it being caused simply by the elasticity of the tissues of the bladder, not true muscular contractility, and also by the pressure accruing from the more or less continual influx of urine from the ureters. As soon as the pressure is reduced by the passing of urine, to a point less than the natural tonicity of the sphincter, that muscle contracts, and for a variable length of time no urine is passed.

The frequent passing of small quantities of urine, which occurs in this lesion, must be distinguished from those cases in which hypertrophy of the bladder, or some affection of the trigonum vesicæ exists. How shall we distinguish between them? If it is atony, there will be a history (unless congenital) of a more or less gradu-

ally lessening of the control of the function of the bladder, urine being passed more frequently and in smaller quantities as the disease progresses. Moreover, the urine almost invariably has an offensive smell, ammoniacal or putrid, due to the alkaline fermentation having taken place as a result of its long stagnation in the bladder, as well as to the fact that the mucous membrane of that viscus has become involved, either on account of the abnormal urine which is constantly in contact with it, or as an outgrowth of the primary lesion which produced the atony. It is not to be lost sight of that atony in the proper sense of the term applies to those cases only in which there is degenerative changes of the muscular apparatus of the bladder, not due to nerve paralysis.

Other points which would assist in making a differential diagnosis might be given, but it is unnecessary to notice them here, since a diagnosis may be made of atony in a very positive and simple manner. After the patient has voided all the urine possible at a given time, introduce the catheter, letting it serve the double purpose of catheter and sound.

If a case of atony be present, not only will a considerable quantity of more or less highly offensive urine pass through the instrument, but if pushed in until it has reached the opposite wall, or top of the fundus, it will be found to be enlarged to a very decided degree, depending very much upon the duration of the disease.

*Case.*—I will give a case illustrating this form, which, so far as my observation goes, is quite rare among children, being an affection most frequently found in aged persons. In the case about to be given, the patient was a girl ten years of age. She had had no difficulty whatever with the urinary organs, so far as her mother knew, until she was nine years of age. At that time she attended a picnic, and partly on account of neglecting nature's demands when she had an opportunity to satisfy them, later because she had not the chance to do so, or at least fancied such to be the case, the bladder became distended to such a degree as to cause great pain, and to have become so nearly paralyzed by the unnatural stretching of its walls, that not until hot fomentations had been applied over the hypogastric region, and various other artifices made use of, did she succeed in emptying it.

Although such conditions are not of infrequent occurrence, especially among young girls, still they seldom terminate as did this one. From the time mentioned, she began to have trouble in the evacuation of the bladder. If she retained the urine a short time after the desire to void it was felt, she was very liable to have more or less difficulty in getting the detrusor to contract. Without entering into unnecessary details, suffice it to say that in less than six months from the date of the first difficulty mentioned, she had lost entirely the control of the bladder.

She had been treated by physicians of both schools at irregular

intervals for several months. She had had, however, no medical attention for about six weeks previous to my first seeing her. The case then was as follows: Evacuation of (generally) small quantities of urine involuntarily from every fifteen minutes to an hour, rarely going two hours. The urine was quite offensive, and deposited large quantities of mucus sediment on standing. The child, from a plump, rosy cheeked lass, had become scrawny and colorless, or rather of a muddy, dingy complexion; almost constantly complained of a headache, of a dull, stupifying character. The tongue was generally loaded with a dirty, yellowish coating, the tongue, mouth and fauces usually being dry. The appetite was almost *nil*, though occasionally she would eat quite heartily, after which she would almost invariably complain of nausea, and frequently would vomit what she had eaten in a more or less imperfectly digested condition. The bowels were obstinately constipated. She was listless and apathetic, taking little or no interest in her surroundings, which were of the most pleasant nature.

Such, then, was the picture of the case when I first saw it. I am free to confess that had I not seen a few similar cases before, albeit they had occurred in adults, I should most probably have been sorely puzzled to have arrived at anything satisfactory in the way of a diagnosis, pathology, or treatment of the case. And without a knowledge of the two former all attempts at treatment must have been at the best but little better than guess-work, for to have relied solely upon symptomatology in such a case would be pure folly. Having suspected from the first the nature of the difficulty, after having made myself acquainted with the subjective and objective symptoms already given, I exposed the hypogastric region, in which was found by palpation a tumor which corresponded in position and shape to a distended bladder. Upon exerting a downward pressure upon this, a considerable quantity of urine was passed of the nature already described. I then introduced the catheter and drew off a large quantity of very offensive urine. The child, who up to this time had been in almost a semi-stupid condition, evincing little or no interest in what was transpiring, almost instantly brightened up and said, "how much better my head feels."

Of course, there was no further question as to diagnosis. The case had previously been diagnosticated variously, one physician having stoutly maintained that it was one of atrophy of the bladder, his diagnosis presumably being based entirely upon the fact of the urine being passed frequently and in small quantities. Nothing could be easier than a differential diagnosis between atrophy of the bladder and atony of that viscus.

The cause of all the symptoms were now plain enough. Not only was there imperfect elimination of the substances which are normally carried out of the system by the urine, but there was undoubtedly a constant resorption of the contents of the bladder

taking place. The headache, the heavily coated tongue, the lack of appetite and wasting, all were accounted for. The thirst was evidently of a proximate and not of a primary nature. The effete matters retained and absorbed into the economy produced dryness of the buccal cavity through their action upon the secretory fibres of the sympathetic, at the same time causing a constant hyperæmia of the mucous membrane of this cavity and the pharynx. The stomach suffered in general with other organs not only through the vitiated condition of the blood, but also through the irritation conveyed to it by way of the hypogastric plexus, which gives the nervous supply to the fundus of the bladder.

Having gained thus much knowledge of the case, the next important question was how to cure it. Taking into consideration the atrophy of the muscular fibres, and the cause thereof, virtually a strain, I concluded to give *Rhus tox.* which I accordingly did; in the third decimal on cones, two cones four times a day. The condition of the mucous membrane of the bladder certainly needed attention. It is not the time or place to enter into the vexed question of alternation, suffice it to say that I believe there are cases in which it is equally if not more skillful and scientific to give two remedies than to rely solely upon one. Understand me, I do not mean in cases where the physician is at a loss as to which of the remedies to give, so gives both, but where different tissues are involved, or where a single tissue is affected; but at one point in one way and at another in a different manner, so that one remedy does not cover the pathological condition, and consequently does not the symptoms. Feeling I had such a case in the one under discussion, I gave, in addition to the *Rhus*, *Chimaphila* 3x on cones, night and morning. While there was, at the time of first seeing the patient, no evidences of surgical kidney, so apt to complicate such cases, I nevertheless felt that the condition of the urine, which was such as generally leads to the kidney lesion referred to, needed correcting.

The *Chimaphila* seemed to have a very beneficial effect upon the mucous membrane, and through this upon the urine, so that in the course of a week both were in much better condition than when treatment was commenced. The catheter was used every day, for the bladder, as yet, of course, had no power to empty itself. It is unnecessary to follow the case step by step; suffice it to say that a persistence in the use of the *Rhus*, in the course of six months, had virtually completed the cure.

*Hypertrophy of the bladder*, though of rare occurrence in children, does sometimes occur. It not only may produce enuresis nocturna, but also cause a greater or less difficulty in the retention of urine during the day; in fact it more usually manifests itself in the latter way.

In what manner does it produce this difficulty? It is, of course, understood that the desire to urinate is caused, normally, by the ac-



cumulated urine irritating, or at least affecting the sensory nerves distributed to the bladder, after which it is emptied in the manner already described. When hypertrophy takes place, an abnormal pressure is exerted upon the peripheral nerve filaments, which gives rise to a sensation similar to that resulting from a distended bladder. As a result of this there occurs in hypertrophy the symptom, frequent desire to evacuate the bladder, which immediately feels as if full again, the desire to empty it at once returning. This gives rise to a fruitless straining, which not only gives no relief, but aggravates the hypertrophy just as an hypertrophied heart is made worse by anything which tends to increase the force or frequency of its contractions. This tenesmus vesicæ is caused in a manner analogous to tenesmus recti, in which the swollen mucous membrane, by its pressure upon the filaments of the pudic, distributed to it, causes a frequent desire for stool.

*Case.*—I once saw a typical case of this kind in a boy eight years of age. It had been caused by an elongated and almost imperforate prepuce. This not only by offering a resistance to the flow of urine, and thus taking the expulsive power of the bladder, was an efficient cause in the production of the lesion, but also by producing a frequent desire to urinate, reflexly through the irritation of the glans penis. Before the case came under my charge, the redundancy of prepuce had been removed by a surgeon.

While the primary cause of the difficulty had thus been removed, the bladder lesion, which had resulted from it, did not disappear. The little fellow was not troubled at night, but during the day was more or less constantly tormented with the desire to urinate. This was not, however, involuntary, unless he was obliged to retain it for some time after feeling the desire, when the urging became too great to be resisted. While, therefore, he would pass the entire night without any difficulty, he could seldom go over an hour during the day, and often not that long.

How was this fact to be accounted for?

Very easily; and in explaining this we also explain another class of cases, which, while they have a different pathological basis, nevertheless, have many symptoms in common. In this case the inability to retain the urine beyond a short time was not due to any paresis of the sphincter, but simply to the *intolerable desire*, which set up so powerful a reflex action as to entirely overcome the restraining influence of the will.

The sensibility of the entire nervous system is diminished during sleep—a sort of normal anæsthesia takes place. The sensory nerves of the bladder are not exempt; in this case, then, sleep diminished the sensibility of the afferent nerves of the bladder to at least a point equal to that which they should have normally during waking hours. This diminishes the abnormal desire felt during the day to such a degree, as to allow the bladder to become full without stimulating the

lumbar automatic center sufficiently to cause contractions of the detrusor urinæ. This little patient, who was an intelligent, manly little fellow, was able to give me some subjective symptoms. He complained of the constant desire, and said he often felt the desire in the abdomen, placing his hand over the spot which corresponded to the hypogastric plexus. This was simply a transmission of the sensation to that plexus through its filaments, which are distributed to the fundus of the bladder. This is analogous to the *Phos. acid* symptom in which nausea, ordinarily felt in the stomach, is reflected through the vagus to its peripheral filaments which enter into the composition of the pharyngeal plexus, the nausea therefore being felt in the throat.

Sometimes such a reflex storm was set up as to cause sharp radiating pains throughout the abdomen. Guided by the fundamental lesion and the reflexes arising from it, I selected *Eupatorium purp.* as the remedy. This I administered in the third decimal dilution, on cones, two, four times a day. Although I presume the organic change which had taken place in the bladder was not lessened, it was in such a way modified as to give the patient relief from the tormenting tenesmus vesicæ with which he had suffered so long, and thus virtually a cure was made.

*Catarrh of the bladder*, though by no means always affecting the act of urination, may at times. It does so in a manner so similar to hypertrophy, that it is unnecessary to enter into detail regarding it.

*Acute and chronic cystitis* of course will affect the quantity and quality of the urine, as well as the frequency of passing it, but in such cases the urinary symptoms are so clearly secondary upon the bladder lesion, and the character of it is so evident, that the subject should be treated of under the heading of cystitis rather than enuresis, though it is well to bear in mind that it is an occasional cause of that symptom.

We now come to speak of the nerve lesions which give rise to enuresis. These are the most difficult to diagnosticate or cure. First we will speak of *hyperæsthesia of the nerves distributed to the region of the trigonum vesicæ*. Enuresis is very frequently an outgrowth of this pathological condition. We are treating of this hyperæsthesia in the light of a pure neurosis, not an irritability due to a localized cystitis or vesical catarrh, nor yet from the presence of a calculus. How shall we distinguish between these? In the pure neurosis, there is not present the pain of cystitis, nor the tenesmus vesicæ of that lesion. The urine does not, upon examination, show evidences of a catarrhal condition of the mucous membrane as in a case of cystic catarrh. The symptoms of stone are all absent with rare exceptions, of which we will speak later on.

Enuresis occurring from the neurosis above given, takes place only as a rule, during the day, similar in this respect to enuresis result-

ing from hypertrophy of the mucous and muscular coats of the bladder, the similarity being increased by the fact that in both cases the urine is passed frequently and in small quantities.

In the hyperæsthesia, as soon as a small quantity of urine has accumulated in the bladder, its irritant action upon the unduly excitable nerves, causes such an intense desire to urinate, that, although the sphincter vesicæ is in a normal state, its natural tonicity, together with what re-enforcement it may receive from the will, is overpowered, and evacuation takes place. In the case of infants and children, particularly in that of the former, the influence of the will, as a factor in the expulsion or retention of the urine, is almost *nil*, the act in such cases being probably entirely carried on by the automatic center in the lumbar medulla. It is often, for this reason, quite difficult to determine whether passages from the bowels or bladder are, in the strict sense of the term, involuntary.

In such cases then, the inability to retain the urine, is due almost altogether to the intensified desire. Such patients very often are not troubled with nocturnal enuresis, for, there being no derangement of the motor nerves distributed to the sphincter or detrusor, there is no obstacle to the retention of urine, outside of the abnormal desire, which becomes so diminished under the influence of sleep, as has already been shown, as to no longer act as a factor in causing involuntary micturition.

The next form of enuresis, is that in which there is present :

*Hyperæsthesia of the nerves of the fundus of the bladder.*—In such cases there is present much the same condition as has been found to exist under hyperæsthesia of the nerves of the base of the bladder, that is to say, the desire is intensified. But in the form now under discussion, instead of small quantities of urine being passed, a considerable quantity is evacuated each time. The reason for this is obvious. The nerves at the base, those from the sacral plexus, are in a normal state, therefore the contact of urine with them produces no unnatural effect, but so soon as it rises to the level of the zone supplied by the irritable nerves, a veritable nerve storm of desire is set up, which hastily terminates in an evacuation of the bladder. Until a considerable quantity of urine has again accumulated, the patient shows or feels no evidence of a vesical lesion.

As I have previously stated, in infants or very young children, it is impossible to say whether they make any effort to retain the urine or not, after the desire to void it is felt. If this could be ascertained, it would clear up an essential point in the pathology as well as treatment. For this reason then, in such patients, we are utterly unable to follow out the pathology in detail, and our prescription must be more or less of an experiment. In such cases, as in many others indeed, the obscure points in the pathology may often be cleared up by the use of drugs, based upon a knowledge of their physiological action.

To illustrate. I have seen and known of several cases in which an inordinate desire to sigh was present. The term sigh, hardly expresses the idea, for at almost every breath the patient not only desired, but was apparently forced to take a sudden, full inspiration. *Ignatia* was of course suggested at once, as well as *Lactucca verosa*, neither had any effect. It was clear it was some lesion involving the vagus, but where was it, and how did it affect that nerve? If it had been a central lesion, one in the corpora quadrigemini, *Ignatia* would, undoubtedly, have relieved and cured it. Was it then the peripheral filaments of the vagus distributed to the air vesicles? It was easy to see. If at this point, or in fact, wherever it might be located, it was an irritative, not a paretic lesion. To ascertain then, whether it was an affection of the pulmonary filaments of the vagus or not, required only a drop or two of *Veratrum viride*. The action of this drug is to paralyze the peripheral pulmonary filaments of the vagus. A small quantity then of the drug would be sufficient to reduce the irritability of these twigs to a normal standard, and at once abolish the inordinate desire for a long breath. This it did, and at once located the lesion and determined its character. It is through this action of the drug that it cuts short so often, asthmatic attacks of the "nervous" type.

In this way then, may drugs be made to serve, virtually, the place of delicate instruments, which enable us to make more accurate and scientific diagnoses, especially in nervous affections.

At another point I will refer to this subject again in connection with the neuroses of the bladder.

We will now take into consideration those forms of enuresis due to paretic conditions of the motor nerves of the bladder.

*Paresis of the motor nerves of the sphincter vesicæ.*—According to the degree in which this is present the urine is passed more or less frequently up to the point where, as a result of complete paralysis, it is constantly dribbling away. In cases where only paresis is present, the involuntary evacuation results from the simple fact that, after a certain amount of urine has accumulated in the bladder, the weakened sphincter gives way, and this too sometimes before there has been felt any desire to void the urine. Again, the sphincter may retain a sufficient degree of its natural tonicity to allow enough urine to collect in the bladder to give rise to the desire to pass it, but for the reason that the inhibitory influence which is conveyed to it from the lumbar medulla, as well as that from the will, can only be imperfectly transmitted on account of the paretic state of the filaments of the pudic nerve supplying it, it yields to the first reflex impulse of desire regardless of time or place.

*Paralysis of the motor nerves of the detrusor urinae.*—At first glance this would hardly seem a cause of incontinence of urine, since it abolishes the power of the bladder to empty itself. While

it is true it does away with the power to evacuate the bladder in a normal way, it induces a condition similar to that resulting from atony. The detrusor cannot contract, and therefore the only expulsive power which can be brought to bear is the contraction of the abdominal muscles and the pressure of the accumulated urine. When the sphincter vesicae is intact, and receives its normal degree of nerve stimulus, it is capable of supporting or resisting a column of water twenty inches high, but when paralyzed, *i. e.* the nerve supplying it, it can only resist the pressure exerted by a column of water six inches high. This would seemingly show that the muscular fibres composing the sphincter possess an inherent contractile power independent of that which results from nervous influence. Undoubtedly though after it has for a long time been subjected to pressure as in a chronic case of paralysis of the detrusor, its powers of resistance are weakened, and it yields to a pressure which in the earlier history of the disease would not have affected it. Patients affected in this way pass the urine involuntarily and often without knowing a passage is about to take place until some of the urine is felt in contact with the membranous portion of the urethra. In the first stages of this lesion, the patient is often tormented with an almost constant desire to void the urine, for since the expulsive power of the detrusor is lost, there is always a quantity of urine within the bladder sufficient to give rise to the desire to pass it. After a time the constantly irritated nerves lose to a great extent their sensibility, so that no desire whatever may be felt, only when the bladder is unusually distended.

This completes the lesions giving rise to enuresis so far as the bladder is concerned, leaving out of course, surgical diseases of that viscus, as vesical calculi, tumors, etc.

We will now turn our attention to spinal lesions which may give rise to, or permit enuresis, for as we shall see both classes of lesion may exist.

*Spinal lesions which permit rather than cause enuresis.*—If the fibres which pass up the cord to the brain, whose function it is to convey to that organ the sensation of desire to urinate, be in a paretic state, or completely paralyzed, and this latter condition may exist, I am led to believe, without actual organic change having taken place, involuntary urination must, as a natural sequence, occur. As has been seen, the center in the lumbar medulla is capable of producing an evacuation of the bladder at regular intervals without any assistance or restraint on the part of the brain. The lesion, lying between the lumbar medulla and the brain, does not, of course, prevent the transmission of the desire to urinate, to the lumbar center, whereupon a reflex motor impulse is sent out, causing contraction of the detrusor and evacuation of the bladder. In this case the involuntary urination is due to the fact that the patient, as a result of the desire not being transmitted to the brain, does

not know that an evacuation is about to take place, which he could restrain if not for this fact, the ability of the brain to re-enforce the contractions of the sphincter being not in the least diminished, neither is there any defect in the conducting fibres which transmit it, but such an impulse being only sent out through an effort of the will, is absent for obvious reasons.

In such cases the bladder is not emptied very frequently and at quite regular intervals, depending, of course, upon the conditions affecting the patient, whether they favor activity of the kidneys or not; in short, it is emptied only when moderately full; as a consequence such patients pass a considerable quantity of urine at each evacuation, and frequently only void it once, or at most, twice during the night, or indeed, may not do so at all during that time, they generally being troubled the most during the day.

*Lesions of the cord.*—The next form we will consider is that in which, while the desire may be normally conveyed to the brain, the fibres passing from the brain to the lumbar medulla, through which the impulse descends which prevents the relaxation of the sphincter until it is desirable, are paralyzed. In patients so afflicted, while they are perfectly aware of the fact that the bladder is about to be emptied, they are nevertheless entirely powerless to prevent or retard the act from taking place.

Either of the conditions just described may result from a number of lesions, into the details of which we will not enter, for at present we only wish to speak of functional lesions. Therefore, we shall not take into consideration affections of the vertebræ or membranes of the cord which by affecting it secondarily might involve the fibres referred to. Idiopathic lesions of the cord may obviously bring about like results.

*Lesions of the brain* which give rise to enuresis may be twofold in character. First, there may be such a condition of the cells whose function it is to receive and take cognizance of the desire to urinate, that they fail to perform their duty. This is, of course, so far as observable results are concerned, the same as paralysis of the fibres in the cord which convey the sensation to the brain, and in our present state of knowledge it is difficult to distinguish between them. Again, the cells, whose duty it is to generate the impulse, which passing down the cord causes the sphincter to remain contracted, may not be capable of generating such impulse. Here again, we see two distinct lesions producing identical results, viz.: the cerebral lesion just referred to is not to be distinguished from a paralysis of the conducting fibres of the cord, whose function it is to convey the cerebral impulse to the sphincter.

On the other hand, enuresis especially nocturnal, may be caused by a cerebral lesion of an entirely different character. Certain irritative lesions of the corpora quadrigemini, and of the center of

poly-uria in the floor of the fourth ventricle may give rise to it, by simply increasing to a great degree the quantity of urine secreted.

In children the reflex mechanism being so much more highly developed than in the adult, or at least void of the restraining influences which exist in the adult, intensify all reflex acts to such an extent as to sometimes almost make them appear to be due to some other cause. This being true, the fact that evacuation of the bladder during sleep is entirely a reflex act, renders it more liable to occur in the child than the adult, and from a much slighter exciting cause. Therefore, when we place in conjunction, the increased secretion of urine already accounted for, the sound sleep of the child, and the exaggerated reflexes which are normal to such patients, we at once see that this is a combination of circumstances which must almost inevitably lead to enuresis. As I have said, it is almost always nocturnal, for the child, if old enough, can express its desire, and at the same time control itself to a certain extent during waking hours.

The differential diagnosis of the two brain lesions spoken of can only be made with the greatest difficulty, and that often only through the assistance of drugs in the manner already described.

*Lesions of the kidneys which may give rise to enuresis.*—These are of such a nature as to either produce an increased flow of urine or to change its character in such a way as to render it more or less of an irritant to the bladder.

The only condition or lesion perhaps, which is in the strict sense of the term confined to the kidneys, which may increase the watery constituents of the urine, is an affection of the epithelial cells lining the *tubuli uriniferi*. It is true, increased pressure in the *glomeruli* may increase the amount of the fluid portion of the urine by increasing filtration, or on the other hand a raising of the pressure in the capillaries formed by the breaking up of the efferent arteries, may augment the quantity of urine passed from the kidney by interfering with the resorption of the fluid secreted by the *glomeruli*. These conditions, however, are generally dependent upon some influence outside of the kidneys.

To return then to the epithelium. That they do not only absorb and return into the circulation albumen, but also a portion of the water which had been filtrated into the *glomeruli*, is beyond doubt. There are many reasons for ascertaining this; among them the evidence gained from comparative physiology. Among those animals which secrete a solid urine, as is true of the ophidians, to which belong snakes, etc., at the point where the uriniferous tubuli emerge from the *glomeruli*, the urine is in a fluid state, but as it passes down these tubes the epithelial lining thereof takes up the watery elements and returns them to the vascular system, so that when the urine passes into the pelvis of the kidney it is in a semi-solid state.

That these cells may be functionally deranged there can be little or no doubt, in such a way as to increase or diminish the liquid portion

of the urine, so that although no more than is normal be filtrated into the glomeruli, there is, nevertheless, an abnormal amount reaches the bladder, producing, or tending to at least, enuresis in the same way the brain lesions last referred to, do.

*Paresis of the renal splanchnics*, may by increasing the quantity of blood passing through the glomeruli in a given time, increase the quantity of urine, and produce an effect upon the bladder identical with that of the last three lesions treated of.

A differential diagnosis in this case can be made only by the use of drugs so far as I know. Sometimes reflex symptoms will assist but cannot be relied upon.

*The stomach and liver* may cause or materially assist in the production of enuresis. How do they do so?

The liver does so in a two-fold way. The liver, as is well known, tends by its functional integrity to modify the quantity of uric acid in the blood. This acid when in excess acts as an irritant to the nerves of the bladder, increasing virtually the tendency of the urine to produce the reflex sensation of desire. The presence of uric acid in the bladder tends to destroy some of its epithelial lining. This is of considerable significance. The epithelium of this viscus is of the pavement variety, and absolutely impermeable to liquids, so long as it maintains its integrity. Thus, if in an animal just killed, a solution of ferro-cyanide of potassium be injected into the bladder, and, after exposing that organ, a ferric salt be placed on its outside, Prussian blue is not formed, as would be the case if the two salts were to come in contact with each other. If now a small portion of the epithelium be scraped off of the surface, Prussian blue is at once formed on the outside, showing conclusively that the salts have come in contact with each other, and that the epithelium was the sole cause of preventing this in the first place.

Anything, therefore, which destroys the epithelium, allows the urine at that point to come in direct contact with the nerves, producing an effect analogous to that which results from any irritating substance being applied to the nerves at a point where the epidermis has been removed. The pain and irritation which occurs in cystitis is largely accounted for in this way. The manner in which enuresis might result from such a condition, is too obvious to need further comment.

In another way it is not highly improbable that the liver may cause enuresis. Certain conditions of the liver frequently cause quite a reflex irritation of the splanchnic, as witnessed by the pain under the scapula. The splanchnics, the greater and lesser, with the renal included, all have their origin from the dorsal ganglia of the sympathetic; it is therefore no flight of the imagination to assume that in a reflex way the liver may affect the renal splanchnic, and in that way modify the secretion of urine.



The stomach may cause enuresis in at least a two-fold way, if not more. Cases which result from gastric as well as hepatic lesions, are apt to be intermittent in character, and I have seen more than one case in which gastric irritability was accompanied by bed-wetting, both difficulties disappearing on the administration of a remedy adapted to the stomach lesion.

The intimate connection of the stomach to the solar plexus reveals the paths through which the reflex impulses pass which cause incontinence of urine. A number of filaments from this plexus unite with the renal splanchnic to form the renal plexus. Other filaments pass down to assist in the formation of the hypogastric plexus, thus forming a connecting link between the stomach and kidneys and bladder.

I had intended to include in this paper the differential diagnosis of the different forms of enuresis referred to, and also their treatment, but the paper has already far exceeded the original limits intended for it, so I shall leave these subjects for a subsequent meeting.

It may be thought that I have spent an unwarrantable amount of time upon so unimportant a subject, but the study of cause and effect is never lost time for the physician; it is something like drilling the raw recruit to better prepare him for battle.

ENDO-CERVITIS.—SUB-INVOLUTION AND COCCYODYNIA.—BY T. F. H. SPRENG, M. D., BUCHANAN, MICH.—*Case*.—Mrs.—consulted me in April, 1884. I solicited from her the following history.—Aged thirty-eight, the mother of two children. Has been an invalid for five years past. Her ill health dates back to her last accouchement, which was not in the least abnormal. Nursed her child for the space of one year; during this time and up to the present she has menstruated from every two to three weeks. She complained of aching in the loins and bearing down pains and pressure within the pelvis, "as if everything would be forced from her." An ache in the lumbar region almost unendurable, a pressure upon the bladder, which was constant, calling to frequent urination. The urine was voided with the greatest difficulty, it being passed in drops or a very small stream. She also suffered much from a very annoying leucorrhœal discharge, which was prostrating in its effect and which was invariably aggravated while on her feet. Intercourse was almost intolerable. Bowels were badly constipated. The appetite was capricious. She was never free from headache; this was most severe in the occiput and immediately over and through the eyes. The eyes were congested when the pain in the head was most severe. The upper lids drooped, imparting to the patient a constant sleepy look.

Another, and by no means the least painful seat of suffering, was referred by the patient to the extreme end of the spine. This also dates back to her last confinement. Without question there was at

that time an injury sustained to the coccyx. The most excruciating pains were experienced when the patient attempted to sit down, or rise again. The pain was just as great in the reclining, as in the sitting posture. She suffered most intensely while at stool, and a pressure with the finger on the coccyx would almost throw her into spasms.

On examination we found the cervix uteri pressing hard against the sacrum, the cervix tumefied and tender. The external os is patulous and everted. The sound reveals the depth of the uterus to be five and a quarter inches; the fundus resting heavily upon the bladder.

Notwithstanding the very characteristic symptoms of uterine difficulty existing here, this poor woman was treated for five long years for "spinal disease." The most heroic measures were employed, even to the extent of applying a Spanish-fly plaster the entire length of the spine, denuding it of the epidermis wherever it came in contact with it. This barbarous treatment compelled the patient to lie on her face for weeks. Nothing that had been done afforded any relief. She had had implicit confidence in her physician, hence it was not an easy matter to convince her of the fact that her trouble was anything but a "spinal disease," and it was only when the cervix was gently drawn forward, removing the pressure from the spine, and thus giving instant relief to her head that she admitted that we were right in our diagnosis.

By the aid of Ludlam's elevator the uterus was raised into position. A pledget of absorbent cotton, saturated with equal parts of Calendula and glycerine was placed into the posterior cul-de-sac. The patient was requested to remove the cotton at the lapse of thirty-six hours, and to remain in the recumbent posture, with the hips well elevated. This treatment at once relieved the head and urinary symptoms. *Belladonna* and *Secale cornutum*, in their turn, greatly diminished the much congested and sub-involuted uterus. These remedies, together with *Lachesis* and *Apis mellifica*, cured the uterine trouble. For the last ten months this patient has menstruated regularly every four weeks, in a perfectly normal way.

The coccydynia, however, did not yield so readily. *Belladonna* relieved it somewhat. *Causticum* gave additional relief. *Tarantula*, *Ruta*, *Phosphorus*, *Cicuta*, *Magnesia Carb.* and *Kali. Carb.* were all given a fair trial, but afforded no relief.

Electricity was now resorted to, combining four cells of the galvanic with the Faradic current. The cathode was placed over the sternum, and the anode was stroked along the muscles directly over

the coccyx. This treatment was continued for ten minutes at a sitting, every other day for two weeks, with very satisfactory results. Myself and battery have, since then, been blessed with the praises of this formerly much afflicted lady.

**APIS MELLIFICA IN VACCINATION-ERYSIPELAS.**—BY THOMAS NICHOL, LL. D., B.C. L., MONTREAL, CANADA.—On September 2, 1885, I was called to see J., aged two years, the child of Mr. S. S., St. Catherine Street. I found that eight days previous she had been vaccinated, that for six days all had gone well, but that, on the morning of the seventh day, erysipelas set in and rapidly spread over the entire body. The arm was greatly swollen, and the cellular tissue was so much infiltrated that the finger left no imprint on it. The entire body was covered with an erysipelatous eruption of a dusky red hue, save a very few islands of healthy skin. On pressing the finger on the erysipelatous portion, it became of the natural color, and the dusky red tint returned but slowly. The temperature was 102°; pulse 130, small and thready; the tongue coated yellowish, with red and enlarged papillæ. The face was flushed, the eyes heavy and dull, the whole aspect denoted illness. *Apis mellifica*, 6th decimal trituration, a small powder in twelve teaspoonfuls of water, a teaspoonful every hour.

Next morning I was astonished to find the child out of bed and dressed. No fever, no erysipelas, tongue clean, expression and action normal. The amendment commenced with the first dose.

**THE CHART OF TUMORS**, by Prof. G. F. Shears, M. D., is a whole volume in a nutshell. The author has presented his subject in a simple, systematic and condensed form, so that the student or practitioner may at a glance classify a growth, become familiar with its characteristic and diagnostic features, make his prognosis and determine upon a line of treatment. The facts are in accordance with our best authorities, and embrace the latest scientific researches.

The Chart is a valuable addition to our working library, and may be cordially recommended to the profession with the assurance that it will serve to solve the perplexing problem which morbid growths present to the beginner, and to the practitioner who has not found time or been able to keep posted in regard to the diagnosis

and treatment of this class of maladies. The Chart will save many dollars in literature, and many hours of laborious research to those who are fortunate enough to possess it.

G. A. H.

**TABULÆ ANATOMICÆ OSTEOLOGIÆ.\*** BY CHARLES H. VON KLEIN, A. M., M. D.—The author has by the aid of the artist, entered upon the minute description of the bones comprising the human skeleton. There is no descriptive text save as the processes, foramen, spines, articulations, etc., are referred to in the illustrations. The artist has done his work so faithfully, however, that the object is well described. The author has challenged the student and the practitioner to a closer study of his work than mere observation, by confining this description to the Latin names. His views in throwing the gauntlet, being that the science of medicine, of which his anatomical hand atlas forms a part, should have a universal language, and that as far as the technology of the science is concerned, all students and physicians in all nations, should be capable of intelligent communication in the Latin. There can be no reasonable objection to a departure in bettering medical nomenclature. As it stands now, it is a strange mixture of poor Latin and worse Greek, and not a little mixed the French, German, Italian and English. The discoverer of any anatomical part not previously described, usually claims the name by some compounding of his own and some strange suffix. The same is true in the description of diseases. The book, admirable as it is, is, we fear, a long way in advance of the age in which it comes to the light, if it is made to become a text book, or even one for ready reference. The busy practitioner looks upon text that greets his comprehension soonest, and the student finds osteology difficult enough to master when revealed by his native tongue.

We commend the work before us, first, that its plates are true to nature and are not copies of other anatomical plates with mistakes and all else bad, as well as good; second, that verbiage is reduced to the minimum, while the object of the book is being accomplished—the illustration of every part of the human skeleton.

B.

**ARNDT'S SYSTEM OF MEDICINE\*.**—We have already expressed a general opinion of this work (see page 204). That good opinion is more than confirmed by Vol. II, which is an improvement on Vol. I. As the work progresses its practical value becomes more apparent, and the wisdom of Dr. Arndt in planning it, as well as his editorial fidelity are to be seen on almost every page. Its scope and character will surely commend it to the earnest physicians of our school who wish to be, and who will be as thoroughly equipped as possible for their conflict with disease. Still, with some it will be a question whether this System is not "ahead of its time; whether the ency-

\*Cincinnati Lithographic Company, 1885, 32 full page lithographic illustrations.

clopædiac form is the better one for a work on the practice; and whether the best and the most representative writers have been chosen as contributors. Time, and not a preconceived theory must answer these questions.

Just now the competition in this special class of publications is very great. From Ziemssen's *Cyclopedia* (the practical part of which a French editor would have put into half as many volumes) to Pepper's excellent work (which thus far is a great credit to American Medicine) there is a wide range of merit. Especially in this country, where there is the greatest need of it, the profession is being rapidly educated to a more thorough appreciation of *monographs* on special topics, and a *cyclopedia*, or a system like Reynold's, or the one under review, is really nothing more nor less than a series of separate monographs which have been bound into volumes.

The adoption of this form of writing makes it necessary to include and to incorporate whatever pertains to the subject in a practical way, no matter whence it came. And one of the most pleasant as well as profitable results of this kind of work is to free our authors, in this case at least, from the charge of being "offensive partisans."

Viewed as an argument *per se* for the peculiar system that we both preach and practice, the text of this work is very indirect, and more clinical than canonical. We would as soon think of recommending Grauvogel's big book as a very clever novel, or Hoynes's Directory as a Catalogue of the Saints, as to extol Arndt's System as an exegesis of homœopathy. Its scope and purpose are of a different nature altogether. If it does not clamor for or ehallenge any medical tenet, it does search for facts that are of value, and, when they are found, puts them within reach of the student and the busy practitioner. And it also shows that the leaven which is liberalizing all the professions, including our own, is working in the minds of these latter-day, but not late-in-the-day authors. Let us have Vol. III as soon as the work can be carefully and thoroughly done.

---

\*A System of Medicine based upon the law of Homœopathy. Edited by H. R. Arndt, M. D. In three volumes. Vol. II. Philadelphia. F. E. Boericke, 1885.

## Hospital Notes.

### THE WOMEN'S CLINIC.

#### SERVICE OF PROF. BAILEY.

SEPTIC ABSORPTION FOLLOWING RETAINED PLACENTA.—*Case* 17,441. Mrs. —, aged twenty-nine, is married, has two children, and had a miscarriage at about the third month, three months ago. At the time of the abortion she was alone in the house, sent for no medical aid, but continued her work as usual. She has not been well since that time. She is very weak, her feet swell, she has constant pain in the extremities, also intra-pelvic bearing-down pain, with a very offensive uterine hemorrhage which is more or less constant, dark in color, and very debilitating.

A local examination discloses a very extensive unilateral laceration of the cervix. There is probably a portion of the retained placenta decomposing. She is directed to take hot water injections twice a day, and *Sabina* 3, to be given four times a day internally.

May 29, reports no improvement, but the oedema of the feet and ankles is greater. *Ars. alb.* 3d trituration, four times daily.

June 5, she is flowing more freely, but feels no worse in any way. *Arsenicum* continued.

June 12, she still has the same hemorrhage, but is feeling stronger and better. *Ars.* continued.

June 26, the flow ceased three days ago. She has had no chills or fever, but complains of headache and pain in the extremities. *Ars.* continued.

This patient would not listen to having dilatation and removal of the retained and decomposing placenta. She kept about her household duties daily, and worked early and late. The amount of septic absorption was considerable. The continued use of *Arsenicum* was followed by good results in a most unpromising case. Unquestionably the retention of portions of the secundines after such an abortion is a frequent source not only of menorrhagia but of chronic endometritis; so that we do well to cure such a case of sepsis on its own account, and also because we may thus avert what would otherwise be certain to follow.

VICARIOUS LEUCORRHOEA WITH CLIMACTERIC RHEUMATISM.—*Case*, 17418—Mrs. —, aged forty-five, is married, and had one child thirteen years ago, which lived only two and a-half months.

The menstrual periods were always irregular, sometimes passing by four or five months. And when they did appear the flow was very scanty. They ceased entirely three years ago, but since that time she has had a constant leucorrhœa, which is increased every four weeks, is thick, yellow, and stiffens the linen. She suffers most from pains extending the entire length of the spine, and at times there has been a tender spot between the scapulæ. Any excitement brings on a headache, when it seems as if the top of the head opened with great heat. She often has pain about the heart, and occasionally it intermits a beat. At these times the head symptoms are aggravated. She has frequent micturition with dysuria. The respiration is sighing. *Veratrum vir. 6.*

May 1.—A local examination finds the cervix in the hollow of the sacrum, and the fundus lying against the bladder. There is a complete anteversion of the uterus. *Veratrum vir. continued.*

May 6.—With the exception of the pain between the scapulæ, she is much better. On the whole, she has not felt as well for twenty years. *Veratrum vir. continued.*

June 3.—The headaches are returning, but not so severely as formerly. Her skin is very yellow, every alternate day, and the tongue is thickly coated.—*Podophyllin 3.*

June 17.—She has been having a slight eruption on her face and neck. Her digestion is poor, and the bowels are loose. She has a good deal of rheumatic pain in and about the joints, which troubles her more before a storm. *Rhus tox. 3.*

June 24.—Better in every respect. *Rhus tox. 3 continued.*

July 22.—Pains about the joints and in the interscapular region are much less. The headache has returned; she is very nervous, cannot sleep, and has much of the sighing respiration. The urine is diminished, with much pain in the region of the kidneys. *Veratrum vir. 6*, until the respiration is relieved, then *Rhus tox. 30.*

August 5.—The urine is diminished, contains a brick-dust sediment, and she has constant pain in the region of the kidneys. She has a dry, scaly, itchy eruption on her neck and chest. She formerly had erysipelas, which she was accustomed to treat with local applications of the sugar of lead. She is very sure the pelvic symptoms have been much worse since her first attack of erysipelas. She now has a constant, steady pain about the heart. *Rhus tox. 30.*

August 26.—A specimen of her urine was analyzed and was found to contain a few blood corpuscles, large quantities of mucous epithelium from the bladder, a few crystals of the phosphate of lime, and some uric acid crystals. No valvular disease of the heart was discovered. After the analysis, two weeks ago, *Merc. sol. 6*, was given her at Dr. Bailey's office, and since then she has been improving. Continue the *Merc. sol. 6.*

September 9.—She has comparatively little of the sighing respiration. The urinary symptoms are relieved. The pain in the back

is not nearly as severe. She still has some rheumatic pains. But, on the whole, she is wonderfully better than when she first came to the clinic, and expects soon to be dismissed. Continue this remedy.

**CLIMACTERIC ENDOMETRITIS.**—*Case 17427, Mrs. —* aged fifty years, is married and has grown up children, while the youngest is only six years old. The menopause had begun as she supposed, before the birth of the last child, but since that event she has had an almost constant uterine hemorrhage. She always had good health before her last confinement, and she made a good recovery from that, excepting the hemorrhage which has followed it. Any lifting, moving anything light or heavy, or any excitement increases the flow, which is bright red, unclotted, and generally painless, although at times it is accompanied by acute ovarian pain. She has at times dizziness, chills, prickling sensations in the extremities, and irregular action of the heart. She is very easily excited. The bowels are very constipated, obstinately so, never moving without drugs. Hot water enemata are useless. She has taken castor oil for a long time, and now the dose required is a coffee-cup full.

She has frequent micturitions, passing large quantities of urine of strong odor, dark red color, but depositing no sediment. She is much troubled with oedema of the feet.

A local examination finds both lips of the cervix entirely gone, the os widely open. The conditions indicate endometritis. Depth of uterus three and three-fourths inches. The rectum is enormously distended, but the sphincters are all right, and there is no hemorrhoidal condition. The patient is directed to have the abdomen and back thoroughly rubbed every day, and is given *Nitric Acid 2*, a dose in the morning and at noon, and *Collinsonia 3*, one dose at night.

After taking the remedies for two weeks, she reported increased appetite, lessened hemorrhage, and the constipation not quite as persistent, and the bowels less painful. The same remedies were continued as before for two weeks.

The next report the bowels are just as constipated, with complete anorexia, but the flow is less and is of lighter color. *Nitric Acid 2*, and *Nux vom. 3*, at night.

June 17.—She has had no hemorrhage for two days, which is the first time the flow has ceased for five months. The constipation is greater than ever. During the last week she took five cathartic pills three times a day for three days, then seven pills at once, after which she had a slight stool consisting of small, hard, black scybala. *Opium 3* three times a day.

June 24.—The last five days she has had a natural passage from the bowels each day. She says that she has not felt as well for five years as she does to-day. *Opium 3* continued.

The patient was, through the long and excessive hemorrhage, reduced to a stage of anæmia that threatened her life, and the fre-



quent use of powerful drugs and compounds increased the danger, to the patient's own alarm. The constipation was chargeable to inertia of the rectum, rather than of the bowels themselves. The local examination determined this, and the exhibition of *Opium 3* remedied this, though not without a struggle on the part of the patient to resort daily to more powerful remedies. The condition of the uterus following chronic endometritis, with daily hemorrhage, which had often been so profuse as to cause her to keep her bed for days and weeks at a time, was met curatively by the use of *Nitric Acid* in a low potency. The patient began to mend immediately upon taking the remedy.

ACNE OF THE UTERINE CERVIX.—*Case 17454.*—Mrs. M. is married and has two living children. Five years ago, at the seventh month of gestation, she had a fall which killed the foetus, but it was carried in uteri for six weeks longer, and when expelled was in a decomposed state. Following that she was quite ill, and ever since has had an eruption about her chin, and upon the mucous membrane of the lips, which does not yield to treatment. The menses are regular and normal, but are always followed by intense pruritus vulvae.

She has a good deal of intra-pelvic pain, back-ache, and a feeling of soreness all through the abdomen. She complains of frontal headache, and neuralgic pains in the right side extending up to her shoulder. Always after sleep, whether at night or a short nap taken during the day, she awakens with a bad taste in her mouth, and a slimy, dark-colored tongue. The bowels and kidneys act normally. *Nitro-Mur. Acid*, 6, three times a day.

June 12. A local examination reveals a prolapsus uteri, slight cervicitis, and an eruption on the cervix which is similar to that on the chin. *Nitro-Mur. Acid* continued.

June 26. In some respects she is better, but there is no change in the eruption. *Rhus Tox.*, 3, four times a day.

In speaking of this case, Prof. Ludlam, who was present, said that it suggested several interesting clinical points. There are those who doubt if a well-defined acne, such as we often see on the face, neck and shoulders, can ever be found upon the vaginal cervix. Others insisted that it was quite common in what they call chronic metritis. Some think it may exist as a purely local eruption, involving the papillæ and the follicles of the cervix; but that it cannot in any case depend upon such a constitutional cause as the darts or the herpetic diathesis.

In such a case the occurrence of the same eruption at an external and internal point, whether they alternate or not, is significant. A few years ago, when so many women were cauterized for a fancied ulceration of the os-uteri, these cases of a chronic and disagreeable eruption on the chin were much more common than they now are. There was a time when by this sign alone, you could have pointed out some of the women on the street, or at church, who were being treated in this way, just as we used to identify the men who took blue mass and quinine in incredible quantities.

In some of these cases of acne of the cervix the eruption alternates with a granulated sore-throat, or with granulations of the eyelids; in others, where the lesion extends within the cervical canal, it is the principal factor in membranous dysmenorrhœa. If this woman had "chronic metritis," either as a cause or a complication of this eruption, she would almost certainly be subject to menorrhagia. A share of these cases of cervical eruption are specific, and some of them develop ultimately into epithelioma. In the great majority of cases, whether benign or not, and syphilitic or not, the discharge from the eruption develops a very troublesome and rebellious pruritus.

I must caution you against the employment of the hot-water douche or irrigation, in this condition of the cervix, for by parboiling the inflamed tissues, under the circumstances the whole mucous epithelium may be separated, and the denuded surface seriously injured. Warm sitz baths, however, are very grateful and beneficial. The topical use of the same remedy as *Rhus tox.* or *Cantharis*, that is being given internally; or of *Borax* or of *Hydrastis* are very beneficial. Cotton tampons are too heating and irritating, and pessaries are almost always intolerable.

## Miscellaneous Items.

The *New England Medical Gazette* has published a careful list of the bureaus for the American Institute for the next year.—Vol. II of Arndt's System of Medicine is out.—Dr. R. Ludlam and son have returned from a month's vacation in the Adirondack Mountains.—The Bureau of Surgery, Dr. G. A. Hall, chairman, will report at the next meeting of the Clinical Society.—We are in receipt of a twenty-nine page pamphlet on the Anatomy and Physiology of Bacteria, by J. M. Selfridge, M. D., of Oakland, Cal.; also an article on Alcohol, read before the Philadelphia Social Science Association, by Dr. A. C. Rembaugh.—Dr. G. A. Mueller, class '85, is located at Alleghany, Penn.—Dr. Joseph P. Cobb, 3424 Calumet Avenue, has had a telephone put in at his residence. Call him up. No. 8050.—*On dit* that Prof. Hoyne is negotiating for the purchase of an island in an inland lake near Ashland, Wis., for a private fishing-ground.—Dr. J. B. Dunham, a Hahnemann alumnus, class '81, is out with a neat little volume on "The Baby; How to Keep it Well."—Dr. Belle L. Reynolds is enjoying a trip in the Lake Minnetonka and St. Paul neighborhood.—The Patriarchal Circle of the fraternity of Odd Fellows, has chosen Dr. Alexander Donald, of Stillwater, Minn., as its medical director.—F. E. Boercke's Publishing House has just issued the third edition of Raue's "Special Pathology and Therapeutic Hints."—There is a splendid opening for a smart young homœopath in the city of Halifax, N. S.—No. 1 of the *Montreal Tracts on Homœopathy*, written by Dr. Thomas Nichol, is on Diphtheria and its management.—Following the example of the "Old Hahnemann," the New York Post-Graduate Medical College and Hospital has organized a clinical society, and begun the issue of a regular bulletin.—C. S. Holton, M. D., at Richmond, Ky., in the heart of the Blue-Grass belt.—E. E. Macy, M. D., has removed from Wabash to Roann, Ind.—Dr. Thomas Lowe has settled at Hadley, Minn.—The *Wisconsin Medical Record*, a monthly journal representing the Homœopathic Medical Society of Wisconsin, appears with August as its initial number; Eugene F. Stork, M. D., editor. Success to the *Record*.—Delinquent subscribers will please send their subscriptions to the business manager now.





**FRANK WHEELER, M. D.**

**ADJUNCT PROFESSOR AND DEMONSTRATOR OF ANATOMY IN THE HAHNEMANN MEDICAL  
COLLEGE, OF CHICAGO.**

# THE CLINIQUE.

---

VOL. VI.]

CHICAGO, OCT. 15, 1885.

[No. 10

---

## Original Lectures.

### MYELITIS.

A CLINICAL LECTURE DELIVERED IN HAHNEMANN HOSPITAL, SEPTEMBER 26, 1885, BY PROF. H. B. FELLOWS, M. D.

*Case 15,027.*—Mrs. V.—, age, fifty-two. The health previous to the attack of the present difficulty was good. There had been no chills and fever, or other acute sickness, but during the previous summer she had suffered from pain mostly in the back of the neck and head. Sometimes one hip would seem to give out in walking. The attack was ushered in by an aching pain in the small of the back and across the hips. The pain was very severe. There was no tenderness of the spine to pressure at that time as far as the patient recollects. During the first thirty-six hours there was some fever. The first premonition of the disease occurred on Saturday morning, and by Monday the legs were completely paralyzed. During the next two weeks there was complete loss of both motion and sensation in the lower limbs. The bladder was also involved, and the urine had to be drawn. The bowels were also obstinately constipated, but this was not an entirely new condition, for constipation had been the habit previously. Some motion of the toes of the right foot was obtained in about two weeks, but it was six months before the patient could move the limbs. Sensation did not return for about a year. The legs were cold and the feet swollen. Ever since the attack pain has been suffered in the back, and a sensation of a tight girdle around the body has been experienced.

Sensation is still very imperfect, and the two points of the æsthesiometer cannot be distinguished at less than three inches apart. The knee reflex is at present much exaggerated, and a marked ankle clonus is easily obtained. The excited state of the reflexes is also shown by the frequent muscular twitches which take place from time

to time, and especially when the bladder fills up. What the reaction of the urine has been during the past time of the disease we have no means of knowing, for it seems never to have been tested. About eight months after the attack an abscess formed near the anus, and a small bed sore started, which was healed without its proving to be of a very serious nature.

The patient can now get about the room with the aid of crutches. The limbs still have a puffy, swollen look, the temperature is below normal to the touch, and it is necessary to keep them very warmly wrapped in order to avoid the discomfort that is sure to arise from any exposure of them to the air. She has but a minimum of strength to move about with, and tires much quicker than her look of good nutrition would indicate. The muscles of the limbs have not atrophied, at least not more than would be indicated from the long non-use of the legs.

There are a number of points in this case to which I want to direct your attention, and in studying them we will try and arrive at a diagnosis of it, and gain some definite knowledge of what has pathologically taken place. The first question that comes up in this case is, Where is the seat of the disease? The absence of head symptoms, and even of symptoms of the upper part of the body, must make it evident that it must be below the waist. As the disease includes both of the lower limbs and the bladder, and as it does not depend upon any general disease like rheumatism, it must be referred to some part of the nervous structure. The common point where all of the nerves from these parts meet is in the spinal cord. Here then will be found the real seat of the difficulty. Judging from the upper limit of the symptoms the chief seat of the diseased action must be somewhere in the lower part of the dorsal region of the cord. The diseased action must have extended entirely through the cord in both sides of it, for the symptoms are bilateral and involve entirely both the sensory and motor functions. The extent of the affection in a longitudinal direction may not be easily made out at this late day. We get no report of such examinations as would enable us to form definite opinions in this respect. From the later symptoms it would appear that the longitudinal section of the cord that was seriously involved in the acute stage was not very extensive. That the membranes of the cord were somewhat involved, also, is shown by the amount of the pain and the well-marked girdle sensation.

Having established the locality of the disease, the next point is to learn its nature. The first question that comes up in cases of this

kind is whether the disease is functional or organic. Of the various forms of functional disturbance that might produce some of this group of symptoms may be mentioned hysterical paraplegia and reflex paraplegia. The history of the patient gives no warrant for the first supposition, notwithstanding a superficial resemblance of some of the symptoms to such a condition. Paralysis, lasting for some time, for some months as this one has, and without any muscular atrophy, may always raise this question. That reflex paralysis taking the form of paraplegia sometimes originates from vesical and uterine disease is true; but in this case there were no such symptoms antecedent to the attack, which rules out this supposition.

Then the question for us to answer is, what kind of a lesion may we expect to find beginning in the way that this one did? We have first to note that it reached a full development in a comparatively short time, that is, the attack was acute, reaching its height in thirty-six or forty-eight hours. Diseases of the nervous centers beginning in this way, which are not purely functional, usually involve the circulatory system. This practically limits us to the consideration of embolism, thrombosis, hyperæmia and inflammation.

Embolism always attacks with the suddenness of a stroke. The artery is suddenly closed with an embolus, and the functions of the parts supplied by the blood vessel cease at once because of the anæmia that at once supervenes. This attack being some time in developing embolism is therefore ruled out.

Thrombosis may close a blood vessel more slowly, producing during the time of partial closure certain symptoms which finally, however, may attain their height in very rapid manner. But they do not begin with fever, as did this case. They are also apt to be followed by sudden extension of the symptoms, as the thrombosis may extend backward, closing other arteries that branch from the one first affected. Moreover, thrombosis is not apt to occur in persons whose physical condition is as good as was the case with this patient. We can therefore rule out this condition from our diagnosis.

Hyperæmia and inflammation may both commence with suddenness, in some cases almost with the suddenness of embolism, but in many cases, perhaps in the majority, there will be a somewhat more gradual development of the symptoms. This case corresponds in that respect to these conditions. It is, therefore, safe to conclude that the pathological process was one of these conditions. With hyper-



æmia the symptoms will usually be of a lesser degree and more transient, while with inflammation the symptoms will be more marked, both in degree and permanency. With hyperæmia the paralysis is apt to be less complete and the anæsthesia not so perfect. In well-developed inflammatory action the abolition of the functions will be complete. Where the grade of inflammation is high, it is almost certain, in nervous centers, to bring about the destruction of parts affected, but from this high degree of inflammatory action to that of simple hyperæmia we will discover various grades, and, as a consequence, various degrees in the development of the symptoms, and this applies equally also to the permanency of the symptoms. Acute hyperæmia may disappear, and leave the functions comparatively intact after a few days, though always the nervous centres regain their normal condition, even from these slight attacks, more slowly than other parts. The hyperæmia of the cord is not usually attended by fever. Inflammation of the cord usually develops some fever, and perhaps always if the meninges are implicated. The fever, however, is not apt to run as high from affection of the cord itself as from the meninges. In this case there was some fever, but, so far as we can gather from the report, not of a high kind. Unfortunately, we have no exact observations as to this state, and can only judge of it by a layman's impression. But in summing up this evidence, taken together with the paralysis of the bladder and rectum, which still remain, and the tendency to bed sores, which seemed to show itself at one time, we must conclude that the diseased action reached, at least, a low grade of inflammation. The sequel of the attack also justifies this conclusion.

The inflammatory action, while it affected more or less the whole of the transverse section of the cord, probably affected different parts of it in different degrees. It did not reach a destructive degree of action in the anterior horns of the gray matter of the cord. It seems to have been more intense in the central and posterior columns of the cord, while it has left some of its worst marks in the white matter forming the pyramidal columns. We judge that it is not destructive in the anterior horns because muscular atrophy did not follow the paralysis. If it had been of sufficient intensity to have destroyed the ganglionic cells in the anterior horns of the gray matter, more or less muscular atrophy would certainly have followed. Had the inflammation been confined to these parts,

we might have had just as complete paralysis, but we would not have had the anæsthesia. We, therefore, must have had sufficient diseased action in the parts of the cord receiving the sensory roots of the nerves to have destroyed the sensory functions. As the return of sensation was so very slow, and still is imperfect after three years of time, we are justified in concluding that that part of the cord through which the sensory nerves are conducted must have been considerably injured.

You have seen how promptly and sharply the foot\* was kicked forward when I tested for the patellar tendon reflex. You also saw how promptly the ankle clonus was produced when I lifted the foot and flexed it by firm pressure on the ball of the foot. The first reflex was much exaggerated over that which would be normal, and the second may be considered a symptom of the disease, it being hardly ever produced in healthy individuals. Nor are these the only symptoms of an aggravated reflex action. Jerkings of different muscles in the limbs are produced from time to time by various irritations, and especially from vesical irritation when the water needs to be drawn. These reflexes all point to damage of the pyramidal columns of sufficient intensity to leave its effects well marked to the present date. Were the cells of the gray matter of the anterior horns much damaged, we would fail to get these symptoms, for the reflexes originate from those cells. The whole reflex arc from the nerves of the lower limbs must have good conducting power. The fibres which pass down the pyramidal columns before making their connection with the gray matter are injured, thus not conducting down the motor impulse from the cerebral centres, thereby enabling the person to have full voluntary control of her motions on one hand, and on the other preventing the inhibitory action of the higher centres from controlling the muscular action of the limbs. In this way we get a physiological explanation of the partial paralysis which remains, and of the aggravated reflex actions. The nerve fibres in the lateral columns, while showing injury, have not been so totally destroyed but what they have partially, at least, recovered. Hence, general improvement.

There is one other disease which this in its earliest stage might, perhaps, have been mistaken for, and that is acute ascending paralysis. This usually begins in the lower extremities, and the paralysis gradually ascends, involving different parts of the cord until it reaches the bulb, when it of course proves fatal. In some cases men, whom we

have every reason to believe competent, have not found, *post-mortem*, any changes in the cord. Ross describes a central myelitis in some cases, and Buzzard has attributed it to syphilitic poisoning. The diagnosis would, however, be made from that by the symptoms not progressing beyond the parts originally attacked. It might be difficult, however, in the beginning of an affection of the lower part of the cord, of the nature of this one, to make this diagnosis in the first few days, but as acute ascending paralysis does its work in a few days, the diagnosis would not long remain in doubt. Even this latter disease is sometimes curable.

Acute myelitis is not ordinarily a hopeful disease. It generally either destroys life directly when it affects the upper part of the cord, or indirectly by the cystitis, bed sores, and consequent exhaustion, and septicæmia. Not a large per cent of cases of myelitis will do as well as this one. Even where death does not speedily follow, contractures, neuralgic pains and other difficulties are apt to be the sequelæ. In this one the legs cannot be separated fully. When the disease affects the upper dorsal or cervical region the chance is still smaller to escape even speedy death.

The cause of this disease is in this case obscure. It comes in some cases from injury, and is not an unfrequent complication in Pott's disease, caused by the pressure of the distorted bones upon the cord.

It is important, in the very beginning of the treatment of this class of cases, even if there be but congestion of the cord, that the patient should go to bed, lying as much as possible upon the face and side rather than upon the back. They should not exert themselves, even where it is possible, in the slightest degree. There must be close watch for, and every precaution must be taken against, the formation of bed sores. All pressure should be taken from the part, and the skin over the sacrum and trochanters should be bathed in whisky or brandy. The condition of the bladder should be watched, and the water drawn early. It should at no time be allowed to collect and distend the bladder. The utmost care should be exercised in cleansing the catheter, which should be washed in a carbolic acid lotion, and lubricated with carbolic oil before its introduction. Carelessness in this respect is almost certain to result in cystitis and decomposition of the urine, which will add very much to the danger and misery of the patient. Ice-bags for the spine have been recommended. In

some cases I prefer hot applications. If I found the patient very sensitive to the cold, and it was disagreeable to him, while the hot applications were pleasanter, I should use the latter. Electricity should not be used in any form until after the acute stage is wholly past. Galvanism may then be of service. It goes without saying that the cause, so far as it can be removed, should receive prompt attention.

Such remedies as *Acon.*, *Bell.*, *Gels.* and *Verat. vir.*, are among the remedies for the earlier stages. If the patient survive the acuter stages, then *Arg. nit.*, *Merc.*, *Nux vom.*, *Plumb.*, or *Secale cor.*, may be of use.

Great care should be used in making any applications to the back for fear of increasing the tendency to bed sores. Where the skin is anæsthetic the danger is greater, and demands the very greatest caution in making all applications, as the patient will give no hint of the danger until the damage is done. At best the attempt in many cases to save the life of the patient will be without avail.

This patient will receive *Arg. nit.* 6.

CASE FROM PRACTICE.—BY DR. ALVA E. BENNETT.—*Case* 1.—Mrs. F——, housekeeper, aged thirty-eight. The eyes are weak and the margins of the lids swollen and red, with bran-like scurf; much sensitiveness to light, with feeling of dryness, all following measles in childhood. I first thought of *Arsenicum*, but observed that the hands were dry, the skin brittle and scaly. On referring to it she said that she had been troubled with “salt rheum” for many years, her hands cracking and bleeding. I asked if they discharged. “Yes; a thin, yellow water, which was sticky, and made the cloths stiff.” Further questions elicited “much leucorrhœa, whitish, coming in gushes, excoriating the parts; menses scanty; much pressure,” and examination revealed two small ulcers on the os uteri, with vesicles on the side, also on posterior part of vagina. Gave her *Graphitis* 30. The remedy was continued for two weeks, when the skin of the hands seemed much softer and smoother, and eyes better. She went without medicine for six weeks, with constant improvement for four weeks, but then relapsed. Gave *Graphitis* 200, after which the improvement was wonderful, almost to complete cure. Many of the symptoms extended back to childhood. If at any time she thinks she is worse I give a dose of the same remedy followed by blanks.

## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

### OCTOBER MEETING, 1885.

The regular monthly meeting of this Society took place in Club Room 4, at the Grand Pacific Hotel, on Saturday evening, October 3, Dr. E. M. P. Ludlam occupying the chair. A relay of students of the Hahnemann College class being present, in addition to the usual attendance of members, the club room was altogether filled. The interest of the meeting was centered on the

### REPORT OF THE BUREAU OF SURGERY.

G. A. HALL, M. D., CHAIRMAN.

**YELLOW ATROPHY OF THE LIVER.**—By G. A. HALL, M. D.—*Case.*—July 10, 1885, I was called to see Mr. O—, aged forty-three years, and obtained the following history of his case. Twelve years previous he had suffered with chills and fever, and for two years following was quite ill with malarial poisoning. Being a merchant he spent the greater portion of his time at his place of business, frequently remaining late at night. His place of business was a wooden structure with a basement in which there was stagnant water the year around. He had taken large quantities of quinine, mercury and other drugs. He had at that time acute hepatitis with icterus and a scanty secretion of the kidneys.

In the spring of 1876 he moved to Chicago, where he regained his health. He considered himself well up to August, 1884, when he began to suffer with irregularity of the bowels and some gastric derangement. He passed under the care of several physicians but his condition grew gradually worse.

In the spring of 1885 he found that there was an increased fullness of the abdomen which was, in a measure relieved, by powerful cathartics and diuretics. Early in June he went to Waukesha and remained six weeks, where he drank freely of the spring waters, which increased the secretions of the kidneys and afforded him slight relief. These waters failed after a time to have the desired effect and the kidneys and bowels relapsed into their former condition.

He returned to Chicago and I was called to see him about the middle of July, when I found him suffering with ascites. He was thin in flesh, very sallow, and had a fair appetite. His food, how-

ever, distressed him after eating and he received little or no benefit from what he ate. The secretions of the kidneys were very scant, high colored and contained an excess of bile and deficiency of uric acid.

The pressure upon the thoracic organs became so great that tapping was resorted to to give him relief, when twenty-eight quarts of straw-colored fluid were drawn off. He speedily filled up again and it was necessary, at the end of two weeks, to perform the same operation. About the same quantity of fluid was taken away and a drainage tube, eighteen inches in length, was introduced into the abdominal cavity for the purpose of drainage. The condition of the kidneys remained unimproved, his appetite failed, and hiccuping or singultus became distressing features of the case. He gradually became weaker and died August 24.

A post mortem revealed a liver about two thirds the normal size, which had undergone perfect degeneration. The gall bladder was moderately distended. There was stenosis of the ductus—communis—choledochus. The appearance of the liver was mottled. There were spots of a yellow saffron color intermingled with reddish yellow or purplish spots. The yellow spots were soft and friable, but the reddish yellow spots were harder and more tenaceous. The pancreas had undergone a similar degeneration, the spleen was normal, the stomach dilated and the kidneys were slightly atrophied.

We have reported this case for the following reasons: First: The infrequency of yellow atrophy of the liver. Second: The diagnostic stress which we place upon the color of the ascitic fluid. It had been pronounced cancer of the liver, but in all such cases which have come under our observation we have found the ascitic fluid much darker, bordering upon a coffee color. Hence, when we saw the color of the fluid drawn off, we felt confident in the belief that we should find amyloid or fatty degeneration and not carcinoma. Third: The introduction of the drainage tube for the purpose of preventing a third operation for paracentesis abdominis. The objection to the introduction of the tube was the admission of air which would convert the effusion into a purulent discharge. This however was not the case, but it produced chronic inflammation and a large quantity of lymph was thrown out agglutinating the omentum, mesentery and colon, and forming a complete sheath around the tube. The drainage through the tube was not perfect, but many gallons of fluid escaped and further tapping was unnecessary. We believe in some instances chronic ascites, not the result of organic disease, may be cured by the introduction of the tube. Dr. W. H. Burt reports one cured in this manner in connection with medical treat-

ment, but in his case the discharge became purulent, decreasing in quantity for several weeks until it finally ceased.

**SCIRRHUS OF THE ABDOMINAL VISCERA.**—By G. A. HALL, M. D.—*Case.*—Mr. H. æt. fifty; consulted me August 25. For some four or five months he had been suffering with gastric derangement. All his life he had been a hard working man, eating heartily of coarse food without the least inconvenience. The trouble came on suddenly and, as he said, without any apparent provocation. He had consulted Dr. Coyner, of Peoria, who had pronounced it carcinoma.

At my examination I found a tumor in the left hypochondriac region, flat and oblong in shape, and about the size of an early rose potato. From the burning pain, the acidity and distress after eating, his emaciation and mahogany complexion, I verified Dr. Coyner's diagnosis.

He returned home and placed himself in the hands of a cancer doctor, who, after experimenting with him for three weeks, pronounced his case hopeless. The patient then, in opposition to his medical adviser, was determined to take the chances of an operation. In view of the fact that there was no other alternative, and to appease his great desire, I was called to operate September 21.

Upon examination I found the tumor rested in a much lower position, occupying a place anterior to the kidney. Pressing the fingers in the subrenal space between the lower margin of the ribs and the crest of the ilium, and with the other hand resting upon the anterior surface of the tumor, an oblong growth was recognized extending through anteriorly. The tumor was movable, and could be lifted up toward the epigastric region.

A crescent shaped incision was made, commencing at the point of the eleventh rib and extending downward and forward to the external border of the rectus, passing through the integument and superficial fascia and the tendons of the oblique muscles to the peritoneal covering. Hemorrhage was very slight and easy to control.

The peritoneal cavity was opened sufficient to admit the hand. The greater and lesser mesentery, stomach, spleen and gastro-splenic mesentery were so thoroughly involved in the scirrhus transformation as to forbid any attempt at removal. The wound was closed up and the antiseptic dressing was applied. The patient suffered little or no inconvenience from the operation, but on the contrary was greatly relieved from the distressing hiccough, anorexia, etc., from which he suffered before. His ability to take food was not increased or diminished. For weeks before the operation he had been able to take but very little food. At our last accounts he was slowly sinking from inanition.

A CASE OF RETAINED MENSES FOR EIGHT YEARS.—By G. A. HALL, M. D.—*Case*.—Miss Jennie G., æt. twenty-three, a healthy, strong girl until the age of fifteen, when she had all the symptoms of menstruation, but there was no flow. Each month thereafter she would have a return of the usual backache, some gastric disturbance and pressure of the head, but no menstrual show. Many were the means tried to establish what was supposed to be retarded menses. The case continued from year to year, and all efforts were abandoned. The young lady keeping to herself the nature of her suffering, as she supposed there was no relief.

I saw her September 1, 1885, and found upon examination an abdominal distention which resembled in shape and form a gravid uterus at full term. In the right infra hypochondriac region there was a projection nearly as large as an apple, which she claimed appeared a few days before while suffering from an attack of vomiting. The tumor was perfectly dull all over, very firm and hard, causing great distention of the abdominal parietes. Palpation revealed fluctuation, but the sense of touch was that of a cystic growth. A vaginal examination revealed only a narrow closed pouch two inches and a half in length, the finger apparently coming to the end, as a glove finger. There was nothing that resembled an os, but we could feel through the walls of the vagina the end of a tumor crowding down into the pelvic cavity. With a proper speculum and a strong light, nothing but the smooth unpunctured walls of the vagina could be seen. Rectal examination revealed the same smooth round tumor pressing down into the pelvic cavity. Nothing resembling a cervix could be detected.

An aspirator was employed through the vagina, and a small quantity of grumous or dark colored blood was drawn off. Owing to the internal obstructions very little could be accomplished in this way. We then employed a No. 4 trochar without the aspirator, and by means of this, several ounces of the same dark colored blood were removed. The discharge was filled with small clots which interrupted the flow through the canula.

Small quantities of carbolized water were thrown into the cavity, and the discharge was much more free. The canula was left in "situ" as a means of drainage, and further surgical procedure postponed.

The points of interest in this case are: *First*: That the growth of the patient ceased about the time of her first evidence of menstruation. *Second*: The large amount of menstrual flux which had been imprisoned within the cavity of the uterus. *Third*: The perfect absence of any open communication between the vagina and uterus. The distention of the uterus was so great as to obliterate all landmarks of a cervix. *Fourth*: That this menstrual flux should be filled with small clots or coagula. *Fifth*: The sudden appearance



of a tumefaction at the right which must have been from a rupture or escape of fluid through the Fallopian tubes. *Sixth*: The depth of the cavity measured by a sound passed through a canula was 13½ inches.

The condition of the patient when we saw her was that of one suffering from septic poison. She was vomiting a fluid which resembled a solution of Liebig's beef tea, and which had a musty smell. After the operation the irritability of the stomach seemed to be increased and the vomiting continued until her death five days later. During this period many ounces of this fluid had drained away, causing a marked diminution and softening of the tumor. We believe the patient might possibly have been saved if surgical measures had been resorted to earlier.

**LOCALIZED COMPRESSION.**—By G. F. SHEARS, M. D.—*Case.*—Mrs. E., twenty years of age, a round, plump, healthy, intelligent woman, while playing with her younger brother, and swinging him around, had her feet knocked from under her, and fell, striking squarely upon the occiput. She made no cry or motion after falling, and was picked up limp and senseless. She remained in this condition for nearly an hour, at the end of which time the limbs commenced to contract and the muscles to stiffen. Gradually this condition began to disappear, the patient turned over in bed and dropped into an easy natural sleep.

In the morning she was aroused, but upon being spoken to did not reply. She indicated by motions that she wanted something to eat, and was given food. During the morning she signified a desire to urinate, and was permitted to arise, and passed a normal quantity of urine. Some eighteen hours after the fall, at the suggestion of her physician, I was called in and made a careful examination. I found her in bed, lying on her left side. I spoke to her, but received no response. Upon touching her and making motions for her to sit up, she did so, and pointed to a spot about the middle of the occiput, which was somewhat swollen and tender. I could discover no depression of the cranium.

I wrote a question on paper, and held it before her. She looked earnestly at it, but could not read it—at least made no sign. She did not appear to be distressed or anxious, only enquiring. Her pulse and temperature were normal. Thinking that where all the functions proceeded so naturally, the conditions might be hysterical or assumed, I determined to test the hearing of the patient. Noticing that she had long, beautiful hair, I told the mother and husband, in her presence, that fearing inflammation, I should cut off her hair at once. They were both very unwilling to have it done, but told me to do

what I thought best. The patient showed no indication of being at all interested.

The next day the patient, who had learned the deaf and dumb alphabet, in order to elude the vigilance of her teacher, when at school, began to talk with the fingers, and asked to be taken to the piano. She was permitted to go, and made some efforts to play, but gave it up with a discouraged look, and said, with her fingers, she could not hear and could not see, because of sparks flying from her eyes. On the third day she gave some indication of hearing loud noises, and answered the signs of her attendants in monosyllables. On the fourth day she was able to hear, to read print for a brief time, and to talk. Three days later she departed for her home, seventy or eighty miles away, and suffered no inconvenience, except a little sickness at the stomach from riding on the cars.

The patient was given *Bryonia*, and kept quiet, except when the tests above mentioned were made.

I have given the case thus minutely, because the common symptoms of concussion or compression of the brain were entirely absent after the first two hours, although the impairment of the special senses remained. The patient had entire control of the bladder and bowels, and was able to move all the voluntary muscles. The pupils were normal and responded to light, and the general sensations of the body perfect.

It is my impression that the symptoms were due to the compression of the visual, aural and speech controlling centers of the brain by effused blood from some capillary ruptured at the time of the fall.

**SARCOMA OF THE HAND.**—BY G. F. SHEARS, M. D.—*Case.*—O. F., aged twenty-eight, a very strong, robust man. Four years ago last December, his right hand was badly crushed while coupling cars, and it remained almost useless for nine months. In October, 1883, while boxing with his brother, he was sensible of hurting his hand, and he noticed, shortly after, that it began to thicken a little. The enlargement showed no sign of increasing until January, 1885, when the hand was again slightly injured by a blow. From that time it began to enlarge more rapidly, and within the last two months it has nearly doubled in size. During this period, the skin changed from its natural color, to a bright red, and the tumor became very sensitive to the touch and was the seat of sharp, shooting pains. These pains were unusually severe at night, and necessitated the use of large quantities of morphine. The tumor occupied the palmar surface of the hand, was irregularly rounded in shape, having a diameter of about four inches, and extended from the web of the fingers and thumb to a little above the annular ligament. The integument over the tumor had a reddish blue color, was

traversed by prominent veins, and at one point seemed almost ready to ulcerate. The metacarpal bones of the hand were curved slightly backward by the pressure of the growth, and the integument on the dorsal surface of the hand was somewhat thickened. The index finger was firmly flexed, the remaining digits slightly flexed, and the thumb widely separated from the fingers by the extension of the growth between the metacarpal bones of the thumb and index finger. No enlargement of the glands of the arm or axilla could be detected. A diagnosis of sarcoma was made, and the amputation above the wrist advised. This the patient accepted with the proviso that an exploratory incision be first made, over the growth. This was done, but as the results proved only as expected, the operation was completed by an anterior and posterior flap amputation just above the wrist joint.

The wound was dressed with an antiseptic dressing, redressed on the second day, because of considerable oozing, and then remained untouched until the eighth day, when the sutures were removed. The whole line of incision was found to be healed, except at the points of drainage. At the end of the second week the wound had entirely healed.

While sarcoma of the hand, originating outside of the bony structures, is uncommon, there are many points in the clinical history of this case which point conclusively to that form of growth: (1) It arose from an injury. I have been repeatedly surprised in hunting up the history of sarcomatous tumors, to find in how many cases the patient was able to ascribe to some injury the location, at least, of the growth. (2) The age and physical condition of the patient. Sarcoma is a malignant disease of early and adult life. (3) The slow growth during its early life and its rapid growth when once aroused, is a common fact in the history of these tumors. (4) The non-involvement of the neighboring lymphatics. With the exception of sarcoma of the testicle, the infection of lymphatic glands does not take place until late in the history of a sarcomatous growth.

---

APIS MELLIFICA IN DIPHTHERIA.—Dr. W. M. Davison, of Parsons, Kas., sends us the notes of a very interesting cure of malignant diphtheria in a child of six years, with this remedy. The chief symptoms were great swelling of the neck, puffiness of the face, both tonsils, and the pharynx covered with the dirty, grey deposit, emitting a foul odor, pulse 140, and temperature 104. The form in which the remedy was given, was the third decimal trituration.

## Opening Exercises

### OF THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, SESSION 1885-86.

The Twenty-sixth Annual Winter Session in this institution opened, as per announcement, on the evening of Tuesday, September 22. The exercises were held in the amphitheater of the new hospital building, the room being crowded with students and physicians. The program consisted of prayer by the Rev. Mr. Marsh, of the Fourteenth Methodist Episcopal Church; singing by the Schubert Quartette, and a warm, hearty address of welcome by the president, Prof. A. E. Small. After assuring the students of his pleasure at seeing them, Prof. Small expressed the hope that they had come to the college with the full intention of improving the superior advantages that were offered them, and the belief that they would never regret their choice of an *alma mater*. There was a time in which a greater measure of sacrifice was demanded of the homœopathic student and physician than now; when it was looked upon as something discreditable to become a pupil in a school like this, or to practice homœopathy, either in town or country; when our doctors were called quacks, and our patients sometimes went behind the door to take their little powders and pellets. But that time has passed, and our graduates are honored and respected wherever they are known. Many of them are filling high civic and professional positions, the compeers of the best physicians in this and other lands. The popularity of the system has so extended that thousands are enjoying its blessings, and not tens but hundreds of students are coming each year to fit and qualify themselves for the responsible duties as medical practitioners. With clinical facilities and advantages that are real, and not fictitious, and earnest didactic drill, and close study on the part of the pupils, he did not doubt that the present session would redound to the credit of the institution, the faculty, the pupils and the whole profession.

Following the remarks of President Small came

## THE INTRODUCTORY LECTURE

BY PROF. LUDLAM.

LADIES AND GENTLEMEN.—On behalf of the Trustees and the Faculty of this institution, my first duty is to welcome you here. Those of you who have been here before, and who now resume your pleasant relations with us; those who have come hither from other colleges for a change of pasture and higher advantages; and those who are new recruits for our army of workers, are all welcome to this school and its privileges. We hope and believe that you will enjoy and improve the session which is formally opened to-night. Your prompt attendance as well as your numbers, and evident interest on this occasion, is a guaranty of good faith and of earnestness on your part; and I pledge you that my colleagues will do their very best to serve you and to help you forward.

Of late years the introductory lectures that I have given have borne some relation not only to the opening of the medical courses in this institution, but likewise to my annual vacation. With your permission this will not be an exception to the rule. Suffice it to say, that I found the text of the lay sermon "to which your attention is now invited" written on the fly-leaf of a number of books in the library of a friend whom I visited last month.\* That text reads as follows:

"When we have to do with an art whose end is the saving of human life, any neglect to make ourselves thorough masters of it becomes a crime."—*Hahnemann*.

There is no better criterion of civilization than the estimate which is placed upon the value of human life. By the application of this simple test we may judge of the past and the present in the history of mankind. Given a nation, a people, a state, or a community, whether it be large or small, its appraisal of this precious inheritance is the measure of its intelligence, of its social and scientific position, and of its Christian character.

The ultimate object of the medical profession is to prevent disease, to diminish suffering, and to prolong life; and it is the only calling which is wholly devoted to that work. It is a profession that is self-adjusting to the physical needs of our race. It guards the jewels of humanity. It stands for a species of skilled labor that is

\* Dr. Thomas Nichol, of Montreal.

full of present compensations and of future rewards. It studies the hidden processes of life, not merely from scientific curiosity, or from self-interest, but with a genuine concern for the welfare and comfort of those who are about us. It shields the community from the shafts of the destroyer; is a staff for the living, who could not walk without it, and a solace for the dying, who soon must leave us behind them.

We have as yet no means of knowing how many among you are imbued with a proper love and appreciation for this "art, whose end is the saving of human life." You have come hither from all quarters of our common country, and even from distant lands. A great variety of circumstances have brought you together. Thus far you have doubtless improved the advantages that have been in your way, and within your reach. Some of you have already been initiated into the quiz and the clinic; and all of you have at least formed a speaking acquaintance with your text-books. You may even have gone so far, and made such progress in your studies as to have overcome the natural propensity to prescribe for every complaint that is made in your hearing, a bias which is so often in the way of further improvement. But whatever your present status as medical students, you must henceforth try to realize that it is not a mere technical excellence which should interest you and occupy your time and your thoughts for the science, as well as the art, of medicine belongs to humanity. I assure you that it is only by a thorough appreciation of human life and its belongings that we can properly estimate the dignity and the character of our mission.

The text is very comprehensive. Not only does it recognize the vital relation that exists between the physician and the patient, but it also refers to the extent of research, and the variety of resource, that the former must make and employ for the benefit of the latter.

The common idea is that the sphere which you have chosen is a narrow one, and that all a doctor needs is a superficial knowledge of science, and a slender stock of prescriptions which may be dealt out as occasion requires. No doubt this tradition had its root in the fact that there are many so-called physicians who flourish and thrive on very slight attainments, and whose curative capabilities are very limited. Something of this distorted view of our function and of its necessary outfit must, however, be charged to the profession itself, for it is the fruit of an undue, illogical, empirical excess of confidence in a single class of remedies, indications and expedients. Sangrado,

with his blood-letting and warm water, as sovereign specifics against disease, has had a numerous progeny, and, to use a homely saying, "the fools are not all dead yet!"

If I am not very much mistaken the proposition will hold good that, when a doctor scouts the idea of a scientific basis for the practice of his art, and shuts himself in to the exclusive use of a single agent or expedient, or of a stereotyped form of prescribing, he is a *fractional* physician. He certainly has no adequate conception of his duty to those who confide in him, or of his professional and personal responsibility. Otherwise he would search more widely and wisely, and store up every grain of knowledge that could possibly be of service in curing the sick.

In the natural division of labor which is a necessary result of the développement of the sciences that are collateral to medicine, and of the expansive growth of applied therapeutics, there is danger of confounding this fractional bias with the sphere of the specialist. But the true specialist is the ripened product of professional training. As a student he grounded himself in the elementary sciences, and then by perseverance in reading, observation, reflection and comparison, became a physician first and a specialist afterward. "A specialist," says a distinguished writer, "is one who knows something of everything and everything of something." You would not trust the pretended oculist who has never studied any portion of human anatomy excepting the eye; and who, beautiful and wonderful as it is, proposes to limit his knowledge to what lies within a little orbit—for you know very well that there is no such animal as a natural oculist.

Neither can you find a natural surgeon, nor a born gynecologist. There are those among us who are possessed of a peculiar adaptation to the practice of these specialties; but the gift is an incentive to hard work and study, and not by any means a substitute for it. It is an element of skill and of success, but it is not sufficient of itself, nor will it compensate for ignorance of very much that concerns the whole animal economy as well as the general literature of our profession.

The medical student of our time is embarrassed by two apparently conflicting conditions that are imposed, and to the fulfillment of which some practical answer must be made. These conditions are the demand for a wider range of knowledge on the part of the

sician than was formerly requisite ; and (2) the fact that, although more is required of the student, the term of his pupilage has not really been extended.

How will it be possible for you to learn more in the same length of time than your teachers did ? This is the practical question that confronts you on the very threshold of your enterprise. Some of the schools have thought it possible to meet the demand by multiplying the number of teachers and lecturers, as well as of the subjects that are taught ; by graded examinations, and by lengthening the term of instruction to seven or even to nine months. This plan is a plausible one, and on its face seems to meet the requirement, but in point of fact it is fallacious and misleading. Let me tell you why :

1. The branches that are essential to a sound medical education do not outnumber the fingers on your two hands. Until those branches have been thoroughly mastered, the multiplication of your studies would be embarrassing and mischievous.

2. The average medical student whose previous reading and training have necessarily been limited, and possibly without the proper direction (for it is almost an exception if he has had a faithful preceptor), cannot thoroughly master these fundamental branches in a single course of lectures. He needs "line upon line, and precept upon precept," if he is to be rooted and grounded in them. To pass him through a mere technical examination at the end of the term, and then permit him to shelve these studies, puts a premium on a smattering of the necessary knowledge, and will tend to make him shallow in all his attainments.

3. Too many teachers, like too many cooks, "spoil the broth," and it becomes unsavory, indigestible and pernicious. When a faculty has too many irons in the fire, too many topics on hand, and too many theories to explain and to defend in the hearing of the class, the ultimate purpose of medical education will be lost sight of, just as "men cease to think when their words become too fine."

There are college faculties that seem to have been organized on the crazy-quilt pattern. They may perhaps have a pretty decent center-piece, but all the rest is made of scraps that would be of precious little value anywhere.

4. If the course of instruction is confusing, it is manifest, I think, that merely to stretch it out for a few weeks or months will not mend the matter. To crucify them in such a way certainly



would not tend to clarify the student's perceptions. And there is another consideration which is that, almost without exception, the added studies of the modern curriculum are theoretical, and not clinical. The consequence is that in the lecture room there is a great and growing excess of *talk* which is lacking in point and in illustration. If the course is prolonged this kind of preaching will become dreary in the extreme. The fact is that there are not more than half a dozen teachers in America who can profitably talk to a class of students on any medical subject in a didactic way for nine, or even for six consecutive months. With the rest of us the risk would be that, if the course was extended, our prosy old sermons would convert the colleges into dormitories, of which there are too many already.

Seriously, there should be and there is a better way. And during your college course that way consists in giving your undivided attention to those studies which are most necessary, avoiding such as are ornamental, and availing yourselves meanwhile of all the clinical advantages that come within your reach. The cardinal branches are to the physician what the multiplication table is to the accountant. He must apply them at every turn, and he cannot, therefore, know them too well.

When I was in college, thirty-five years ago, our professor of obstetrics\* devoted the first half of his course to a careful and thorough analysis of the mechanism of labor. His lectures and demonstrations were sometimes very dry and tedious, and we did not always or all of us, get the practical bearing of what might be called his obstetric geometry while we were yet on the benches; but it came to us afterward in the lying-in chamber, and I have never yet seen one of that grand old man's pupils who was not a good and safe obstetrician.

Strange as it may appear to you, there is a tradition that, in the earlier history of that same college, the subject of chemistry was not very popular with the students. The story goes that, because very few members of the class attended the lectures on chemistry, it was the habit of the teacher† to punish the absentees with a severe final examination, and afterward, as a rule, to black-ball them. At the time of which I speak, the faculty examined the students singly, but in

---

\*Prof. H. L. Hodge, of the University of Pennsylvania.

†Prof. Robert Hare.

what was called "a joint session," the candidate being questioned in turn by one after another of his teachers, and in the hearing of them all. A student who had thus far acquitted himself cleverly, came finally to be interrogated by Prof. Hare, who said: "Give me the chemical composition of glass?" The poor fellow was badly scared, for he knew next to nothing of chemistry, but was cudgelling his wits for an answer when Prof. Chapman came to his rescue. "Pshaw!" said he; "what's the use of asking that question? I have been a practitioner of medicine for forty years, and *never gave a dose of glass in my life!*"

Let me speak plainly. Whether you expect to graduate this year or not, your time is limited. The line of your studies must be drawn somewhere, and the knowledge that will be of most worth to you as physicians is what you really want. The essentials can be mastered now, and better than at any other time; and the extra subjects can be studied more profitably further on. It is well enough to know what elements enter into the composition of glass, or how to make a good bleaching powder or a first-class telephone, but that kind of knowledge is no part of *medical* or of *physiological* chemistry, and if you should attempt to acquire it just now, would be so much rubbish in your way.

There is a great deal that is germane to the other branches as well as to chemistry, which at present you can not pause to consider. There are studies within studies, and numerous branches that spring from the old ones—endogenous and exogenous growths that will claim your attention by-and-by, but the parent type and source of their life is what concerns you now. And any neglect of study in the eight practical departments that are included in a sound medical education would indeed be a crime on your part.

By a thorough mastery of these essential branches we do not mean that you will be expected to know all, or for that matter, any of them perfectly. There is no danger of that result, either with teacher or pupil. Moreover, to be a good physician is something more than to be sound as an anatomist or a physiologist, or even as a sanitarian. Put the doctor who is ignorant of *materia medica* at the bedside of one who is very ill, and he will be like a man who is at sea in a ship without a rudder. Put the doctor who knows nothing *except* *materia medica* in the same position, and he is like a man at sea with nothing but a rudder.

My colleagues, and the physicians who have honored us with their presence to-night, could tell you what degree of importance has attached to this question of medical education.

It is a Banquo's ghost at all of our medical gatherings; a bone from which certain juvenile reformers have made oceans of a very vapid broth. Our national society, the American Institute of Homœopathy, now in its forty-third year, always has a special committee on that subject. And so likewise have many of our State and other auxiliary organizations. This is all very proper, and quite as it should be. But through these committees the most curious and the most conflicting, the most sensible and the most silly ideas have sometimes been advanced. I am not aware, however, that, with all that has been said and written upon this very important topic, any one has proposed a practical division of the subjects in question into those which are proper for the undergraduate, and those which should be elective and post-graduate. The whole contention has been limited to what the student should accomplish while he is in college, and before taking his degree. As if it were possible to crowd all the branches that lie within the broad domain of medicine into the regular college curriculum! Or, as if cramming the student's mind with too many dishes would not inevitably turn him out a mental dyspeptic!

My own idea is that, although there is something in the notion that more can be taught, and learned, too, in a limited time than was possible a few years ago, still the natural growth and multiplication of the sciences related to medicine make it necessary that supplementary courses of instruction shall be given. If these extra courses could be objective and clinical, so much the better. And if several of the existing schools could join, each contributing its best teachers to form a post-graduate faculty that had the confidence of the profession, and under which the pupils might perfect themselves according to their tastes, abilities and inclination, a great end would be gained. Such a faculty could carefully and thoroughly discuss all those subjects which naturally lie beyond the scope of the undergraduate, and which, no matter how ambitious or how capable he may be, are out of place in the annual college session.

The proper and thorough study of medicine is the work of a life-time. I would not by any means detract from the value of a single branch that bears even the slightest practical relation to the

healing art, an art which "concerns the cure of the noblest of created beings, the saving of human life, the most difficult, the most sublime, and the most important of all imaginable occupations." But the side-dishes to our intellectual feasts should be fitly prepared and presented or they will clog the appetite, and ruin the desire and the relish for more substantial food.

As you very well know, the work of this school is largely clinical. For the illustration of the various forms of disease in the different departments of clinical study, we have no lack of material. For plain, honest service in teaching, my colleagues have the experience, the talent and the capacity that are requisite, and their former labors and reputation are a sufficient guarantee of their zeal and their fidelity. You will have advantages of this kind that are ample and abundant. But let me remind you in the outset that one of the most serious obstacles with which we have had to contend in building up our clinical reputation must be laid at the door of a share of our pupils. I mean of those who have frequented the clinics, more especially the sub-clinics, when they were but illy prepared to appreciate them. For a certain amount of previous reading and study are absolutely necessary to illuminate and to emphasize a bedside lecture; and so also is the habit of noting carefully and correctly what one sees and hears in such a way.

The work of the teacher is greatly facilitated if he sees (and he surely will discover it) that the student is already familiar with the clinical history of the disease in question; and if he knows (and he is certain to find out) that the case will not pass out of the student's mind before the subject is carefully studied, the proper authorities consulted, and the facts that are of value recorded for future reference.

Your pathway is beset by peculiar difficulties, not the least discouraging of which is the discrepancy that you will find between what you have read in your books in many cases and what you will see and hear at the bedside. Our clinical lessons will set this matter right, but only on condition that you labor incessantly to get the most that you can out of them. For a good clinic is the test and touchstone of what is practical and useful in medicine and surgery. There is no such antidote for useless speculation in medical matters as contact with the sick and the suffering, and with the necessity for giving the why and the wherefore of a prescription, or of an operation, to an intelligent and progressive class of pupils. In former times and elsewhere,

medical students have been and are being drilled in everything excepting the kind of knowledge that they will need in the sick chamber. This commodious and comfortable amphitheatre was built and rebuilt to correct that very abuse.

But the best *clinicien* in the world can not succeed as a teacher if the students regard him as a mere showman, whose business it is to amuse the class, to exhibit anomalous cases, to "shed blood" in astounding operations, or to deliver a harangue upon sectarian medicine. With a well-stored intellect, a sound judgment, a skillful hand and a warm heart, he will bring the light of science and of experience to bear upon the case that is before the class; but the pupils must be earnest and intelligent, ready and eager to grasp and to retain the lesson that is imparted, or the occasion will slip, and they will go away without being benefited. Depend upon it that if you are equal to your privileges under this roof, the more difficult the task, the greater the fascination, and the greater the reward.

"All our life is a meeting of cross-roads where the choice of directions is perilous." Your option to-night is a personal one, and so, likewise, is your responsibility. It is for you to say whether you will fill your minds with the solid merchandise of knowledge, or with its empty packing-cases; whether you will concentrate yourselves upon the work before you, and consecrate your lives to the duties and the rewards of the thorough physician, or whether your neglect to make yourselves masters of the art of healing shall involve a crime on your part.

Good lawyers know that in many cases where the decisions are correct, the reasons that are given to sustain them may be entirely wrong. This is a thousand times more likely to be true in the practice of medicine than in that of the law, and hence the impropriety, not to say the folly, of spending your time in the discussion of medical belief and theories of cure that are more ingenious and seductive than they are profitable. When I think how much time has been wasted, and worse than wasted, in this way, I am reminded of the words of Hahnemann, from whose writings, indeed, my text was originally taken. He says:\*

"The rallying motto of a sectarian name is incapable of exciting to sober, calm, scientific investigation; it only rouses the explosive

---

\**The Lesser Writings of Samuel Hahnemann*, collected and translated from the Latin and the German by R. E. Dugeon, M. D., New York. Wm. Radde, 1852, page 363.

spirit of accusations of heresy to a fierce volcanic flame. Truth and the weal of humanity should be the only motto of the genuine elucidators of the art, and the watch-word of their brotherly, peaceful bond of union, *without slavish adherence to any sectarian leader, if we would not see the little good that we know completely sacrificed to party-spirit and discord.*"

At the close of the lecture Prof. Hoyne announced that the regular course would begin at 9 o'clock the next morning.

#### THE STUDENTS' ANNUAL REUNION AND RECEPTION.

For the convenience of those members of the class who could not be present on the opening night, the annual reception was postponed for one week. It accordingly took place on the evening of September 29, at the Palmer House. The occasion was a thoroughly enjoyable one, and was participated in by over 200 pupils, besides a number of alumni, physicians and invited guests. Without disparagement of former experiences of a similar kind, when everybody was happy and hopeful and gay and bright, we may chronicle this reunion as the most successful and satisfactory in all respects of any that have been held during the more than a quarter of a century since the "Old Hahnemann" was first opened. Surely we never had such a delightful social mix-up—such music, such food for the palate, and such after-dinner speeches before. If any old croaker with a voice full of night and of darkness had been within sight or hearing of the happy throng, he must have changed his tone *instantly*.

A pleasing feature of the affair was the speeches of the students from different and distant parts of the country, with kind and complimentary reference to the reasons which had induced them to select this school in preference to others. Their remarks were also full of appreciation for the style, character and thoroughness of the lectures which they had already heard in the opening of the course, and for the clinics, which had taken them by surprise, and, in numbers and excellence, had exceeded their most sanguine expectations.

## Hospital Notes.

### MEDICAL CLINIC.

#### SERVICE OF PROF. HAWKES.

GASTRALGIA.—*Case 13080.*—Mrs. D. is a middle-aged, slender, very delicate, blue-eyed woman, extremely mild and gentle in manner; came for treatment March 9, 1885. Mother of six children, the youngest three years old, and she has not been well since its birth. She had her first miscarriage six months ago. 'All her labors have been very nearly painless. She never had bearing down, nor other evidence of female weakness. The placenta was retained after birth of the youngest child. (She was attended by a midwife.) On the ninth day she tried to sit up, and being taken with hæmorrhage was carried to bed. The flow continued three days, the odor being so offensive that the husband and family complained of it. A physician was sent for, and he removed, he said, a large part of the placenta. She has not been well since. At the proper time she menstruated naturally. She thinks she has never had female weakness, although the different physicians she has had referred her trouble to that cause. She has taken enough medicine to kill an ordinary woman, she is sure, and never wants to take another dose; is sure, too, that medicine will not help her. Her stomach will not bear it. She refers all sickness to the stomach, and the cause of the suffering to taking food, which brings on paroxysms of pain almost unendurable. Gas fills the stomach and abdomen nearly to bursting. The heart palpitates, and breathing is interrupted. The head feels as though it would burst. She "feels gas to the tips of her fingers," she is sure. The pain seems to culminate in the region of the solar plexus, and is of a bursting, stinging character. At these times she has frequent micturition with tenesmus. She has suffered from obstinate constipation from the first; a passage every fourth day; stool not hard, but small in amount. She thinks that abortion six months ago was caused by one of these spells. She cannot take anything into the stomach without having this terrible distress. Food looks good, but after eating it makes her extremely miserable. She always has a bad taste in the mouth, and

the tongue is covered with a tenacious mucus like a membrane. She is always chilly. Not usually thirsty; but at times drinks large quantities. She dislikes anything that has grease in it. There is much rumbling in the bowels; flatus constantly moving and pinching. She feels better out of doors, but is too weak to go out. She craves fresh air, although it makes her chilly. She sleeps poorly the fore part of the night. She dreams constantly, mostly of animals.

*Pulsatilla* 3 three times a day was prescribed.

March 16 I saw her; the change was wonderful. Her face was bright, smiling and cheerful. She said that after taking the medicine one day all the gas symptoms disappeared. She has since been able to eat like the rest of the family. All her courage has returned. She has not cried since here last; thinks she was starving then. Gave the same prescription. I have seen her twice since March 16, and the report is "still well."

"SNAKE IN THE STOMACH."—*Case 13088.* March 12, Mrs. Lizzie B., aged thirty-three, a widow and mother of four children. She was taken sick seventeen months ago, and has been treated by five different physicians without the slightest relief in any particular. She awakens in the night with her mouth full of foam, which causes choking; at other times a lump seems to suffocate her as if something had lodged in her throat; the least pressure in this region is distressing. For about a year she was troubled with a sensation of something in left side like a ball filled with water, which caused great pain by constantly changing position, especially in the region of the stomach; her appetite is poor; frequently she has gnawing in the stomach, which a little food relieves. She has a longing for dry starch, which, when taken, always makes her worse. She has had pain in the left ovarian region since January, and has been nearly wild with a sensation like something alive starting in the left side, with a whirling rapid movement, causing a burning, sticking pain, which is nearly constant. *She is positive there is a snake or something else alive in her stomach, and there is no use of treating her unless that is first removed.* This notion was humored in order to hold her, she being assured the snake would be removed after we had her sufficiently built up.

The menses are scanty, sometimes delayed a little; obstinate



constipation. She is in the habit of taking cathartics; she is feverish, and has hot flashes at such times.

She cannot bear pressure of clothing about the throat, stomach, or abdomen; she has taken off her corset, and has a constant desire to raise her clothing from the lower part of the abdomen; "they make her feel so uncomfortable."

She does not sleep well; dreams of snakes, worms and irregular shapes, and awakens very much disturbed and unhappy. *All her symptoms worse after sleep.* Head feels heavy; she can scarcely raise it from the pillow in the morning. Flickering before the eyes, and dimness of vision; slight exertion causes great exhaustion; she is very nervous; cannot sit still, and is unable to apply herself to any task. Worse mornings and evenings. Gave *Lachesis* 200, four doses.

March 19. Much better, all the throat and stomach symptoms have disappeared. She rests well at night, feels rested in the morning, and is not so nervous; has a stinging sensation in the abdomen. *Placebo.*

April 9. Moving sensation has returned, but mostly in the pelvis; never higher than the iliac region. It feels like a girdle at times; again it moves more rapidly. The same sensation is felt in the upper part of the brain. *Lachesis* 200, four doses.

April 16. Decided improvement since the last report. She complains now chiefly of a sense of weight in the pelvic region. *Placebo.*

AMENORRHOEA WITH ANÆMIC CONDITION.—*Case* 13064.—December 4, 1884. Betty P——, aged 18, Swede. She has been in this country six months. Her periods have failed to appear since her arrival; they were established one year ago. The patient has blue eyes, light complexion, very quiet in manner and speech; pale, colorless skin, decidedly chlorotic in appearance; variable appetite. She does not like meat, and especially fat; has headache nearly all the time; is better in open air, worse in a warm room; very bad taste in the mouth mornings; cries very easily, and is very despondent. Menses were profuse at first, and stopped suddenly. *Pulsatilla*, a dose of 6th at noon, and one of 200 at bed time.

January 8, 1885. Looks very much better; more color in face and lips; appetite is better; is less despondent. Menses have not yet returned. *Sac lac.*

January 15. Improvement continues; has no bad taste in the mouth; head has ached some; generally better. Menses not returned. No medicine.

January 29. Does not look so well. Has more headache than last week. Menses not returned. Three doses *Pulsatilla* 2m.

February 12. Growing stronger; not so much headache; spirits better; some pain in the abdomen; sleeps well. *Sac lac*.

March 5. Improving; color better; no headache; no bad taste in mouth; more cheerful. *Placebo*.

March 19. Same report of improvement as 5th instant, but menses have not returned. *Placebo*.

March 26. Improvement continues, excepting her complexion, which is not so good as when last here. Probable cause a severe "cold." *Placebo*.

April 16. Says she has grown steadily stronger since she first came to this clinic; can now "do quite a day's work." Overdoing causes discomfort in the "small of the back." Otherwise says she feels quite well. *Her menses have returned*.

CHRONIC LARYNGITIS. — Case 13068. — January 8, 1885. James D., Irish, aged forty. Had pneumonia twelve or thirteen years ago, and his chest has been sensitive ever since; soreness across upper part of chest at present, with difficult respiration; dull heavy pain in the region of the heart; gets out of breath and has palpitation on going up stairs or exercising. He is worse in open air. Cold air chills him. He has constipation of small, slender stools. *Phosphorus*, dose of 6th at noon and of 200th at bed time.

January 15. He is better; ability to expand chest improved. Soreness across the chest has disappeared; as has also the dull pain in the cardiac region; less palpitation; does not get out of breath so easily. *Sac. lac*.

January 29. He has been gradually improving; appetite better; still has some pain in region of the heart, though not so much; does not get out of breath so easily. The bowels are regular. *Sac. Lac*.

February 5. The throat troubles him but little; pain in chest not so bad as before; growing stronger. *Sac. lac*.

February 12. The pain in the region of the heart is a great deal better; has very little palpitation; bowels normal; can endure cold better; sleeps better. *Sac. lac*.

February 19. He says his throat is almost well. Chest does not trouble him at all. "Feels he is almost entirely cured." *Sac. lac.*

**CHRONIC BRONCHITIS.**—*Case 13072.*—January 15, 1885. Rev. C. M. H., aged forty-five, has had bronchial trouble four months; has tried nearly everything; received most help from compound oxygen; has had three attacks of acute bronchitis in last twenty-five years. His mother died at the age of thirty-four of phthisis, and his son of the same disease at the age of twenty-one.

His present trouble was brought on by taking cold, while speaking in a cold room. Throat is dry; almost constant hoarseness; constricted feeling in chest, and feeling of obstruction in larynx. When he gets warmed up in speaking, hoarseness disappears; heat relieves; short hacking cough at times, with sudden expulsion of plugs of sputa; some rheumatic pain in chest, of sharp or cutting character; better in open air. *Bryonia*, dose of 3d at noon, and of 200th at bed time—two doses only.

January 29. Constricted feeling in chest and obstruction in larynx have disappeared; also hoarseness and hacking cough and raising of plugs of sputa. He took a slight cold, which he thinks causes rheumatic pain in chest. *Sac. lac.*

February 5. He is entirely free from bronchial trouble. The pleurodynia, of which he complained last week, has disappeared. He had some rheumatic pain in the thigh and leg last night. *Sac. lac.*

### THE GYNECOLOGICAL CLINIC.

**VESICAL EXPLORATION FOR THE DETECTION OF DISEASED TUBES AND OVARIES.**—The operation was made in the sub-clinic before class No. 4, October 2. The following is a brief history of the case:

*Case 17342.*—Miss —, æt. thirty, while swinging, six years ago, fell against a tree and injured the left pubic region. Since then, she has never passed her urine without the aid of a catheter, the introduction of the instrument at times producing vomiting and vertigo. Occasionally she has a spasmodic stricture of the œsophagus, which prevents the swallowing of food, or causes its rejection, and an inveterate nausea which lasts for days together. She is of a decidedly hysterical temperament. January 9, a local examination showed a stricture of the urethra, latero-version of the uterus and inflammation and enlargement of the left ovary. *Ignatia* 3, and *Arnica* 3, were prescribed, and she was sent home to Wisconsin.

September 25.—She improved for a time, was better of the stricture of the œsophagus and of the nausea, but the urinary retention and the dysmenorrhœa continued. The bowels move but once a week, and she cannot sleep or rest without morphine. She is a complete nervous wreck.

In commenting upon this case Prof. Ludlam said that a considerable share of bladder troubles in women are of traumatic origin. Falls and blows upon the pubic region, and also upon the lumbo-sacral portion of the spine, are very apt to induce a dysuria, retention, or incontinence that may continue to vex the patient until the cause has been forgotten, or other complications are set up that mask the case and mislead the doctor. This patient has been ill for six years in consequence of such an injury, and during all that time has never passed her urine naturally. Meanwhile her menstruation has become so painful, and her nervous system so demoralized, that it would "deceive the very elect" to decide upon the nature and cause of her difficulty. It really seemed as if the mischief was in the ovaries, and I said to one of the clinical classes in January last that the way to a rational diagnosis was through an abdominal section, after which Tait's extirpation of the ovaries and the tubes would probably be necessary.

While she is being anæsthetized in the ante-room, I must tell you that we propose to explore the bladder by a thorough digital examination. First, we shall dilate the urethra after the manner already described.\* This will be done rapidly, because it is safer and more satisfactory than the old method, and, once my index is in that cavity, it will determine if there is any foreign body or morbid growth that needs attention. If we find nothing wrong within the bladder, we shall feel about it by the conjoined touch through its walls. In this way we propose to settle the question of ovarian and Fallopian enlargement, providing, of course, that those organs, upon one side or the other, have not drifted into the Douglas pouch, where they might perhaps be inaccessible by this method of exploration. \* \* \* \*

Every portion of the interior of the bladder having been examined by vesico-abdominal palpation, without finding anything abnormal, the same method was extended to the ovaries and the tubes. The ovaries being *in situ* could be distinctly felt, and the left one was found to be somewhat enlarged, but the right one was normal. Nothing of the sausage-like form of the tubes, which is proper to salpingitis, could be detected, and the conclusion was obvious that neither Tait's nor Battey's operation was necessary.

The patient left the hospital in a week with a slight incontinence at times, but with an increasing ability to hold and to void the urine at will, and with entire relief of all the other symptoms.

---

\*See page 254 of this volume.

## Miscellaneous Items.

The portrait of Dr. Frank Wheeler, assistant professor and demonstrator of anatomy, will bring the face of an old friend to a host of our students.—Prof. Small's work on the Practice, embodying the results of forty-five years' experience, is nearly through the press, and will be ready for delivery before the holidays.—Dr. W. E. Keith has located in San Jose, Cal.; Dr. G. E. Blackburn in Galveston, Tex., and Dr. C. W. Crary at Kenwood, a Chicago suburb.—Dr. Winterburn, 29 West Twenty-sixth Street, New York, would like to hear from any reader of the CLINIQUE, who has successfully treated cases of purpura.—Dr. J. D. Wetmore, '82, is examining physician and surgeon of the Pension Bureau of the Northwest District of Iowa.—The Berlin pessary, elsewhere advertised, is an excellent instrument.—Prof. Crawford is spending a week at duck-shooting in Wisconsin.—Copies of the CLINIQUE are in demand in several large medical libraries.—Drs. Gee and Harvey are doing excellent service in their college capacity; ditto Drs. Stevens and Bushnell in the hospital.—Over an hundred senior students have already taken tickets for the hospital sub-clinics in the "Old Hahnemann" for the winter, while the general class exceeds 250.—Dr. C. I. Douglas has removed to Belleville, Kas.; I. N. Paul, to Perry, Iowa; O. R. Leidy to Belleville, Ohio; J. S. Nitterauer to Ontonagon, Mich.; F. W. Flower to Carthage, Mo., and Emma Cornwall to Cedar Rapids, Iowa.—At the next meeting of the Clinical Society Dr. C. H. Vilas will report upon the diseases of the eye and the ear.—The announcement of the post-graduate course in the "Old Hahnemann" will be found in our advertising columns.—The construction of our new college building will not begin until after the close of the present winter session.—Lea Brothers & Co., of Philadelphia, have issued a new and elegant edition of Barnes's *Obstetric Medicine and Surgery*.—The Illinois State Board of Health will meet in Springfield, October 29.—From Otis Clapp & Son, of Boston, we have a course of *Lectures on Clinical Otology*, by Prof. St. C. Houghton, of the New York Homœopathic Medical College, and the justly celebrated *Lecture on Homœopathy*, by Prof. Conrad Wesselhœft, of the Boston University Medical School.—The editor of the CLINIQUE cannot return rejected MSS., or forward them to any other journal unless the postage stamps are enclosed.





A. K. CRAWFORD, M. D.

PROFESSOR OF PHYSICAL DIAGNOSIS IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL,  
OF CHICAGO.

# THE CLINIQUE.

---

VOL. VI.]

CHICAGO, NOV. 15, 1885.

[No. 11.]

---

## Original Lectures.

### *TYPHOID FEVER AND ITS HYGIENIC AND SANITARY TREATMENT.*

IN TWO LECTURES, BY J. E. GILMAN, M. D., PROFESSOR OF SANITARY SCIENCE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, CHICAGO.\*

#### LECTURE I.

To the sanitarian there are few among the modern epidemic diseases that possess more interest than typhoid fever, for the reason that it is almost an absolutely preventible disease, and in the development and propagation of its virus is such that it is essentially in the province of sanitary work, to interfere and avert a widespread epidemic following individual cases. Typhoid fever as a distinctly differentiated disorder is of quite modern origin, although it must have existed from time immemorial. But until within a few years only, typhoid fever, typhus fever, typhoid conditions and typho-malarial fever were known under the general title of continued or typhus fever. This is the more singular, when we consider that the essential features of the disorders present so many marked points of difference that it would seem that the differential diagnosis must have been outlined in common with other troubles by the earlier physicians, but not until as late as 1849 or 1850, was this done by Jenner. The recognition of typhoid fever in distinction from the other forms with which it has so long been confounded is of great importance. First, in the care that must be given the patient and the attendants; next in the precautions that must be taken to prevent the spread of

---

\* Published by request of the class.



the infection. With typhus fever, the contagion is eliminated, active and ready to strike its victims at once; and the instances are numerous where physicians, nurses and others coming within the immediate surroundings of the disease are at once infected, while the typhoid poison requires a certain, or an uncertain time for development after its excretion from the individual before it has power to infect others. The typhoid poison is of a specific character, and has a very great and long-continued vitality. It was supposed that it was generated in the process of putrefaction of animal or vegetable substances; and yet no experiments in decomposing materials have ever produced the typhoid forms. Sewer gas, and the exhalations of privy vaults from decaying animal or plant matter may permeate the atmosphere of a house, be breathed and absorbed until the individual is saturated with it, and typhoid is not necessarily developed by it. The filthiest places may be exempt and the cleanest localities suffer. Sewage contaminated water may be drunk for years, and no typhoid appear. So that we are forced to the conclusion that it requires something more than putrefaction to produce the disease. In view of the fact that all these unsanitary conditions which we know favor the spread of typhoid, may exist for years without inducing an outbreak, and then upon the contamination of some water source with typhoid excreta the disease appears at once with direful effect; in view of these facts, we are forced to the conclusion that the intimate cause of typhoid is a specific germ, and while its especial form and microscopical history are still unknown, the general method of its propagation is well recognized and understood. The disorder originates in a previous case. All cases come from an earlier one, as animal or plant life does from its parent, and a complete account will always show an origin from some preceding case. Parkes instances many cases illustrative of this point. Of these, one may be introduced as typical. The village of Nunney had been supplied with polluted water for years without causing a case of typhoid. An individual ill with the disease came from a distance to the town. The excreta from this individual reached the stream supplying the town, and a severe outbreak of typhoid followed. All who were attacked drank the stream water. All who used other water supply escaped.

The characteristic excretion or secretion from an infectious disorder carries the distinctive virus of the disease. Says Budd: "In typhoid the stools are the characteristic excreta, and the discharges

from the intestines contain the germ from which new infection is evolved." That the germ is not immediately infectious is proven by the fact that the physicians and attendants do not contract the disease directly, as is the case with typhus and other infectious disorders. Liebermeister says he never has seen a case of direct infection. Dr. Austin Flint bears the same witness, and many other authors with long and great experience agree on this point. We may accept it as a fact that the development of the typhoid virus must take place outside of the body, and the soiled garments or bed clothing, or the excreta deposited in sewers or cess-pools may serve the purpose. Undoubtedly the cess-pools, piles of filth or moldering vegetation will act as a hot-bed to engender a vigorous growth more readily than soiled clothing, yet there are trustworthy instances of the latter serving as foci of infection. The germ is not easily destroyed. It will evolve its power in water that is clear and ice cold, and in the recesses of drains, and will filter through earth for considerable distances without oxidation. It will retain its vitality in an unmolested spot for years, and strike with deadly force when uncovered. It reproduces only its kind, as is the common characteristic of plant and animal life, and in the same regular type and order of development. By the most marked analogy the disease belongs in the group of disorders that are due to the existence of minute organisms and presumably of bacterial origin. Numerous tribes of bacteria inhabit the intestinal canal, and the difficulty of selecting the one that is the especial cause of any disorder is great. There have been several bacterial forms ascribed as the typhoid bacillus, notably Ebert's; but the crucial test of the reproduction of the disease with its characteristic intestinal lesions is still wanting. But its round of existence is, first, the absorption of the active germ in the body, then its location in the intestine, the excretion in the stools, the dormant state of sporification, and the waking into vitality ready to renew its life history. It is of very modern date that the influence that water exerts in the dissemination of the disease has been known. If the stools are so placed that they percolate through the soil into the water courses or wells, the individuals who imbibe the contaminated fluid drink to their own injury; or if deposited in confined places, after the lapse of time if the covering is removed and the effluvia be allowed to escape the susceptible person who inhales its spores receives them as the initial of the disease in

his organism. Through the respiratory organs and through the alimentary canal the virus is received, the latter being the most common method, and is followed by more speedy and active results than the former, and as the water is the most frequent vehicle of transmission it should be one of the first of the subjects investigated when a case of typhoid occurs. Dr. Flint's account of the epidemic at New Boston is an instance of the transmission of the disease through the water supply. This was in a small hamlet where no case of typhoid had ever appeared. A man traveling, ill with the disease, and unable to continue his journey, stopped at the hotel and there died. The privy of the inn was situated three or four rods from the well, which was the water supply of the whole village except two families, one but a few rods distant, the other too far away for it to be conveniently used. Within a few weeks twenty-eight of the forty-three inhabitants were ill with typhoid. Owing to a quarrel the family within four rods of the inn were debarred the use of the well, and so had another one dug. Not one of this family took the disease, although they lived in the same conditions of the rest of the neighbors, who suffered severely, but did not use the same water. The water of the inn well was sufficiently near the privy vault to allow percolation of the contents through the intervening strata, and so the water was infected. The village of Lausen for nearly sixty years had been free from any epidemic of typhoid. Individual imported cases had failed to spread the disease. All at once a severe epidemic broke out, and about seventeen per cent of the inhabitants of the village were taken ill with the disease. The most general water supply was that furnished by a stream running through the village. All the inhabitants using other water than this escaped entirely. The source of the infection was traced to a farm house on the other side of the mountain ridge, where there had been an imported case of typhoid, followed by two others. A small stream ran past this house, into which the dejections of the patient were emptied, and the brook, as was ascertained, was so situated that it percolated through the mountain into the source of the Lausen supply. To determine this fact eighteen cwt. of common salt was emptied into the brook, and the saline taste was soon perceptible at Lausen. As a further test fifty cwt. of flour was thoroughly mixed with the water of the stream, and not a trace of the flour was found in the water issuing from the spring on the other side of the mountain; showing that its passage was not by unbroken channels, but

was filtered through earth strata. As the investigation of the origin of typhoid is an important one, let me instance the account given in the Connecticut State Board of Health Reports for 1884.

This narrates the history of the course of typhoid in a family consisting of seven persons, aged from six to forty-two years of age—a father, mother and five children. The father was taken ill first, and the others followed in rapid succession, so that from the 23d of February to the 19th of March the whole seven were down with the disease. The house was an isolated one, with no neighbors nearer than one-eighth of a mile, and another one-half of a mile distant. The house was one-fourth of a mile from the public road, and there had been no typhoid near them. The house was clean and tidy. The ventilation was superabundant, for the cracks and crannies between shrunken windowsills and enormous spaces between the doors and door frames gave rise to more study how to keep the air out than how to let it in. The cellar was clean, and contained no offensive material. The natural drainage of the place was away from the well to the privy vault, so no danger could be feared from the closet drainage. Above the house and well, however, was a sort of sidehill, upon which a garden had been made, and an investigation showed where two lines of drainage from the garden had formed directly to the well, and channels had been worn in the passage of the water to this receptacle. A careful inquiry set forth that a quantity of house refuse had been spread over the garden spot on this hill side, and this washing down to the well introduced and continued the disease. In the Massachusetts State Board of Health Reports for 1879 there is a case where the water was infected, yet gave no indication from either smell or taste of its character. At Fairhaven, in the latter part of August, Mr. ——— was taken ill with what appeared at first to be dysentery, but proved to be typhoid fever. The dejections were emptied into the privy vault, situated one hundred feet distant from the well, and separated from it by intervening strata of gravel and loam. The well was twenty feet deep and quite low. It could be pumped dry in ten minutes. There came on two heavy rains, presumably washing the soluble and fluid portions of the excreta from the vault through the soil into the well by a channel already formed or by seepage through the ground water. From the date of these rains to the middle of October eight of the members of the family, all in fact who used the water, were ill with typhoid, and at about the time, allowing for the usual incu-

batory stage of the disease, when the well might naturally become contaminated with the specific poison of typhoid. Prof. Nichols examined the water, and found ample evidence of organic material in it. To test the connection between the privy and the well a bushel of coarse salt was emptied in the vault October 24th, and a week later a bushel of fine salt, and the salt was presently found in the well water; thus proving the directness of the seepage from the privy vault to the well water, a connection that it is fair to infer, had existed for a considerable time, and only made its specific action in inducing typhoid on the entrance of the specific germ. In the village of Terling, in England, a severe epidemic of typhoid broke out, and carbolic acid was poured into the cess-pools to destroy the poison. Within a short time the water in the wells was so tainted with the odor of the carbolic acid as to render the water too unpleasant to use, and demonstrated the contamination of the wells from the privy vaults. The instances of similar character to those already narrated are almost numberless, and if the unwritten reports were made on all cases of typhoid outbreaks whole libraries would result. Another source of introduction of typhoid is found in milk. Dr. Ernest Hart, in the fourth volume of the Transactions of the Medical Congress, in London, 1881, has collated and tabulated fifty epidemics of enteric fever, comprising no less than 3,500 cases traced to this source. In this report were included also details of epidemics, comprising 800 cases of scarlatina, and 7 of diphtheria with 500 cases, all traceable to the use of milk from infected sources. Whether the germs entered the milk from tainted water that was added to adulterate it, or by absorption of emanations from infected cess-pools, it is impossible to say, although, in the cases of the scarlatinal and diphtheritic infection, it would be quite easily conveyed by discharges from the throat or skin of persons affected by these diseases and employed about the dairy. Without doubt the milk would prove to be a suitable nutritive material for the development of the typhoid bacterial forms, if such exist. We know the absorptive power of water. A glass of water exposed in a room will speedily become too foul to be used, simply from its absorption of air abominations. Even in our medicine glasses, covered with a book, the liquid will speedily derive a flavor of literature from the bookbinding only a little less than would result from soaking the cover in the fluid. So there may be a possibility of the milk becoming infected in other ways than by the fraud of adding water as an adulteration, or from washing the uten-

sils used in the dairy in water that is infected. Simply being in the room or locality where the effluvia of typhoid is present in sufficient quantity to come in contact with the milk, and this absorptive action would be active enough to contaminate the lacteal fluid and convey infection to the consumers. The possibility also must be considered of the infection of the milk by the animal itself, a subject that is being investigated and of which very little has been determined. That from this source a poison may be furnished capable of producing disease, read the records of the milk sickness of our own State; and there have been well authenticated and careful experiments by Dr. Klein and others, which show that a cow may be inoculated with scarlatinal poison and transmit an acute specific disease to pigs. There is also strong reason to believe that tuberculosis may be transmitted through the agency of the milk of cows suffering from that disorder. Hirsch gives numerous instances of outbreaks of typhoid through the agency of milk.

In the summer of 1873, in one of the most fashionable parts of London there was an epidemic of typhoid fever, and among about ninety families, some 300 cases of typhoid were found within four weeks of each other. The outbreak was in an extended district where the sanitation was good, as all the families were well to do, and among people that had but one thing in common, and that was, that they received their milk from one dairy company. Inquiry elicited the fact that at one of the sources of supply of the company a man had died of typhoid. The cess-pools into which the stools were thrown communicated with the well from whence the water was drawn for washing the milk cans, and perhaps diluting the milk. Besides the entry into the system through the alimentary canal, the typhoid poison infects through the organs of respiration. Air containing a concentrated contagion is a much more dangerous element than when the same amount of contagious principle is largely diluted, and free ventilation and the introduction of fresh air into confined spaces is one of the best of sanitary measures. Budd, in his work on typhoid, narrates the history of the outbreak in the orphan asylum near Bristol, illustrative of this. The fever broke out in the person of one child the first week in August. As soon as she began to droop, she was placed in the sick room of the institution away from the others. Early in September, in the fourth week of the illness of the first case, others came down with the disease in quick succession until in November. During this time twenty-three of

the fifty inmates were attacked. Diarrhœa was a troublesome symptom of the epidemic, and the discharges were emptied into the latrine in common use by all the inmates, but the sick were absolutely isolated from the well. In all other respects than one, the institution was a model one. The water supply was not infected, and the sanitary condition of the premises was apparently all that could be desired, with the exception of the privy, and to this, very serious objections could be made. It was an ordinary vault and not a water closet, and the place was close and poorly ventilated. A dead wall stood directly in front of the door, and the windows of the small room could not be opened, so the emanations from the fecal matters were not diluted by that admission of free air so necessary to safety, but were inhaled in a highly concentrated form. For nearly twenty years this latrine had served its purpose for the whole asylum, and up to this time there had been no fever, while hundreds had breathed its exhalations. It was no more offensive during these months of sickness than it had been for years, and as Budd says: "To suppose that an agency, which for so many years had not caused one case, should now cause more than twenty at once, would be on its face absurd. The extreme contrast between present great prevalence and past total immunity, was in this instance, also, clear proof of the introduction of a new element." This new element was the germs contained in the stools of the one patient ill with typhoid. These emptied into the common receptacle when the conditions for its development were present, soon infected the close and stagnating air of the apartment and the fifty persons who daily were exposed to its baleful breath, soon exhibited the effects of its influences. Numerous other instances of infections in barracks, in prisons, in schools, in asylums and hotels have occurred when the outbreaks have been carefully investigated and the other possible causes inquired into and eliminated, leaving this one of infected sewer emanations as the only possible origin of the disease. If time and space would permit, the proposition could be further emphasized by the narration of similar histories. There may be an occasional case of enteric fever which has a starting point from so remote a cause as to elude the most careful scrutiny, and those isolated cases have given rise to the theory of spontaneous generation of the poison. But facts do not seem sufficient to bear out this theory, for all the elements which favor its production may be present, such as animal and vegetable decomposition or sewer gases for years; yet, not a single

case of typhoid fever be developed until the typhoid poison is brought within the boundaries favorable to its development, then a severe epidemic of the disease may appear. Decomposition is simply the soil in which the specific poison finds its pabulum.

The history of typhoid shows that the disease is found in all parts of the habitable portions of the world. Greenland has suffered with repeated epidemics during the last thirty years, and in Mexico and the West Indies it adds largely to the bills of mortality. In India, among the hills and "on her coral strands" typhoid is found, and the Australian continent loses many inhabitants blasted and burnt with its pestilential breath. Africa finds typhoid one of its catalogue of severe and fatal fevers, and Europe and the isles of the sea furnish annually a long list of victims to the ravages of this disease. No country is free, no climate exempt, and while some latitudes suffer less than others, all are affected. As a general rule, it is most prevalent and severe in the temperate zones, but frequent outbreaks have been observed in the West Indies, the Bermudas, Cayenne, Brazil and other countries; and in the remarkably frequent cases of typhoid sickness among the crews of ships in harbors in the tropics (Hirsch's Handbook, page 642,) we have evidence enough of its very general diffusion and disregard of climatic influence. There is a greater influence than climate in disposing to the contracting of the disease, and that is age. Extreme youth and old age are not as liable to take the disorder as youth and early adult life, although no age is absolutely exempt. Murchison says that persons under thirty are more than four times as liable to enteric fever as persons over thirty; while from fifteen to thirty years of age will include largely the greater proportion of all cases occurring. It is a matter of record that there have been numerous cases of typhoid arising in extreme old age and in infants born with the disease. "Panelli on Typhoid," page 32, gives an instance of a child dying on the eighth day of its life and the fifteenth of the disease, and speaks of others but little older who have unmistakably passed through the ordeal of typhoid. The time in the year has a great influence on the disease, the four months, August, September, October and November developing more cases of typhoid than all the other months inclusive. The condition of moisture and dryness of the soil, Pettinkoffer says, has a marked effect on the production of typhoid, especially if rapidly succeeding one another. Pettinkoffer and his associates, after a long series of observations in Germany, claim to have discovered that



there exists a very close relation between the height of the ground water and the typhoid fever. When the ground water was low, especially if it had lowered rapidly, the disease was increased. Parkes says that observations in England do not confirm this in that country, for in some instances the disease made its appearance, and was at its height while the ground water was rising or high. Liebermeister explains the German scientists' facts and theory in this manner. He says: "When the water level sinks the layers of earth saturated with water and organic substances which are left exposed to the air undergo extensive changes of a putrefactive nature. When the water rises these layers of earth are again covered, decomposition stops, and the products of previous decomposition are covered over by the water." Now, as the water recedes it becomes more concentrated in solid materials. The higher the ground water in the spring or well the purer it is. The lower it becomes, especially if it recedes rapidly, the larger portion of organic matter it will hold in solution, and if the typhoid germ finds a lodgment in any spot connected with the well by drainage it would more readily follow the drift into the water receptacle. In this country, as in England, the majority of observers agree that Pettinkoffer's theory does not coincide with the facts, and while it may be so in Germany, it cannot be relied upon implicitly to explain the phenomena of the disease generation elsewhere. In the Michigan State Board of Health Reports for 1884 is a very excellent paper by Dr. Henry Baker, who adopts the Pettinkoffer theory substantially as observed by him in the State of Michigan. When the ground water is low he thinks that there is a greater tendency for a more rapid drainage of foul matters toward the wells. But an analysis of the statistics upon which he bases his opinion only gives to my mind the idea that the lowness of the ground water in the cases where it did correspond was an accidental coincidence, and not a cause of the disease. I can, however, see how it might be a factor to produce it in some instances by the method of gravitation of water from privy vaults to a lower level, conveying disease germs with it. This is quite in consonance with the observations of Hirsch, who says: "So far as we may form an opinion neither absolute dryness nor absolute dampness of the soil appears to be decisive for one side or the other, inasmuch as typhoid is as often prevalent on wet as upon dry ground" (Hirsch's Geographical and Historical Pathology, page 658).

## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

---

NOVEMBER MEETING, 1885.

The regular session of this Society for the current month occurred on Saturday evening the 7th, in Club Room 4, at the Grand Pacific Hotel, Dr. H. B. Fellows, president, in the chair.

There was a large attendance of physicians and students, and they exhibited manifest interest in the chief business of the meeting, which was the

### REPORT OF THE BUREAU OF OPHTHALMOLOGY AND OTOTOLOGY.

C. H. VILAS, M. D., CHAIRMAN.

A REPORT ON EYE OPERATIONS FROM THE EYE AND EAR DEPARTMENT OF THE HAHNEMANN HOSPITAL, BY C. H. VILAS, M. D.,  
CLINICAL PROFESSOR OF EYE AND EAR DISEASES.

Since the Eye and Ear Department of the Hahnemann Hospital was placed in my charge, through the courtesy of our many friends and alumni, and what they are pleased to term the excellent reputation of its surgery, its circle and wards have never been without material to demonstrate before the class of attending students and practitioners the varied operations peculiar to the ophthalmological and otological specialty.

Before each successive class there have been performed the typical operations so essential to a proper understanding of the technical intricacies of these delicate organs. If the numerous, warm encomiums received from many of our graduates since their departure, is any indication of the practical value of these clinical expositions, I may feel well rewarded for all the pains taken to properly present

them. But a small number of the many physicians and surgeons, however, who look to this already great and increasing center for the dissemination of medical knowledge, can directly share in the benefits so freely accorded. It seems the part of wisdom, then, in some other way than by direct observation, to place the results of such operations and medical treatment so plainly on record that all who desire—however remote they may be—may glean from them as much as is possible of the practical value they may have had to those present.

I shall, therefore, present to-night, so far as time and space may permit, a summary of the salient points of successive groups of operations (numbering 163 cases in all), following them up hereafter by groups of cases treated medically, often for the same troubles, that a comparison, so essential to the formation of a correct judgment, of the true ways and various methods may be made. While neither in number, nor practical results, embracing but a portion of all presented to the clinic, the taking of individual cases may result in carrying with them knowledge and conviction otherwise unattainable. Time does not permit of much comment or discussion of these cases. The report will be made to-night, and hereafter I hope to more fully discuss them.

I therefore begin with the enucleations. While there are often omissions, and seemingly careless ones, of statistical facts, any one who has had the charge of a large clinic will readily understand that my clerks have done well in keeping as accurate records as are here presented; they being quite as full and accurate as are to be found in infirmaries. Where I have been able to do so, I have supplied, from my memory and concurrent circumstances, such data as were missing, but in all such cases have marked them with an asterisk (\*) to show that they were not taken from the record; where it has been impracticable to do even this, an X has been substituted as indicating that the information desired was an unknown quantity. To one who has conducted a large public clinic, and knows its wearying labors, the various parts lacking are, indeed, but guarantees that the cases are real and truthfully presented. An occasional case from private practice has also been added, when presenting some point which the others did not seem clearly to bring out.

This general method will be followed out in treating of the various groups.

## ENUCLEATION OPERATIONS.

| Consecutive No. | Operation No. | DATE.           | Designation. | Sex. | Age. | Right or Left Eye. | Consecutive No. | Operation No. | DATE.           | Designation. | Sex. | Age. | Right or Left Eye. |
|-----------------|---------------|-----------------|--------------|------|------|--------------------|-----------------|---------------|-----------------|--------------|------|------|--------------------|
| 20              | 1             | Dec. 10, 1878.  | F. H. S.     | M.   | 30*  | L.                 | 89              | 21            | Nov. 21, 1882.  | P. W.        | F.   | 8    | L.                 |
| 29              | 2             | May 13, 1879.   | C. E.        | M.   | 35   | R.                 | 96              | 22            | Mch. 6, 1883.   | A. B.        | F.   | 44   | R.                 |
| 30              | 3             | May 23, 1879.   | C. B.        | M.   | 19   | L.                 | 99              | 23            | Mch. 15, 1883.  | H. S.        | M.   | 21   | R.                 |
| 33              | 4             | Sept. 17, 1879. | J. W. W.     | M.   | 38*  | R.                 | 103             | 24            | Sept. 25, 1883. | C. B.        | M.   | 38*  | R.                 |
| 34              | 5             | Sept. 23, 1879. | B. H.        | M.   | 9    | R.                 | 104             | 25            | Sept. 26, 1883. | W. C.        | M.   | 17*  | R.                 |
| 35              | 6             | Oct. 22, 1879.  | H. C.        | M.   | 4    | R.                 | 105             | 26            | Oct. 2, 1883.   | M. F.        | F.   | 18*  | L.                 |
| 37              | 7             | Nov. 13, 1879.  | M. H.        | M.   | 40*  | L.                 | 118             | 27            | Feb. 12, 1884.  | W. O. O.     | M.   | 84   | R.                 |
| 39              | 8             | Jan. 14, 1880.  | C. S.        | M.   | 35   | L.                 | 119             | 28            | Mch. 4, 1884.   | L. T.        | F.   | 21   | R.                 |
| 41              | 9             | June 2, 1880.   | C. J.        | M.   | 30   | L.                 | 120             | 29            | Mch. 11, 1884.  | A. A.        | M.   | 33   | R.                 |
| 44              | 10            | Aug. 11, 1880.  | M. F.        | M.   | 25*  | L.                 | 125             | 30            | May 28, 1884.   | T. H. D.     | M.   | 46   | R.                 |
| 46              | 11            | Sept. 30, 1880. | S. L.        | F.   | 40*  | R.                 | 128             | 31            | Oct. 28, 1884.  | W. G.        | M.   | 30   | L.                 |
| 47              | 12            | Sept. 30, 1880. | J. T.        | F.   | 60   | R.                 | 143             | 32            | Jan. 13, 1885.  | L. T.        | M.   | 56   | R.                 |
| 49              | 13            | Oct. 12, 1880.  | M. B.        | F.   | 18   | R.                 | 146             | 33            | Jan. 21, 1885.  | M. S.        | M.   | 25*  | R.                 |
| 53              | 14            | Jan. 21, 1881.  | W. McL.      | M.   | 40*  | L.                 | 148             | 34            | Feb. 3, 1885.   | T. S. M.     | M.   | 32   | R.                 |
| 54              | 15            | Mch. 8, 1881.   | P. L.        | M.   | 48*  | L.                 | 150             | 35            | Feb. 7, 1885.   | T. T.        | M.   | 55*  | R.                 |
| 60              | 16            | Oct. 11, 1881.  | A. F.        | F.   | 12   | R.                 | 151             | 36            | Mch. 11, 1885.  | D. C.        | M.   | 40*  | R.                 |
| 70              | 17            | Dec. 5, 1881.   | O. S.        | M.   | 8    | R.                 | 156             | 37            | May 16, 1885.   | M. M.        | M.   | 45*  | R.                 |
| 79              | 18            | Apr. 4, 1882.   | N. L.        | F.   | 18   | R.                 | 161             | 38            | July 31, 1885.  | E. L.        | M.   | 35*  | R.                 |
| 83              | 19            | Oct. 16, 1882.  | A. S. M.     | F.   | 9    | L.                 | 162             | 39            | Aug. 28, 1885.  | S. P.        | M.   | 40   | L.                 |
| 88              | 20            | Nov. 7, 1882.   | E. A. S.     | M.   | 22   | R.                 | 163             | 40            | Sept. 29, 1885. | M. R.        | F.   | 38*  | L.                 |

29 males, 11 females; 25 right eyes, 15 left eyes.

In Vol. I of the *CLINIQUE*, beginning at page 153, may be found a lecture delivered to the students of the Hahnemann Medical College and Hospital on Sympathetic Ophthalmia. In that lecture I divided cases of injury into five classifications as follows:

*First Classification.*—Most dangerous of all in their liability to set up sympathetic ophthalmia in the companion eye, and with scarcely enough exceptions to prove the rule, are those cases in which the wound is penetrating and involves the ciliary region, penetrating wounds from blunt points being especially dangerous.

*Second Classification.*—Those cases in which a foreign body penetrates the globe and passes from the sight.

*Third Classification.*—Those cases in which the last named conditions obtain, but the foreign body remains in view.

*Fourth Classification.*—Those cases in which the wound is near the cornea or in it, involving the ciliary region, and especially when in the process of repair, a portion of the iris, ciliary processes or anterior lens capsule has become entangled.

*Fifth Classification.*—Those cases in which degenerative changes have taken place in an eye already lost.

Cases 30, 37, 46, 79, 83, 88, 151 and 162 were all cases of the first classification. Case 30 was an injury from the sharp corner of a piece of tin; case 37 by a blunt knife; cases 46, 79 and 83 were injured by the points of shears; case 88 by the points of scissors; and case 162 by the horn of a cow.

Cases 20, 39, 53 and 119 were cases of the second classification, all being the direct result of particles of steel getting through the cornea into the globe. Case 54 was of this classification, the result of a piece of glass getting into the globe, I believe.

Cases 29, 60, 89, 103, 104, 120, 128, 143 and 150 were of the fourth classification. Case 29 was one of a gun-shot wound, ruining the globe. Case 104 the result of a gunpowder explosion. Case 120 was from the kick of a horse. Case 150 from a mining explosion.

Cases 33, 34, 41, 47, 118, 125, 146, 148, 156, 161 and 163 were of the fifth classification, and may serve for the text of many discussions hereafter.

Cases 35 and 70 were sent with unknown diagnoses, and examination showed them to be cases of glioma of the retina. I enucleated promptly, but with little hopes of saving. No favorable result more than delaying the progress of the disease was obtained.

Case 44 was one of hydrops bulbi. The eye was enormously distended and disorganized, and relief could only be obtained in this way.

Case 96 was a melanotic sarcoma, and proved most interesting. The woman is alive and apparently in good health.

Case 99 was one of phthisis bulbi.

Case 105 was a fine illustration of how eye complaints affect the general system. She had long suffered from general neuralgia of the body, and was believed to be going into a decline. I advised that enucleation of the staphylomatous eye would cure her. She submitted to the operation, and has had no return of her almost instantly relieved neuralgia and decline, and is in excellent health.

## HARD CATARACT OPERATIONS.

| Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. | Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. |
|-----------------|---------------|----------------|--------------|------|------|--------------------|-----------------|---------------|----------------|--------------|------|------|--------------------|
| 15              | 1             | Apr. 25, 1878. | J. P.        | M.   | 40*  | X.                 | 85              | 15            | Oct. 18, 1882. | R. S. A.     | F.   | 74   | X.                 |
| 22              | 2             | Jan. 14, 1879. | M. T.        | F.   | 60*  | X.                 | 87              | 16            | Nov. 7, 1882.  | M. S.        | F.   | 69   | X.                 |
| 23              | 3             | Feb. 3, 1879.  | O. M.        | M.   | 84*  | X.                 | 97              | 17            | Mch. 6, 1883.  | E. F.        | F.   | 70   | X.                 |
| 55              | 4             | Apr. 12, 1881. | W. H. L.     | M.   | 60*  | X.                 | 100             | 18            | Mch. 15, 1883. | M. E.        | F.   | 70*  | X.                 |
| 56              | 5             | Apr. 19, 1881. | M. M.        | F.   | 65*  | X.                 | 107             | 19            | Oct. 5, 1883.  | C. H.        | F.   | 75*  | L.                 |
| 57              | 6             | Apr. 26, 1881. | B. W.        | F.   | 65*  | X.                 | 108             | 20            | Oct. 9, 1883.  | J. L. B.     | F.   | 74*  | X.                 |
| 58              | 7             | May 3, 1881.   | M. T.        | F.   | 60*  | X.                 | 114             | 21            | Nov. 27, 1883. | C. T.        | M.   | 85*  | X.                 |
| 68              | 8             | Oct. 24, 1881. | G. H. D.     | F.   | 58*  | R.                 | 117             | 22            | Feb. 4, 1884.  | M. B. C.     | F.   | 65*  | R.                 |
| 69              | 9             | Oct. 24, 1881. | S. R.        | F.   | 60*  | X.                 | 122             | 23            | Apr. 14, 1884. | J. A.        | M.   | 78   | R.                 |
| 76              | 10            | Feb. 22, 1882. | A. R.        | M.   | 74*  | X.                 | 123             | 24            | Apr. 22, 1884. | S. A. K.     | F.   | 67   | L.                 |
| 77              | 11            | Mch. 28, 1882. | S. W. B.     | M.   | 60*  | X.                 | 124             | 25            | May 14, 1884.  | G. H. D.     | F.   | 68*  | R.                 |
| 81              | 12            | Apr. 12, 1882. | M. C.        | F.   | 60*  | X.                 | 132             | 26            | Nov. 5, 1884.  | M. R.        | F.   | 74   | R.                 |
| 82              | 13            | Oct. 12, 1882. | M. H.        | M.   | 50*  | X.                 | 144             | 27            | Jan. 15, 1885. | M. N.        | M.   | 64   | R.                 |
| 84              | 14            | Oct. 17, 1882. | M. E.        | F.   | 55*  | X.                 | 160             | 28            | July 18, 1885. | E. C. F.     | F.   | 60*  | R.                 |

9 males, 19 females.

Cases 15, 22, 58, 68 and 97 were all operated upon by the classical Von Graefe peripheral linear incision, with previous iridectomy.

Cases 23, 55, 56, 57, 69, 76, 77, 81, 82, 84, 85, 87, 100, 107, 108, 114, 117, 122, 123, 124, 132, 144 and 160 were subjected to the same operation, but the iridectomy was done at the time of the operation.

I have not recorded any attempt with Liebreich's, the old flap, and other ways. I believe I have tried most of the new ways. I have operated with the most success with Knapp's modification of Von Graefe's knife. I have used Beers' knife when I have made a flap. One case, No. 23, sloughed slightly, but not materially. One, No. 76, developed malarial fever after the operation, went into panophthalmitis, and was lost; another, No. 56, unknown to me at the time of the operation, was the victim of syphilis and gonorrhoea (a happy combination!), but got along decently well. Nearly all were poorly nourished, many from the poor-houses, where they returned. Only one was lost, another was damaged, the rest recovered. Considering the material, the record is excellent. Of all operations, I believe Von Graefe's, with a slight modification (to the extent of keeping the incision nearer to, and perhaps quite in, the cornea) will give the greater number of successes. Nearly all will require secondary needling to remove the remnants of the anterior capsule from

the visual line, but this is easily done. I prefer Knapp's instruments to do this with. I see no material advantage in doing the iridectomy previous to the operation for removal of the lens, and there are many minor objections.

Unquestionably, the old flap operation, without iridectomy, will give the typical result when successful. But so many eyes are lost in the process of healing, that it seems better to perform an operation in which most are saved. Von Graefe's yields more moderate successes and has very few losses. But all this must be discussed hereafter. Liebreich's operation is easy to perform, but the lens comes out with difficulty. I have never performed it but I wished I had not.

#### IRIDECTOMY OPERATIONS.

| Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. | Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. |
|-----------------|---------------|----------------|--------------|------|------|--------------------|-----------------|---------------|----------------|--------------|------|------|--------------------|
| 10              | 1             | Mch. 26, 1878. | J. P.        | M.   | X    | X.                 | 86              | 19            | Nov. 2, 1882.  | K. P.        | F.   | X    | X.                 |
| 11              | 2             | Mch. 27, 1878. | C. S.        | M.   | X    | X.                 | 90              | 20            | Nov. 25, 1882  | G. C. B.     | M.   | 29   | B. B.              |
| 14              | 3             | Apr. 8, 1878.  | R. P.        | M.   | X    | B.                 | 91              | 21            | Dec. 5, 1882.  | J. T. S.     | M.   | X    | X.                 |
| 16              | 4             | May 25, 1878.  | M. B.        | F.   | X    | B.                 | 93              | 22            | Dec. 5, 1882.  | A. B.        | F.   | X    | X.                 |
| 18              | 5             | Nov. 5, 1878.  | M. T.        | F.   | X    | X.                 | 94              | 23            | Dec. 12, 1882. | M. T.        | F.   | X    | X.                 |
| 19              | 6             | Nov. 12, 1878. | J. C.        | M.   | X    | X.                 | 98              | 24            | Mch. 7, 1883.  | H. M.        | F.   | X    | R.                 |
| 24              | 7             | Mch. 11, 1879. | J. P.        | M.   | X    | X.                 | 102             | 25            | May 14, 1883.  | F. L.        | M.   | X    | X.                 |
| 25              | 8             | Mch. 13, 1879. | G. S.        | M.   | X    | X.                 | 133             | 26            | Nov. 6, 1883.  | J. E. C.     | M.   | X    | X.                 |
| 43              | 9             | July 27, 1880. | M. C.        | F.   | X    | X.                 | 138             | 27            | Nov. 21, 1883. | R. H.        | M.   | 68*  | X.                 |
| 45              | 10            | Aug. 19, 1880. | M. C.        | F.   | X    | X.                 | 139             | 28            | Dec. 2, 1883.  | F. B.        | M.   | 7    | X.                 |
| 48              | 11            | Oct. 7, 1880.  | A. A.        | F.   | X    | X.                 | 141             | 29            | Dec. 30, 1884. | J. H. B.     | M.   | X    | R.                 |
| 51              | 12            | Nov. 16, 1880. | M. T.        | F.   | X    | X.                 | 145             | 30            | Jan. 21, 1885. | M. C.        | F.   | X    | X.                 |
| 59              | 13            | May 11, 1881.  | G. H. D.     | F.   | X    | X.                 | 147             | 31            | Jan. 23, 1885. | G. C. B.     | M.   | 32   | X.                 |
| 63              | 14            | Oct. 18, 1881. | M. B.        | F.   | X    | B.                 | 149             | 32            | Feb. 5, 1885.  | F. B.        | M.   | 7    | X.                 |
| 66              | 15            | Oct. 19, 1881. | W. T. P.     | M.   | X    | X.                 | 152             | 33            | May 7, 1885.   | F. B.        | M.   | 7    | X.                 |
| 72              | 16            | Jan. 3, 1882.  | J. A. M.     | M.   | X    | X.                 | 154             | 34            | May 11, 1885.  | G. R.        | M.   | 56   | L.                 |
| 73              | 17            | Jan. 10, 1882. | S. W. B.     | M.   | X    | X.                 | 155             | 35            | May 12, 1885.  | F. S.        | M.   | 66   | R.                 |
| 80              | 18            | Apr. 8, 1882.  | M. F.        | F.   | X    | X.                 | 157             | 36            | May 25, 1885.  | W. L. C.     | F.   | 48   | R.                 |

21 males, 15 females.

Cases 10, 14, 18, 19, 24, 25, 48, 51, 59, 73, 86, 91 and 94 were all iridectomized preliminary to cataract extraction. This was usually done about six weeks before the cataract was removed.

Cases 11, 66, 72 and 80 were all thus treated for obstinate, recurrent iritis. In all cases the result was excellent; and though iridectomy is a formidable remedy, it is sometimes the only one which will give relief from this terrible affliction. Like the victims of long-continued neuralgia, the patients are willing to sacrifice much to be rid of the affliction.

Cases 139, 149 and 152 were iridectomized for laminar cataract, as the cases would not permit of successful needling. All were gone through with without any untoward result.

Cases 16, 43, 45, 63, 90, 98, 138, 145, 147, 154 and 157 were all operated on for glaucoma.

Much stress has been laid on the size of the piece of the iris removed, many holding that at least one-fifth, and some one-third, of the iris must be removed to ensure success. But when I was in Vienna in 1878, Prof. Arlt, the veteran ophthalmologist, said that this was of small importance in his opinion; so since then I have tried large and small according to my judgment. In my mind it is evident that the size of the coloboma has little to do with the success of the result. The question is one on which much could be said, but until more has been done, even this operation is trifling for the relief and cure of so terrible an affliction.

Cases 102 and 155 were iridectomized for the prevention of sympathetic ophthalmia.

Just how iridectomy accomplishes this is unsettled, but in certain cases enucleation is averted by this operation. Both were successful.

Case 93 was thus treated for the reducing of the tension in a choroidal tumor, which was subsequently removed.

Cases 133 and 141 were operated on for artificial pupil, and were cases where the cornea had been damaged by extensive suppuration.

## STRABISMUS OPERATIONS.

| Consecutive No. | Operation No. | DATE.         | Designation. | Sex. | Age. | Right or Left Eye. | Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. |
|-----------------|---------------|---------------|--------------|------|------|--------------------|-----------------|---------------|----------------|--------------|------|------|--------------------|
| 2               | 1             | July 17, 1876 | J. H.        | F.   | X    | X.                 | 65              | 15            | Oct. 18, 1881. | L. W.        | M.   | X    | X.                 |
| 2               | 2             | Oct. 17, 1876 | J. H.        | F.   | X    | X.                 | 101             | 16            | Mch. 20, 1883. | A. O.        | F.   | X    | X.                 |
| 5               | 3             | Jan. 8, 1877  | M. J.        | F.   | X    | X.                 | 106             | 17            | Oct. 2, 1883.  | C. B.        | M.   | X    | X.                 |
| 7               | 4             | June 5, 1877  | M. K.        | F.   | X    | X.                 | 109             | 18            | Oct. 16, 1883. | E. H.        | F.   | X    | X.                 |
| 8               | 5             | Oct. 29, 1877 | G. D.        | M.   | X    | X.                 | 121             | 19            | Apr. 12, 1884. | E. S.        | F.   | X    | X.                 |
| 9               | 6             | Nov. 13, 1877 | L. S.        | M.   | X    | X.                 | 129             | 20            | Oct. 23, 1884. | O. R.        | M.   | 10   | B.                 |
| 12              | 7             | Apr. 2, 1878  | L. S.        | M.   | X    | X.                 | 130             | 21            | Oct. 23, 1884. | C. C. K.     | M.   | 6    | X.                 |
| 13              | 8             | Apr. 3, 1878  | W. H.        | M.   | X    | X.                 | 131             | 22            | Oct. 23, 1884. | F. B.        | M.   | 9    | X.                 |
| 21              | 9             | Dec. 14, 1878 | L. R.        | M.   | X    | X.                 | 135             | 23            | Nov. 12, 1884. | L. S.        | M.   | 15   | L.                 |
| 26              | 10            | Mch. 27, 1879 | A. K.        | F.   | X    | X.                 | 136             | 24            | Nov. 18, 1884. | J. O.        | M.   | 15   | R.                 |
| 27              | 11            | Mch. 27, 1879 | L. K.        | F.   | X    | X.                 | 137             | 25            | Nov. 18, 1884. | J. O'M.      | M.   | 23   | X.                 |
| 28              | 12            | May 13, 1879  | P. F.        | F.   | X    | X.                 | 158             | 26            | June 23, 1884. | M. R.        | F.   | 26   | B.                 |
| 50              | 13            | Nov. 9, 1880  | F. L.        | M.   | X    | X.                 | 159             | 27            | July 15, 1884. | M. O.        | F.   | 16   | R.                 |
| 64              | 14            | Oct. 18, 1881 | A. S.        | F.   | X    | X.                 |                 |               |                |              |      |      |                    |

14 males, 13 females.



I have put down all these cases as I have noticed them in running over the records, picking one here and one there, but I need not particularize much. All the various kinds of operations were performed for demonstration to the class. With the exception of Cases 121 and 158 all were for one eye only; in these two cases both eyes were operated on.

All cases were operated on once only, except Cases 2, 9, 26 and 27, which were operated on twice, and Case 12, which was subjected to the third operation. Many were old cases hitherto unsuccessfully operated on.

In Case 28 the conjunctiva refused to heal, a very unusual thing, and occasioned me much annoyance.

In Case 5 the tendon inflamed, and there was a prospect of serious trouble. But all inflammation was subdued and perfect recovery resulted. This is the only time this accident has ever happened to me.

## CANALICULUS OPERATIONS.

| Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. | Consecutive No. | Operation No. | DATE.           | Designation. | Sex. | Age. | Right or Left Eye. |
|-----------------|---------------|----------------|--------------|------|------|--------------------|-----------------|---------------|-----------------|--------------|------|------|--------------------|
| 1               | 1             | May 26, 1876.  | J. P. M.     | F.   | X    | X                  | 71              | 7             | Dec. 6, 1881.   | A. M.        | F.   | X    | X                  |
| 4               | 2             | Oct. 23, 1876. | M. M.        | M.   | X    | X                  | 78              | 8             | Apr. 4, 1882.   | A. M.        | F.   | X    | X                  |
| 17              | 3             | Nov. 1, 1878.  | D. F.        | F.   | X    | X                  | 92              | 9             | Dec. 5, 1882.   | C. C.        | M.   | X    | X                  |
| 31              | 4             | May 28, 1879.  | W. G. W.     | M.   | X    | X                  | 127             | 10            | Sept. 12, 1884. | A. A. R.     | M.   | 8    | X                  |
| 32              | 5             | Aug. 14, 1879. | W. L.        | F.   | X    | X                  | 142             | 11            | Jan. 12, 1885.  | J. H. S. E.  | M.   | 30*  | B.                 |
| 36              | 6             | Oct. 23, 1879. | A. W.        | F.   | X    | X                  |                 |               |                 |              |      |      |                    |

5 males, 6 females.

Nothing of unusual interest was developed in these cases. I find I have omitted the one of greatest interest perhaps, that of a patient on whom I was probing. Noticing that something dropped on the floor, examination showed it to be a gold tube previously inserted to keep the duct open, which the patient said he had lost some weeks before. Inquiry elicited that he had worn the tube over twenty years, but supposed he had lost it and had had another one made, which he said would never fit as the first one had done. Probing showed the reason why. It is remarkable that so large a tube as this one could be lost in such a small cavity.

## PTERYGIUM OPERATIONS.

| Consecutive No. | Operation No. | DATE.           | Designation. | Sex. | Age. | Right or Left Eye. | Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. |
|-----------------|---------------|-----------------|--------------|------|------|--------------------|-----------------|---------------|----------------|--------------|------|------|--------------------|
| 38              | 1             | Nov. 11, 1879.  | W. S.        | M.   | X    | B.                 | 112             | 5             | Nov. 20, 1883. | C. H.        | M.   | X    | X                  |
| 40              | 2             | Feb. 3, 1880.   | A. H. M.     | M.   | X    | X.                 | 115             | 6             | Dec. 11, 1883. | N. R. S.     | M.   | X    | X                  |
| 52              | 3             | Nov. 17*, 1880. | M. E.        | F.   | X    | X.                 | 134             | 7             | Nov. 11, 1884. | R. E. K.     | F.   | 35   | P.                 |
| 111             | 4             | Nov. 13, 1883.  | D. L.        | M.   | X    | B.                 | 140             | 8             | Dec. 8, 1884.  | H. G.        | M.   | 18   | P.                 |

6 males, 2 females.

Case 38 was double—one pterygium on the inner part of each globe.

Case 111 was quadruple—one pterygium being on the inner and outer part of each globe.

Excision, ligation, and transplantation were tried on these cases. None of the pterygia ever returned. I am of the opinion that transplantation is the most generally successful operation in preventing the return, but either of the others will usually suffice in destroying a small pterygium.

## SOFT CATARACT OPERATIONS.

| Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. | Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. |
|-----------------|---------------|----------------|--------------|------|------|--------------------|-----------------|---------------|----------------|--------------|------|------|--------------------|
| 42              | 1             | July 1, 1880.  | C. W.        | M.   | 1    | B.                 | 75              | 4             | Jan. 27, 1882. | M. R.        | F.   | 2    | P.                 |
| 67              | 2             | Oct. 19, 1881. | F. L.        | M.   | 16*  | X.                 | 110             | 5             | Oct. 16, 1882. | F. B.        | M.   | 4    | P.                 |
| 74              | 3             | Jan. 10, 1882. | L. B. M.     | F.   | 14   | X.                 | 153             | 6             | May 8, 1885.   | S. B.        | M.   | 21   | P.                 |

4 males, 2 females.

Case 42 recovered absolutely perfect, so far as could be discovered, and is now the delight of a household.

Case 67 was an old siliquate case, many times operated on unsuccessfully; under the last operation he recovered sufficient sight to become a useful member of society and is now earning his own living.

Case 74 was only operated on once and did not return.

Case 110 was fairly successful, and a subsequent operation removed the patient from a blind asylum, and enabled him to learn to read.

Case 153 is not yet completed, having been operated on but once.

## SECONDARY NEEDLING OPERATIONS.

| Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. | Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. |
|-----------------|---------------|----------------|--------------|------|------|--------------------|-----------------|---------------|----------------|--------------|------|------|--------------------|
| 61              | 1             | Oct. 11, 1881. | B. W.        | F.   | X    | X.                 | 116             | 3             | Jan. 22, 1884. | E. F.        | F.   | X    | X.                 |
| 95              | 2             | Jan. 16, 1883. | M. E.        | F.   | X    | X.                 |                 |               |                |              |      |      |                    |

3 females.

All these cases were needled to improve vision after Von Graefe's operation for cataract. I introduce them simply for a text; and explanatory of the intention and process, would say of the Von Graefe operation that the remaining lens capsule often becomes cataractous. This much damages the acuity of vision, but is quickly removed by passing a knife-needle into it and making a stellate opening in the line of vision. I always do it before the patient leaves the infirmary if vision is not as good as it ought to be. Indeed, it may be said to be a part of the improved Von Graefe operation.

## MISCELLANEOUS OPERATIONS.

| Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. | Consecutive No. | Operation No. | DATE.          | Designation. | Sex. | Age. | Right or Left Eye. |
|-----------------|---------------|----------------|--------------|------|------|--------------------|-----------------|---------------|----------------|--------------|------|------|--------------------|
| 6               | 1             | Jan. 26, 1877. | M. G.        | F.   | 72   | B.                 | 113             | 3             | Nov. 24, 1883. | L. G. S.     | M.   | 18   | P.                 |
| 62              | 2             | Oct. 11, 1881. | C. R.        | F.   | X    | X.                 | 126             | 4             | June 28, 1884. | M. E.        | M.   | 11   | P.                 |

Case 6 recalls a case of very bad ptosis after small-pox. The great looseness of the skin of the lids and adjacent parts permitted the upper lids to fall and fully close the palpebral aperture. The sight was excellent, and a free operation restored the means of raising the lids.

Case 62 reminds of the removal of the entire upper lid for a black cancer. I have little doubt but that an arrest only was obtained of this horrible malady, but I never saw the patient again.

Case 113 was a plastic operation to restore the upper lid after its destruction from the kick of a horse. The parts were dissected up, restored to place, and the interspaces allowed to heal by granulation. A fair result was attained.

Case 126 was a very bad cut of the upper lid with pieces of glass. The parts were carefully stitched together and made a perfect recovery. Nothing unusual was noticed about the case, but so extensive a laceration seldom recovers with so slight scars.

I trust, I may say in closing, that it should be remembered that these cases are not selected ones, but those which drift into a charitable institution in a great city. Good results attained in such cases, while not enriching the operator, afford great satisfaction; for if good results can be obtained in cases so forbidding, we may confidently expect them in cases where everything conducive to recovery can be freely commanded.

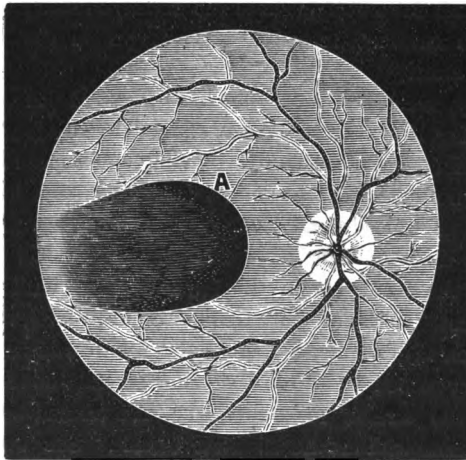
FOUR INTERESTING CASES, BY F. A. STEVENS, M. D., OF ST. PAUL, MINN.—The following four cases present points of interest and singularity sufficient to warrant their being placed upon record.

*Foreign body in the globe.—Recovery.*—About the first of last May, Johnnie Kennedy, a lad of about fourteen, who operates an elevator in a large manufacturing establishment, left his elevator to watch the sawing of some large thick sheets of lead on a buzz saw. While partially stooping in front of the saw, a fragment, presumably of lead, struck him in the eye. For two or three days he had nothing done for it except to let his friends pick at it and to put on tea leaves, etc. The managers of the institution in which he worked learning of the affair sent him to their surgeon, who, upon examining the eye, said the foreign body had entered the eyeball and recommended that the boy be placed under the care of an oculist, since, in all probability, the eye would be lost or have to be removed. The boy was sent to me with the request to save the eye entire in the orbit, if possible, as such cases usually resulted in a suit at law for damages, although the boy was injured while out of the line of duty and against orders. On examining the eye I found a small jagged wound through the cornea, at and just within the corneo-scleral junction. The iris was also perforated and the vitreous escaped through the inflamed edges of the wound. There was naturally considerable iritis. Vision was very much dimmed. On ophthalmoscopic examination I found the details of the fundus somewhat obscured by cloudiness of the media and though I could see no wound in the fundus, or nothing of the foreign body, I could make out that there was a distinct inflammation of the optic nerve. As there was no in-

dication of suppurative choroiditis and owing to the circumstances of the case I determined to give the eye perfect rest and wait. I cleansed the wound and, notwithstanding that the wound was in the periphery, considering the inflamed iris I put the eye under the influence of atropine, applied a compress bandage and kept the boy quiet in a recumbent position. In a few days the corneal wound healed kindly. There also developed some symptoms of cyclitis which yielded however to hot applications. Throughout the whole course of treatment I simply kept the eye under the influence of atropine with *Belladonna* internally, with some *Merc.* in the later stages; the patient being kept very quiet. In about four weeks all symptoms of iritis had disappeared, and in two months I allowed the boy to resume his work which was light, yet at this time there remained some optic neuritis. Among the interesting features of this case is the fact that the foreign body must have passed through the apex of the ciliary processes and the zonula of Zinn without wounding the lens, since no cataract developed, and yet the vitreous escaped through the wound. I am unable to determine what caused the inflammation of the optic nerve, since I could never discover any point of injury nor has there since occurred any atrophy. The foreign body I could never locate; it may have lodged in the ciliary processes or become embedded in the tissues and encapsuled while the media clouded by inflammation. The vision in the eye is now about  $\frac{1}{8}$ , whether the defect is due to previous amblyopia or to the recent neuritis, I cannot tell. But at any rate the refractive media are clear and the only defect to be seen is a slightly distorted pupil. This case demonstrates what rest and a severe letting alone will sometimes accomplish in what may seem a hopeless case, and seems to me to be an argument in favor of more conservative surgery in these very unfortunate cases of the entrance of a foreign body into the eye. The case certainly did seem hopeless in the beginning, and it is one of those cases in which some of our foremost surgeons are crying, "out with the eye at once, if the foreign body cannot be removed by hook or magnet, and prevent the long course of inflammation and the danger of sympathetic ophthalmia." It has certainly taught me to try by every possible means to save such an eye rather than to hurriedly enucleate. For even a blind eye is better than an artificial one, and care may preserve a useful one as it did in this case. After the inflammation has subsided, if the eye then be blind it can be enuc-

leated, while if useful sight remain, the great number of cases in which the injured eye is removed after the symptoms of sympathetic irritation appear, proves that under observation such eyes can be left with safety.

*Retinal hemorrhage involving the fovea centralis.*—During the early part of July last, Dr. Higbee, of this city, sent me a nephew of his with the request to examine his eye. Mr. Richardson, a robust young man of about sixteen years, complained of a blur before one eye, so that the center of any large object at which he looked was wanting. Small objects he could not see. The large central scotoma suggested trouble in the region of the macula lutea, and on ophthalmoscopic examination, I discovered a large retinal hemorrhage, with its center apparently over the macula lutea. Not in an irregular patch or following the course of any vessel, as is the case in retinitis apoplectica, but in the form of a large drop. This occurred a week before my examination, yet the blood was of a bright red color and the inner margin of the hemorrhage was as even and clear cut as the margin of the optic nerve; the outer portion becoming thinner and shading off into nothing; altogether presenting the appearance of the accompanying drawing made at the time.



Inverted image, A.—Hemorrhage.

Mr. Richardson gave the following history: About a week before, he was chasing a chicken across his lawn, and just as he was stooping after running, he perceived a blur come over his eye which

remained. There was no pain, but in a day or two he consulted an oculist in Minneapolis, where he lives, who told him that he had an inflammation in his eye. Not satisfied with this, Dr. Higbee sent him to me. He is a strong, healthy young man, a perfect picture of health. He had never previously had hemorrhages of any character. The refraction of the eye is normal, there being no myopia. In fact, the cause is very obscure, but the perfect recovery which took place without atrophy of the retina is more remarkable, the hemorrhage being very dense and much larger in diameter than the optic nerve. I sent him to Dr. Higbee with the diagnosis, who gave him *Arnica*, which I understand was continued throughout. In about six weeks the patient came again for examination, and I found the hemorrhage markedly thinner, with central vision improved so that shadows were perceptible. I might say that at no time did there ever develop the slightest trace of inflammation in the fundus. At the present writing, all traces of the hemorrhage have disappeared and vision is perfect.

This single large hemorrhage occurring in such a healthy young man and at a point where the vessels are scarce, as well as of the smallest, and the more remarkable fact of the perfect absorption of the hemorrhage without damage to the retina, contrary to universal experience in cases of extensive hemorrhages in that locality, are points of interest.

*Persistent, recurrent, subconjunctival hemorrhage.*—About the first of last May, Miss R., a young lady of about twenty-four, called upon me for relief from a constantly recurring subconjunctival hemorrhage which from the frequency of its occurrence kept her eye continually red and bloodshot. She gave in substance the following history: For three or four years this hemorrhage had occasionally occurred in the same eye in the inner canthus, but in the fall of 1884 it "burst" more and more frequently, until for several months previous to her visit to me, it had "burst" with comparative regularity on every second or third day. For several months she had been under the care of an oculist, who had treated her eye with astringent washes without the slightest benefit. She was and had been well and healthy, otherwise being troubled, however, with large and itching hives which come and go suddenly. She has never been subject to other hemorrhages of any kind. The only point in the family history of significance was that her father had died of

epilepsy. This hemorrhage always occurred in the same eye in the neighborhood of the inner canthus. The refraction of the eye I found to be normal and vision perfect. There was no inflammation, no point or focus from which the hemorrhage could emanate. At the time of the hemorrhage there was simply a sensation of something giving away, and then the subconjunctival tissue was filled with blood, as is usually the case. At first, I gave her *Ledum* with a wash of alum, with apparently some benefit; afterward I gave *Phosphorus* and also *Hammamelis*, and still later *Ledum* again with *Vinum opii* to drop into the eye. Under this treatment, the frequency of the hemorrhages decreased very much at last accounts, not oftener than once in two weeks, and sometimes three. The patient being out of the city a great part of the time, I have had but little opportunity to observe the case. I have never heard or read of such a persistently recurring, subconjunctival hemorrhage; occurring in this case, according to her story, as often as every second or third day, for a period of several months. There was absolutely no apparent systemic derangements to which I could ascribe the trouble.

*Pseudo-erysipelas of the lids.*—August 25, Millie H—, a fair, slender girl of about thirteen years, was brought to me with an intensely red, swollen upper lid; the swelling, indeed, exceeding anything I had ever seen, causing the lid to hang far down over the lower. This swelling had been more or less present at times for a period of about two months, disappearing entirely at times, and returning again. During this time she had been under medical care, but the physician who treated her did not state what he called the trouble. An exposure to cold brought on this acute exacerbation, and her parents' alarm brought her to me. I had here three things to decide between, namely: phlegmonous inflammation of the lid, inflammation of the lachrymal gland, and erysipelas. The swelling, though not great, was of a shining, rosy-red hue, the surface being smooth. On manipulation I could discover no tumor in the region of the lachrymal gland, and on forcibly everting the lid, I found the ocular conjunctiva free from infection. This fact, together with the febrile disturbance of the system; the fact that the swelling was oedematous, not being very hard, and that the color disappeared on pressure, decided me that the inflammation was erysipelalous.

Fearing suppuration from the duration of the case, I ordered hot fomentations applied locally, and gave *Belladonna* internally. After



a day or two, the febrile symptoms abated somewhat, but the cedematous swelling recurred every day, abating some at night. I gave *Apis* with no better result. On the fourth day I gave a few three-grain doses of *Quinine*, and had the satisfaction of seeing marked and rapid improvement, and the case was well, apparently, in a couple of days. About two weeks ago the patient came to me with the same affection of upper lid of the other eye, only not so intense. I again ordered *Quinine*, with equally gratifying results, the improvement being rapid from the start, the swelling disappearing almost in a day. This inflammation was undoubtedly erysipelatous in character; the intense cedematous, shining, red swelling; the disappearance of the blush on pressure; the fever and debility of the patient, showing a general systemic disturbance. Although but a single case, it seems to me to be a grain of proof in favor of the malarial origin of erysipelas, and at least demonstrates that *Quinine* may prove very efficacious in many of these cases, and perhaps save the distressing results of suppuration in them.

*Discussion.*—DR. VILAS.—As no one seems inclined to discuss these cases, I must not let them pass without calling attention to them as interesting. But we cannot ever say just what an eye will do when injured as the first case was. No one is perhaps justified in removing an eye recovering so nicely, and with such good sight, and I agree with Dr. Stevens that it requires careful watching; but we must not felicitate ourselves that we have saved the eye. Such cases are very trying. Hence, it is that in lecturing on these and similar cases at the Hospital, I have tried, in so far as is possible, to lay down a law to guide practitioners. Too long to quote here, I ask you, if interested in such cases (and who of you is not?) to read a lecture reported in the May, 1880, number of the CLINIQUE. With your permission I will read from it a few of my concluding lines: "It avails nothing to report cures of eyes injured, \* \* \* for any one skilled in eye diseases can, so far as we can see, cure such cases; no one can say they are not cured, and yet months (or mayhap years) elapsing, without the least disturbance in the injured eye, or any manifest sign of any morbid change whatever, vision in the companion eye will slowly sink into darkness, or with consuming inflammation quickly go out forever. Neither does it avail anything that any physician of any school of

therapeutics cures a case of this kind after another physician of any school has declared it incurable, because the latter has no knowledge entitling him to such a dictum, and the former knows not if the disease be skilfully lulled to rest, forever quieted by his medicine, or only lies dormant from its peculiar nature, rousing into spontaneous activity when the hour shall have come. He knows not if it lurk behind the quiet exterior, or when it may steal forth, for he knows not what it is, where it is located or what incites it to activity. All that you are warranted at the present time in saying is this: That the experience of all oculists of all schools permits the assertion that it is not at all likely that sympathetic irritation or ophthalmia will arise after all nervous connection has been severed and the irritating globe or remnant is removed, provided there have been no sympathetic symptoms already manifest; and if there has been sympathetic irritation, sympathetic ophthalmia will most likely be prevented by such removal. \* \* \* You will now be able to appreciate why it is that the judgment and skill of the surgeon is so severely tried to determine whether he may or may not leave the offending eye, when the injured eye belongs to youth, and retains partial sight, or even nearly perfect vision, \* \* \* for the conscientious surgeon hesitates to sacrifice the useful eyes of youth which show no signs of inflammation, and yet he knows that there often skulks behind the placid front an enemy so subtle that our present knowledge cannot detect, much less vanquish."

Regarding his second case, it can be truthfully said that the recovery was fortunate, and the treatment as successful as any that could be applied.

His third case is interesting. Recurring conjunctival hemorrhages are suggestive of engorged conditions, and, as the doctor says, the history of epilepsy is a point of significance. I have known a case of sub-conjunctival hemorrhage recurring every month with the menses in an otherwise healthy female. I presume Dr. Ludlam, were he here, could say much more than I can on this point.

His fourth case bearing on a point on which we oculists cry for light, I can only say that I strongly approve of quinine in erysipelas, having found much benefit from its use, and while I would not rely on it to cure a case, in surgery we must use anything which for the time being will help us out of just such a dilemma as this case was in.

These are all interesting cases, and the lessons they teach pregnant

with wisdom to us all, and I thank Dr. Stevens for calling our attention to them.

DR. H. B. FELLOWS.—It is even a more serious matter than destruction of sight that may follow injury to the orb, for the inflammation may extend to and involve the optic nerve. A case in mind is one sent to me by Dr. Hall. The patient had sometime previously got some acid in his eye. For this he was treated at the time, but after a while vision became impaired, and finally went out. Then he came to me, and when I had carefully examined him I said there was present disease of the brain. My belief was that the inflammation had traveled along the optic nerve and invaded the brain substance. At that time his mind was clear, and his intelligence intact, but in two weeks he had become a raving maniac. The eye was enucleated, but there was no interruption in the downward course of the disease. The patient went on to the state of dementia paralytica, and soon after died.

DR. G. A. HALL.—There is a case in my charge just now about which I would like to ask Dr. Vilas, for there have been some peculiar symptoms in it: A lady forty-two years of age, both of whose mammae have been removed for sarcoma. Since the operation she has suffered some with intercostal neuralgia, and the axillary glands have become infiltrated, giving rise to some pain down the arms. Last Wednesday she felt better, freer from pain than she had been for a long while. She went into the back room and lay down for a while. When she raised up again she called out, for she felt a sudden sense of dizziness and pressure at the base of the brain, and her sight was blotted out. An hour later I arrived, but found nothing bad-looking in the patient's appearance. The pupils were dilated. She remained in this state until Saturday, when she said she could see as though looking through a pin hole. This small aperture has been gradually widening to her, until now she sees very well, although still much more limited than normal vision. What is the diagnosis in this case?

DR. VILAS.—To diagnosticate by subjective symptoms alone is quite a difficult matter. I should not give a scientific opinion in these days of the ophthalmoscope by so doing. But it is very probable that the trouble is a hemorrhage into the retina, involving the yellow spot, for this would give rise to a train of symptoms such as Dr. Hall has

given us. In a case of this kind *Belladonna* is the best remedy that can be chosen. It seems to possess the power of hastening and completing the process of absorption. If the hemorrhage happens to be a large one the result will not be good because the absorbents paralyze before the hemorrhage is disposed of.

DR. HALL.—The patient still complains of the pressure and fulness at the base of the brain.

DR. FELLOWS.—If a hemorrhage occurred somewhere in the course of the optic nerve the same condition might result as that observed in Dr. Hall's patient.

DR. VILAS.—It is impossible to give an unqualified diagnosis on the subjective symptoms alone. An ophthalmoscopic examination would be essential to an accurate and proper diagnosis.

CASES FROM PRACTICE—BY ALVA E. BENNETT, M. D.—  
*Case 2.*—Mr. D. B., aged forty, works about a green-house. He called one cold day, and his appearance indicated the remedy, even before detailing any symptoms. Thin, pointed nose; narrow between the eyes; eyes anxious and restless; with such a distressed looking countenance. The weather was quite cold, but he was wrapped up to a remarkable extent about the neck and head, and hugged the stove as if it were his best friend. He seemed very nervous, starting every time he was addressed. Had been an invalid for many years; confirmed dyspeptic; all food and drink, especially cold water, causing great distress and burning, with nausea; very restless, especially nights; often sat up in bed in great fear and apprehension of death, sometimes walking the floor in his agitation; periodical headaches over right eye, with intense thirst and nausea. *Arsenicum* 30, cured the case.

*Case 3.*—Willie J., aged eighteen months. He has very delicate skin, large blue eyes, flaxen hair, and small neck. Fontanelles open, has only four teeth, and is not able to walk. On removing his shoes his feet and stockings are damp and cold. His mother said his head perspires to a wonderful extent during sleep. He has been sick five weeks with scarlet fever, and has recovered to a certain point, but did not further improve. He is bloated, has scanty urine, is very weak, and has no appetite.

He had had *Apis*. *Hyos*. *Apocynum*, etc. Being called in consultation, I advised *Calc. carb.* 200, which was given, and was followed by rapid recovery.

## Hospital Notes.

### THE GYNECOLOGICAL CLINIC.

#### SERVICE OF PROFS. LUDLAM AND BAILEY.

A CYSTO-CARCINOMA OF THE UTERUS AND BOTH OVARIES WEIGHING SEVENTY-FIVE POUNDS.—October 5, Prof. Ludlam showed the class a cancerous tumor of which he gave the following history:

*Case.*—Mrs. —, aged fifty, was the patient of Dr. W. H. Misick, of Marengo, Ill. Dr. M. was called to treat her in March last, for painful urination and vesical catarrh. On local examination he found a tumor which pressed upon the neck of the bladder, and also caused constipation, with much intra-pelvic pressure. These symptoms were soon relieved, but were followed by ascites, and extreme anasarca of the lower limbs, especially below the knees. The abdominal surface of the tumor was irregular and nodulated, with a horizontal sulcus, sensitive on the left side, and fluctuating on the right. The womb was apparently lost in the mass. Remedies were faithfully given, with but temporary relief, the tumor continuing to grow very rapidly. Hoping that an operation for its removal might be expedient, Dr. M. called me to the case on the 23d of June. I decided upon its malignant character, and on account of the extent of the adhesions and the involvement of adjacent organs, as well as of an evident cachexia, I declined to operate. Indeed, I said very plainly that, in all probability, she would die upon the table before we could get through with the operation, an accident which I am pleased to say has never happened to me.

This tumor was therefore removed at *post-mortem*, October 2, by Dr. Misick, assisted by Drs. Eshbaugh and Peck. It was attached by strong adhesions to the spine and to all the abdominal viscera, including the liver, the spleen and the pancreas, a portion of the colon, and also of the small intestines being enclosed in the mass. Some of the adhesions were so firm that they could only be separated by the knife. About a week before her death, and while in a sitting posture, she felt a strange sensation, "like the tearing of new cloth," as she expressed it, extending from the right to the left side, corresponding to a rupture in the omentum, which was observed at the autopsy.

The cystic character of a portion of the growth, and its cancerous nature also, were shown the class by cutting open the sacs and disclosing the encephaloid nature of their contents. The solid part of

the tumor also showed its malignancy throughout. The fluid contents of the tumor weighed forty pounds, and the solid portion thirty-five pounds, or seventy-five pounds in all. It was a clear case of cysto-carcinoma of the uterus and the ovaries.

GENITAL PHTHISIS.—Wednesday, October 21, two interesting cases which had been thoroughly examined before the class, were made the subject of some remarks upon genital phthisis. The following is their clinical history :

*Incipient tuberculosis with amenorrhœa for forty-two months.*—Case 17,515.—Mrs. —, aged thirty, has been married four years, but has never been pregnant. The menses were established at fifteen, but were then suppressed for a year, and afterward until her marriage came at irregular periods of from four to eight weeks. For the last forty-two months she has menstruated only once, and that was twenty-two months ago, when the flow was very free for five days and without much pain. She has lost the record of the time for the appearance of the monthly flow, but at irregular periods the abdomen bloats, the feet swell, the limbs ache and feel heavy, and she has severe frontal headache, with of late bearing-down pains within the pelvis. For three or four weeks past, she has had burning pain in the right ovarian region, which shoots down the limb but is relieved by walking. She has no leucorrhœal flow. Her appetite is poor, and she is wakeful at night; the bowels are regular. She complains of frequent and painful urination, but only a small amount of urine is passed. Her father has rheumatism, otherwise the family history is good.

A local examination finds the cervix nearly *in situ*, of less than normal size, the uterus in position, with a depth of two and three-quarter inches. There is no obstruction to menstruation. *Apis mel.* 3, four times a day.

September 30.—The urine was tested before the class with heat and nitric acid, and was found to contain no albumen. She has had a slight cough for four or five years, but does not expectorate much. She has had night sweats. The patient was referred to the clinic on physical diagnosis for an examination of her lungs. *Apis mel.* continued.

October 7.—Prof. Crawford has examined her lungs thoroughly, and reports evidence of solidification in the apex of the right lung, but softening has not yet begun. *Calc. phos.* 3, four doses per diem.

October 10.—Complains of pains in the right lung and between the shoulders. *Calc. phos.* continued.

October 21.—She feels stronger, and yesterday felt somewhat as if menstruation might be coming on, but has had no flow. *Calc. phos.*

October 28.—To-day she complains of a sensation of fullness through the abdomen, with frontal headache. The bowels are irregular in action. *Nux vom.* 3, and *Calc. phos.* 3, alternately.

*Tuberculosis Peritonitis.*—Case 17,527.—Miss H.—, aged twenty-eight years, and unmarried. She came to America from England eleven years ago. On the ocean, during the menstrual period, she was seized with a slow fever, and following this the catamenia were suppressed for six months, and their reappearance was attended with great pain. Since then, while the flow has been regular, she has always had dysmenorrhœa, and for the last few years the return of the monthly cycle has found her extremely nervous, and unable to bear the slightest noise or jar. Four years ago, during the menstrual period, she was obliged to run a machine continuously, sewing on very heavy cloth. After that she was very ill, having severe uterine pain, and always since, if she attempts to sit up, she has pelvic pain, with bearing down, and a sensation of weight and coldness on the top of the head. Sometimes since a physician made a very rough local examination, which greatly increased her sufferings. She has had prolapsus uteri, which she has been obliged to remedy by lifting up the uterus with tampons; for this she has used tampons, medicated with glycerine, before she could urinate. Since March she has coughed considerably, and expectorates a frothy mucus. Her appetite is poor, and she has a scalding sensation when food is swallowed. The bowels are regular, and the urine is normal.

October 16.—A local examination finds the vaginal canal much relaxed and distended, but the uterus in position and the cervix undeveloped. The bimanual touch and external manipulation also, finds the abdominal walls hardened, showing inflammation and infiltration in the part. *Phosphorus* 6.

The clinical relation of amenorrhœa to tuberculosis is not always clear and explicit, but there are certain rules which may help us to decide what that relation is in a given case. For example: If the primary lesion has developed within the thorax, the menstrual involvement may be late in making its appearance. This is the form of suppression that usually occurs in the last stages of "consumption." But, if the original deposit is anywhere within the abdomen or the pelvis, in the peritoneum or the internal generative organs, the interruption of the monthly flow will happen much earlier, or it may perhaps be the first and most prominent of the morbid symptoms. These facts square with the spread of the disease and the invasion of the adjacent organs, everything depending upon the point of attack.

In both of these cases the amenorrhœa preceded the development of thoracic phthisis. In the second one the peculiar lesion of the peritoneum is the result of a tuberculous deposit in that membrane, and the menstrual suffering and derangement are easily accounted for.

But, in the first case we have not positively detected the seat of the intra-pelvic deposition. The most careful local examination did not disclose any cause for the obstruction to the flow, or any organic cause for the suppression. It was only on the principle of exclusion that we were forced to refer the arrest of the menses for so many months, to an underlying cachexia. My colleague, Prof. Crawford, recognized the signs of incipient tuberculosis in the apex of the right lung, and the etiology of the amenorrhœa was explained. For with the torpid phthisis there was an anæmic condition which was quite sufficient to suspend the monthly discharge, even although the function of ovulation might have continued without any periodical flow, as it often does to the close of life in those who die of that disease. \* \* \*

Whether it is primary or secondary, genital phthisis is of the chronic form, *chronique d'emblee*, or chronic at its very beginning. It is particularly incident to puberty and the climacteric. The seat of the deposit varies, the peritoneum being most frequently attacked, and after it the Fallopian tubes, the ovaries and the uterus in the order named. The neck of the womb and the vagina are sometimes, but rarely, the seat of this disease. \* \* \*

The clinical history of tubal tuberculosis has acquired a new interest since Tait's operation has been in vogue.

We shall watch the result of this method of abruptly arresting the menstrual function, and of temporarily disposing of a localized phthisis; for if the lesion is limited to the Fallopian tubes and they are removed, the operation also results in a suspension of the tuberculosis. How soon, how certainly, and in what form it will be likely to return will be decided by the subsequent history of these cases. The careful record of all the cases upon which the extirpation of the tubes and the ovaries has been practiced for a series of years after the operation would certainly furnish a valuable contribution to the clinical history of genital phthisis.

THE ELECTRIC LIGHT IN UTERINE DIAGNOSIS.—At his sub-clinic, November 6, Prof. Ludlam showed the class a very interesting case of suspicious ulceration of the cervix uteri. The lesion being freely exposed, its features were most clearly and vividly seen and studied by all present, the electric light being so arranged as to form a part of the speculum. The simplicity of the instrument, its avail-



ability in the study of diseases affecting the neck of the womb and the vagina, and especially the detail of its illuminating power, will undoubtedly make this a valuable means of illustration in the clinique and also in private practice.

November 13. This same case having been brought before Class No. 11, and the lesion developed by the electric light, Prof. Bailey proceeded to photograph it in the field of the speculum.

**THE MURIATE OF COCAINE IN GYNECOLOGY.**—In his sub-clinic of Friday October 30, being about to practice Storer's method of everting the rectum, Prof. L. first applied a four per cent solution of the cocaine within the margin of the anus and also upon the recto-vaginal septum and then said: While we are waiting for this local aæsthetic to take effect I must tell you that as a means of facilitating such examinations as this, as well as for rendering the exploration of the vagina and the urethra possible without pain, this solution is invaluable. In the case of irritable bladder with extreme tenderness of the urethr it works like a charm, and renders thorough manipulation possible without pain or antagonism on the part of the patient. In spasm of the vagina its application just within the vulva renders the touch and the use of the speculum easy and painless.

**MENSTRUAL EPILEPSY.**—*Case 17542*, brought to the clinic by Dr. M. A. Bowerman, presented the following history: Aged thirty-nine, married, has one child; her parents are living and healthy, and there is no family history of epilepsy. The menses first came at fifteen, but she soon began to have spasms at or before the periods, the spasms appearing during sleep. The flow was dark and scanty. She married at nineteen. Her boy of seventeen is strong and well, but nervous. She had no spasms during gestation or the lying-in, the baby being a year old when they returned, and after a little they came in the day-time. After having had numerous physicians of all schools, she sent for Dr. Bowerman June 21, 1884, who found her looking like one addicted to morphine. The eye-lids drooped, the skin was shriveled and yellow; she could not look at me when talking, for both eyeballs were turned outward; half the time she did not seem to know what she was saying or doing; was forgetful, with transient aphasia; pain in the left temple and over the left ear; the breath was foetid, and so also was the perspiration. There was a profuse and putrid lueorrhœa, and extreme constipation with frequent hemorrhages from the rectum. There were also ecchymosed spots on the body and the thighs. The hands and feet were cold and sticky, especially before the menses.

The prodroma of the attack were a troubled expression with corrugated brows, dark circles under the eyes, slight twitchings of the facial muscles, trembling of the hands, vertigo, bright spots and colored rings before the eyes, and sometimes palpitation and dyspnoea. She does not cry out as most epileptics do, but, when the fit is partially over, grates her teeth and makes a noise as if trying to articulate; the pupils are fixed and contracted, the eyes protrude; the hands are clenched, and the face becomes purple and swollen. Then she is relaxed and exhausted, surprised, confused and feels as if she had done or was compelled to do something very wrong. At one time she had insomnia, which was relived by *Svapnia* 2.

The remedies given were *Nux. V.*, *Valerianate of Zinc*, *Ferric. et Strych.*, *Calcarea phos.* and *Pulsatilla*. July 27, I prescribed *Ænanthe croc.* 3, four times a day, and as she improved changed to the 6th, which was continued until December 1, with marked benefit. After this, although when she began to take this remedy she had four or five fits during the day, she had no more of them, excepting at night. The purpura and the lassitude yielded to *Lachesis* 30; and her general condition, appetite and weight improved in ratio, so that now she does her own housekeeping and can trust herself to go out or down town alone—something she has not been able to do for twelve years. Her mind is restored, and nothing remains but the possibility of one or two slight spasms during sleep two or three days in advance of the monthly flow. From December 7 to April 7 she had but one slight spasm per month, and then had none until June 10. After the last date they followed the flow and seem to have changed in other particulars, being more apt to be induced by worry or overwork. The right eyeball is *in situ*, but the left is still somewhat divergent. The constipation is less obstinate, the leucorrhœa has disappeared, menstruation is normal, but is a little too frequent.

In the remarks that followed the reading of the history of this case, especial emphasis was put upon the advent of the fit during sleep, which could not have happened if it were purely hysterical, nor could the divergent strabismus of both eyes be regarded as a hysterical lesion. The peculiar impairment of the mental faculties, the history of the paroxysms and the effect of the *Ænanthe* showed an admixture of epilepsy, indeed were epileptoid. The menstrual influence was illustrated in the regular monthly recurrence of the convulsions, the depraved character of the catamenial discharge, the partial relief when the flow was most free, the incidental purpura, and the mitigation of the symptoms when that function finally became natural.

## Miscellaneous Items.

The History of Homœopathy, its Origin and Conflicts, by Wilhelm Ameke, M. D., of Berlin; translated by Alfred E. Drysdale, M. B., and edited by our good friend Dr. R. E. Dudgeon of London, is the most readable and satisfactory book of its kind ever published. —Otis Clapp & Son, of Boston, are out with their new and valuable Visiting List and Prescription Record; ditto Bœricke & Tafel, with their Visiting List, the price of which is \$2. —The American Obstetrical Society, a new organization, will hold its annual meeting in Saratoga, during the next session of the American Institute. Dr. E. Hasbrouck, the secretary can be addressed at 253, 13th Street, Brooklyn. —The Home Mutual Life Insurance Co. has removed to 117 W. 42d Street, New York. —With the new purchase the Chicago Medical Library will already contain 8,000 volumes. —Dr. E. E. Gwynne has removed his office to 407 Centre Street, Telephone 3109. —Dr. C. B. Graves, '81, has settled in Moline, Ill. —The Tuesday evening entertainments of handsomely illuminated microscopical studies are exceedingly popular with the students of the "old Hahnemann." The program thus far arranged includes the *Connective Tissues*, by Prof. Bailey; the *Heart and Lungs*, by Prof. Crawford; the *Glands and Tumors*, by Prof. Shears; the *Brain and Spinal Cord*, by Prof. Laning; *Bacteria and Disease Germs*, Prof. Gilman; *Foods and Food Adulterations*, Prof. Harvey, and the *Microscope in Science and Art*, by Prof. Bailey. —*Bodily Posture in Gynecology*, is a practical application and amplification by its author, Dr. S. T. Donaldson, of New York, of the principles advanced by Sims and Campbell. —Dr. M. O. Terry, of Utica, President of the New York Homœopathic Medical Society, will accept our thanks for a copy of his recent address entitled "Shall the Homœopathic School represent true Progress in Medicine?" We vote in the affirmative. —Lea Brothers & Co., of 706 and 708 Sansom Street, Philadelphia, have placed the CLINIQUE under renewed obligation for a copy of "A Manual on the Diseases of Women," by Dr. Charles H. May. —All the clinics in the Hahnemann Hospital are full and interesting. —One more No. closes the sixth volume of this Journal. —*On dit* that Prof. Hoyne's *Medical Visitor* will soon be made a specialty of the history of Homœopathy here and hereabout. —The Compound Oxygen Craze is epidemic. —Prof. Hoyne will present the report at the December meeting of the Clinical Society. —The Women's Homœopathic Medical Society of this city is in a flourishing condition. —While in town, a host of clever doctors have recently honored the editor of the CLINIQUE with a call.

# THE CLINIQUE.

VOL. VI.]

CHICAGO, DEC. 15, 1885.

[No. 12.]

## Original Lectures.

### *TYPHOID FEVER AND ITS HYGIENIC AND SANITARY TREATMENT.*

IN TWO LECTURES, BY J. E. GILMAN, M. D., PROFESSOR OF SANITARY SCIENCE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, CHICAGO.\*

#### LECTURE II.

Without going further into the theories relating to the origin of the disease, whether it has its origin *ab ovo* or *de novo*, the fact remains certain that in the excreta of the typhoid patient the germs of the disease are found active and vigorous to spread the disease, and that animal or vegetable putrefaction, so placed that its emanations, or material draining from it, may reach the air we breath in a degree of concentration, or be absorbed in the water, or other fluids we drink, the result, if the individual is a suitable subject, is typhoid fever. Having made its lodgment in the individual, the stools, after a longer or shorter period, pass through a stage of development, after which they are ripe for renewed mischief in repeating the disease in other persons. Therefore, it becomes the duty of the physician and attendants to adopt such measures as shall destroy this specific principle which produces the typhoid poison. The stools, as I said before, are not immediately infectious; that is, that offensive as they sometimes are, the active reproductive power of the emanations is lacking, and the attendants run but a slight risk in removing and caring for the thorough disinfection or destruction of the excreta. To this end a

\*Published by request of the class.

disinfectant solution should be placed in the vessel receiving the excreta, so that it is at once deodorized, and the germinal elements in a fair way to be destroyed. In the bed-pan (and in almost all cases of typhoid a bed-pan is necessary) you will place spirits of thymol, or the copperas solution, or some Labarraque's solution; and if in the country, it would be well to empty the stools in a special pit, dug and prepared for their reception, and not in the privy used by other persons. This pit should be three feet or so deep, in a locality where by no possibility could drainage from it reach a spring, well, or other water source, the water from which is used as a supply for domestic purposes. In the pit a quantity of charcoal and copperas, or chloride of lime, should be placed. On these the stools, and refuse from the sick room, are poured, and fresh earth and copperas solution is used to cover. Use freely of the disinfectants—enough to destroy the germs. In the care you give to this matter, you are doing work for the public benefit. Corral the disease at the initial stage of its career. The germs are long-lived, and not easily destroyed; but it can be done if you try carefully. In the city the discharges should be disinfected thoroughly, before being emptied into the water-closet, with the copperas solution, or some other of value. The sheets and other bed-clothing should be changed frequently enough to keep free from the fever odor, and should be immersed in a solution of chloride of zinc, and afterward boiled for some time. With our remedies typhoid fever is often cut short or abated. Some allopathic writers claim that the fever, if it fails to run its course, is not typhoid, but some other disorder. This is simply ignorance of any method of treatment whereby the disease may be conquered. As homœopathic physicians we are sure of the diagnosis of typhoid fever as any one can be, and it is not an uncommon thing to abate the disease at the end of the first week, so that the remaining two weeks are really weeks of convalescence. More frequently the fever is practically broken up at the end of the second week, and very rarely indeed does it ever continue on and renew its career for another three weeks, as may occur under the management of old school practice—if the patient survives long enough. A from the therapeutical management of the disease, much may be done to promote the comfort of the patient, conserve his strength and energies, and subdue the force of the fever by hygienic and accessory measures. The intestinal portion of the alimentary canal is the seat of the disease in its most

characteristic form. Patches of inflammation are present in more or less profusion, and the diarrhoea provoked by the inflammation is dangerous and exhausting to a considerable degree. Herring says if he can avoid the diarrhoea, his patient is out of danger; and even if for the whole three weeks there is no stool, his patient is doing well. Exhaustion is one of the great dangers. If the temperature of the body rises high, and continues at an elevated point day and night, the danger of the patient succumbing to the sickness is greater than when there is a remission of the temperature in the morning, even though the mean average height is the same. The remission gives a rest and a break from the long continued strain. The high temperature adds to the danger of the extension of the intestinal inflammation, and burns out the strength of the patient rapidly.

Taking these facts into consideration, we must adopt such measures as shall tend to prevent the increase of the intestinal irritation, preserving the strength of the patient in every possible way, and keep the fever-heat down as low as possible. In the way of controlling the temperature, Liebermeister advocates the use of immersion in a cold-water bath, frequently repeating it as the temperature rises. He advocates using them perhaps as many as four to eight times per day. But a more practical method may be adopted of frequently sponging the body with tepid water, or water that is not quite tepid. This will reduce the heat with less danger of its sudden revival than the too prolonged or too frequently repeated bath of gradually reduced temperature, and there is no danger of causing collapse, as may occur from the too rapid abstraction of heat in the other method. Drinks of cold water, or other beverages of which mention will be made under the head of diet, will also aid in relieving the heat. The inunction with olive oil, frequently repeated, aids in quieting nervous irritability, relieves the dryness of the skin, and prevents, to a considerable extent, the bedsores that give so much annoyance in some instances. The oil, also, in some manner, furnishes nutrition, for, while it may not be actually absorbed into the tissues and laid away, I am satisfied that an individual that is given baths of oil to the full extent that the skin will receive, will be in much better nourished condition than the one without this accessory. When the oil has been used for some time to excess, and there is an unpleasant odor from it, or if the fever smell is pronounced, a bath with the following will be very refreshing: Take 8 ounces of alcohol, 8 ounces

of water, 1 ounce of salt, 2 ounces aromatic spirits of ammonia (this is the aromatic ammonia, not hartshorn), mix this in a bottle, and use by pouring on the hand and then applying to the body. In bathing the sick, the hand should be used, and very seldom should a wet sponge or towel be taken for the purpose. The hand will temper the bath and cool the skin without chilling the patient, while the cloth or sponge, especially on the body, is much more apt to send a sensation of cold that is objectionable. The formula as above given, you will find a very satisfactory preparation for use, and your patients will enjoy the delicious sensation of softness which it imparts to the skin, the feeling of cleanliness, and the faint but refreshing odor which follows its application. After you have given the bath with this, if your patient is not too tired, follow with inunction with the oil, but if fatigued or very weak, allow a little time for rest to elapse before this is done. The directions you may be able to give the nurse, will largely increase your success with the cases, if properly followed by that functionary. You must endeavor to preserve the strength of the patient as much as possible. The character of the disease is to produce exhaustion, therefore the avoidance of any exercise or exertion on the part of the patient is to be inculcated. Those individuals of strong will power who endeavor to work off approaching illness, and by sheer mental force determine that they are not sick, and will not succumb to the invasion of the fever, little know the power of the disorder which they defy. In the person whose organism presents a suitable condition for the development of the typhoid germ, and already infected with its poison, the struggle to resist the increasing domination of the disease only exhausts the victim, lessens his endurance for the time of need, and his chances of final recovery. Like the deadly octopus it clutches its prey, adding tentacle after tentacle as it draws the sufferer more and more into its grasp; and the patient who most readily takes to his bed and struggles the least, fares the best in the end, for toward the termination of the disease, the will may exert an influence for good, and the man who has not already exhausted that, may will to live at a critical time.

During the war, in company with two physicians, I went through an army hospital. On a couch lay a soldier in the final stage of coma and collapse of typhoid fever. The blood had already ceased its circulation in the extremities; the nose was cold, and the life was ebbing away rapidly. One of the physicians made the remark as he

stood by the bed: "There's a poor fellow whose course is run and his work finished." A slight movement of the lips followed, and evidence of saying something on the part of the patient. The attending surgeon put his ear down to listen. The dying soldier had heard the remark and was engaged in swearing at the man who said he was going to die, and vowing that he would not this time; and as he progressed in his anathemas his pulse reappeared at the wrist, warmth returned, reaction set in and the inaudible whisper became a voice, and the determination was the initial movement of convalescence. The man recovered and returned to his regiment, while without the excitement of the occasion his existence would have ended with an hour.

No amount of mental and physical resistance will succeed in aborting the disease. Medicine alone will accomplish that in the cases where it is obtainable; but after the disease has spent its force, the organism, shattered and wrecked as it may be in the passage of the disorder, will again respond to the impelling force of the mind. When the struggle against the disease has been a hard one, the disorder gains an intensity that is much greater than when so much of the energies of the individual have been wasted. So when, as often happens, you find a walking case of typhoid, send him to bed. It is his best place. In those cases of delirium, where the patient insists on leaving the bed and wandering about (ambulatory typhoid, as it is called), much tact will be required to prevent the patient from taking the exertion which may cause fatal collapse, either from his struggles to get up and do himself an injury, or from actual movements and exposure, if in his delirium he escapes from the apartment. Careful watching is required in all cases of typhoid, when the mind is impaired; and in almost all cases the intellect is enfeebled, and illusions of one kind or another play fantastic tricks with the patient's judgment. The unreal seems often vividly real, and a typhoid fever patient will, while answering all your questions to the best of his ability, give you exceedingly false statements as to his condition since your preceding visit. Unless, then, a patient is attended carefully by night and day, there is danger of his absconding through the incentive of these delirious fancies. It is a matter also of great importance that there are no disquieting causes that may disturb and fatigue the patient. A typhoid fever patient may be apparently unconscious of what is passing about him, yet confusion



and noise in his apartment, too many visits, or any other disturbing influence, may be felt and the effect be produced of restlessness and increase of fever. Whispering or sibilant sounds are generally irritants to the nervous system, and even if a patient is apparently oblivious to his surroundings, the nervous system will vibrate unpleasantly in response to the rasping of that loud whisper that thoughtless individuals so often use in a sick room. If any of the surroundings—the pictures, ornaments or furniture of the room—produce mental inquietude, or if any attendant or visitor seems to cause annoyance, the offending article or person should be at once removed and excluded from the room. A typhoid patient will often become restless simply from some desire which he is unable to express. Thirst may be present, and he will ask for no water, seemingly unconscious of what the needs are. The attendant should somewhat frequently moisten the mouth with water, so that this thirst may be relieved. The nurse will find that the patient will often greedily take the welcome moisture; and if, when the sordes collect on the teeth, a little pains is used to remove them, it will also be a comfort and relief to the patient. Salt water is admirable for this purpose.

The danger of exhaustion of the heart is one thing to look carefully after, and if there are evidences of a lack of circulation or heart failure, stimulation must be used freely until the danger is over. In few diseases does the use of alcoholic drinks, combined with milk or without, play as important a part as in typhoid, after the temperature has perceptibly lowered in its regular decline, or in the collapse condition. Milk punch is an article that you will find good use for in the third week of the disease and in the first week of convalescence. But the use of stimulants is not to be ordered at once, because the convalescence is begun, or because the fever is diminishing. It is to be used to combat weakness or exhaustion which may threaten collapse or interfere with the absorption of nutritive material necessary to building up the strength of the patient. It may then be used freely, rapidly, or only occasionally, as needed.

There are but a limited number of articles that may enter into the bill of fare of a typhoid fever patient. In the beginning almost any article of solid food, especially meats, will add increased inflammation to the enteric glands, and so lead to the diarrhoea which so

rapidly exhausts the patient. Therefore, after you have reason to suspect typhoid, you must give the patient no solid food, and but scant amount of liquid food, until you can get the disease under control. Milk diluted with water (if your milk dealer has not already forestalled you) is one of the most important articles you may use. The milk diet may be varied with benefit, sometimes by using it fermented as koumiss, or frozen into a sort of ice-cream, or using the milk whey with or without the addition of cream. Milk is almost the only general article which may be used in any considerable quantities with impunity. Almost all patients can take it without producing ill effects. Broth so weak that it is but the shadow of a soup may be cautiously tried, and rice water and water gruels, and such drinks as may be made from water flavored with fruit acids, or toast or cracker water, or to a limited extent slippery elm or gum-arabic water, or other demulcent drinks, may be given. There is danger in the use of some of these things that they may sour in the stomach, or set up a fermentation that generates a gas, in which case a little extract of malt may relieve the latter, and lime water the former difficulty. If the milk shows a tendency to form into curds in the stomach, barley water or corn-meal gruel very thin, added to the milk will lessen, by mechanical disruption of the curd, the liability to coagulation in solid masses. During the earlier days of the disease you must not force the diet. Confine the case to the simplest articles of drink as catalogued above, and only when in its decline can you add articles of more nutrient character to it.

Rapou, in his work on typhoid fever, gives a diagnostic symptom of great value; a method of procedure that in pure cases of typhoid fever, furnishes you with almost a certain knowledge of the necessities of your patient, and his ability to manage food. In typhoid conditions it is not always as clear or as satisfactory as in enteric fever. Beginning at about the period when the fever is declining, each morning a glassfull of the water is set aside to settle and cool for the doctor's inspection. When the disorder begins to decline, a slight opaque cloudiness forms in the heretofore clear urine, and floats in the center and upper part of the fluid. As the disease progresses favorably, this opalescent cloud increases in density, and sinks down toward the bottom of the glass. If any untoward event retards the recovery, and there is an aggravation of the disease, the cloud rises and becomes less, or disappears altogether. In

proportion to the increase of the clouded portion, and its descent in the glass, we may augur favorably. Some morning you will find the family (who also watch the glass) very much alarmed (unless you have previously notified them) by the appearance of a gray, rose-colored deposit, which is of a sandy character, and is present in considerable quantity, sometimes reaching nearly one-half the depth of the water in the glass. When this comes the recovery of the patient is certain, unless there is great imprudence. According to the density of the opaque cloud in the urine, and its proximity to the bottom of the glass, the patient may be fed with a more or less quantity and better quality of food; and when the red sand has been deposited profusely, you must then add very nutritious and exceedingly easily digestible articles of food to his bill of fare. If, on the contrary, you feed the patient on broths, beef tea, and other articles of that character, during the course of the disease, and while the cloud is absent from the urine, or only developed, and in the upper portion of the glass, you will find the moisture leaving the tongue, and a dry, black or brown streak taking the place, and the temperature, that was nearly normal, becomes again elevated, and if the diet is not speedily changed, the patient is forced to death's door. As your case progresses toward recovery, the water gruels, milk and flavored water foods, with which you begin, are supplemented by broths and bread. Experiment carefully with each increase of food, or you may light up a relapse as the result of imprudence. Follow the broths with a baked potato mealy and light. Then advance your patient to chewing a piece of beefsteak, swallowing the juice, and rejecting the solid meat; a dropped egg on toast, or with the potato, and so on gradually build up the fabric of the quantity and quality of the food, according to the ability of the patient to receive it. When your patient is taking food in small quantities, and in diluted quality, you must feed frequently, once in one or two hours during the day. When you find the improvement great enough to advance his diet, you must then make him use for the three meals of the day something more substantial than at other times, giving the less solid food between. For instance, if you have advanced your patient taking his first solid food, you would order for his breakfast a piece of bread with the milk, then his milk or water gruels once or twice between; at noon a baked potato with milk or broth; then again the milk or flavored water foods until supper, when again a more solid substance may be

given. In the whole course of feeding the patient the greatest care must be observed that the quality of the food does not irritate the enfeebled alimentary canal, and so increase the intensity of the fever. The patient's longing and demands for larger amounts of food must be resisted firmly, and only acceded to as your judgment dictates.

If diarrhœa appears during the convalescence the diet must be restricted to the milk foods again. Especial attention must be paid to the diet through the whole course of the disease. The quantity and quality are matters of the greatest importance, and the physician should lay down rigid rules for the administration of aliment, and as he hopes for success in these cases, see that his orders are obeyed. In one case which I attended, there was an abnormal hunger, but any increase of the dietary was immediately followed by a rise in temperature. By care in the regulation of the food, the fever was, apparently, about conquered, when one morning I found a rise of three degrees in temperature, and a dry, typhoid tongue, with a return of the typhoid symptoms. This was the result of the kind offices of a neighbor, who, in the goodness of her heart, could not bear to hear the child beg for food without gratifying her wishes with some "very simple cookies" which she had made and brought over for the express purpose of giving her. Yet my orders were explicit that the feeding should be repeated once in two hours, and should consist only and strictly of the milk or Ridge's food.

In the books, repeating one after another, you will find a different rule of diet from this I have laid down, but the patients do not have as light fevers as under this method. That the beef teas and extracts of beef that are given so profusely, are an important factor in causing the prolongation of the disease through the three weeks, I am fully convinced. That in the manner of the administration as they are usually directed to be given in the text books, the frequency of the troublesome diarrhœa is due, I have no doubt; and that a very much smaller proportion of deaths would occur, if the different method of feeding, as I have tried to express in this lecture, were adopted, I am sure. Typhoid fever is a disease in which the accessory measures and sanitary regulations are of more value in relieving the individual patient, or in preventing the progress of the epidemic, than the administration of remedies. This is said not in the least undervaluing the necessity for the appropriate medication. I have seen a goodly number of patients in whom the disease has been practically

aborted within the first week by the use of medicines, but as a rule in these cases there is danger of a relapse from any imprudence during the succeeding two weeks, when the disease ordinarily would be in progress. It is as though the germs were alive but not active enough to overcome the vital resistance arrayed against them, and any lessening of the strength or vitality of the patient, is marked by an increase of the disturbing element of the fever germs. The convalescence is a matter of careful attendance and nursing. To restore to health a patient in whom the fever has raged furiously, after its decadence, is almost as much a careful study as the fight for mastery over the complications of the disorder. It is a continual experimentation; carefully testing the articles that may be used for food, adding stronger dietary as the patient can take it. And with the exercise, in the same manner, it is literally step by step, and often so painfully slow that the patient decidedly rebels against the doctor's orders. The appetite is often so craving that the patient has no restraint over it, and would eat kinds and quantities of food that would be sufficient to cause speedy death, simply to gratify the desire; and the typhoid fever patient is not out of danger unless carefully guarded, even after the doctor has taken his leave.

The whole course of a severe attack of typhoid fever is that of a furious fire which burns out the individual, and leaves but a wreck of ashes and *debris*. Out of this must be reconstructed the former health, and it is like the rebuilding of a burned building, and takes a period of weeks, running into months often, before the work is completed. A trip away often hastens recovery, and is an agreeable and timely aid to invigorate both mind and body.

As soon as your patient is sufficiently recovered to move from one room to another, it is well to use the sulphur fumigation of the apartments where the sick person has been. Repeat once or twice to make sure of destroying all remains of fomites in the apartment.

Pasteur's studies and experiments in producing weakened cultures for vaccination teach us a lesson in the sanitary treatment of this disease. Pasteur, by reducing the nutritive quality of the fluids in which his bacteria grew, lowered the vitality and vigor of their action. They grew old, decrepid, and lacked the power to overcome the vital force of the inoculated subject to an extent to do an injury of a permanent character, so he could rouse this action, strong to resist and protect, by using first the weak, next the

s. ronger, and lastly the strongest of his preparations. So in the preparation to resist typhoid invasion. If the premises are clean, free from decomposing piles of animal or vegetable substance; ventilation free, and fresh air in abundance in all portions of our dwellings, and noxious elements from sewer exhalations rigidly excluded, the typhoid germ would find a lack of nutritive material upon which to grow strong and active enough to sweep through a community with epidemic effect, and would furnish but those low types of the fever in which a patient is only in danger if there is imprudence in diet or exercise. Or the vigor of the germ supplied with its proper nutritive material would be lacking in those localities under good sanitary regulations, so that the vital resistance of the individual would be strong enough to resist entirely the effect of the typhoid invasion. As a proof of what results may be obtained by removing sanitary defects take the health records of Munich. The mortality from enteric fever in that city for 1,000,000 of inhabitants was  $24\frac{2}{10}$  from the period from 1854 to 1859, five years, when there were absolutely no regulations for keeping the soil clean. The next five years some reforms were instituted. Many of the cess-pools were cemented on the hitherto porous sides, and the result was a decrease in the mortality to  $16\frac{8}{10}$ . The next five years, from 1866 to 1873, a partial sewerage system was introduced with the result of again lowering the death record, it reading  $13\frac{8}{10}$ ; while from 1876 to 1880, when the sewerage was completed, the mortality was still farther reduced to  $8\frac{7}{10}$ ; the completion of a good sewerage system having lowered the death rate, in an average taken for five years, of two-thirds of the mortality from this disease. (Michigan State Board of Health Reports for 1884, page 114.) Similar statistics are furnished in other towns. Virchow, who collected records of the death rate in Hamburg from 1838 to 1869, points out that before the town was sewered the average deaths in 1,000 from all causes was 48.5. There was a reduction in a ratio to the progress of the sewer building, and after the sewerage was completed the death rate during the seventeen years from 1852 to 1869 was only 22 in 1,000, deaths from all causes, reducing the death rate here one-half. At Dantzic the difference was still greater, the death rate from typhoid fever falling from 10.01 to 3.62. (Hirsch: Historical and Geographical Pathology, Vol. I, page 666.) The great change made in the mode of the water supply for the larger towns and cities is a factor

of great force in lessening the danger of typhoid and kindred disorders. The purity of the water source is looked after much more carefully than formerly, and its preservation from defilement before reaching the consumer is made a constant study. The knowledge of where our danger exists, and the certainty of infection and disease of a severe type if water contaminated with the disease germs is allowed to reach a community, has spurred to action the majority of large centers of population; and when the soil contaminated with the products of refuse from densely settled districts is no longer allowed to drain into the reservoirs from which the water supplies are taken, the great and most prolific source of the dissemination of the typhoid poison will be obliterated.

---

ITEMS.—Those who have found Schüssler's remedies useful will be glad to know that Boericke has put out a new and enlarged edition of his work entitled the "Biochemical Treatment of Disease," translated, with the addition of a repertory, by Dr. J. T. O'Connor, etc.—The Tuesday evening entertainments at the "Old Hahne-mann" are very popular and instructive. The program given in our last issue has been faithfully carried out.—Prof. Small will close his course for the winter December 22.—The midwinter holiday begins December 24. The course reopens Monday, January 4.—The Bureau of Obstetrics, Dr. S. Leavitt, chairman, will report at the next meeting of the Clinical Society.—Halsey Bros., 27 Washington Street, are making the tablet triturates.—Diphtheria is prevalent in two of our suburbs, and there are scattering cases in the city.—Letters come in like a shower of valentines concerning the post-graduate course for April and May. "Don't all come at once."—Look out for the Hospital Notes in the next year's CLINIQUE.—The Alumni Fellows are busy with preparations for their February meeting.—Bound volumes of this journal for 1885 may be had by addressing Dr. E. S. Bailey, 3034 Michigan Avenue, Chicago.

---

## Transactions of the Clinical Society.

DR. A. K. CRAWFORD, SECRETARY.

### DECEMBER MEETING, 1885.

This constituted the one hundred and sixth regular session of the Clinical Society, and it was attended, as usual, by a goodly number of physicians and students. Dr. H. B. Fellows, president, took the chair on Saturday evening, December 5, in club room 4 of the Grand Pacific Hotel, and called for the

### REPORT OF THE BUREAU OF SKIN AND VENEREAL DISEASES.

T. S. HOYNE, M. D., CHAIRMAN.

CONTAGIOUS SKIN DISEASES—BY DR. T. S. HOYNE.—In these days of uninterrupted progress every reasonable precaution is taken by our school authorities, boards of health and health officers to properly protect the child of school age, as well as the adult, from certain contagious diseases. Before entering school every child must be vaccinated. No pupil is admitted or allowed to attend the various classes if scarlet fever, measles, small pox, chicken pox, whooping cough, diphtheria or typhoid fever is present in the house where the child resides, although it is a disputed point whether all of these diseases can be carried from the home to the school room.

In many of the smaller cities and towns the schools are even closed for weeks at a time when any one of these diseases prevails to a considerable extent. Especially is this true of variola, scarlatina and diphtheria.

No great objection, so far as I know, has ever been raised by parents or guardians to the enforcement of such rules—the closing of the schools or the exclusion of the child. How is it, however, when the physician insists that a child should not attend school on account of a contagious skin disease? At once there is a decided opposition and a refusal to take the advice.

So far I have yet to learn of the first instance in which a school



board or even a teacher excluded a child afflicted with scabies, syphilis, tinea tonsurans, impetigo contagiosa, pediculus capitis or other parasitic diseases, and yet there is no physician, who does not consider these affections contagious. The two probable reasons why these diseases have not been put upon the black list are, first, because they are not considered destructive to life, although so very disagreeable to the afflicted one and his neighbors; and secondly, because the attention of those having authority over our common and county schools has not been called to the matter.

It is a question worthy of careful consideration, whether such sufferers should not be excluded for many reasons, but mainly because these diseases are not only contagious and repulsive, but sometimes leave disfiguring marks.

It is not necessary to speak of the disfigurements left by that terrible disorder—syphilis. It is a disease that is observed in quite a number of children of school age. A much more frequent affection is tinea tonsurans. The spores of this vegetable parasite float about in the air of the heated recitation room, finding a lodging place upon the head or skin of an unaffected child or teacher. The hair becomes diseased, breaks off or falls out and is more or less destroyed for ever. Ordinarily it grows again when the parasite is gotten rid of, but not invariably by any means, and the child may have bald spots or at least thinning of the hair.

And yet the mother of this pupil with tinea tonsurans, or any form of tinea for that matter, sees no earthly reason why the physician should advise that the child be kept at home or away from other children. An argument frequently used is this: "If the disease is contagious why have not the rest of us caught it?"

Tinea favosa or favus is fortunately a comparatively rare disease in this country. I say, fortunately, because when the disease is at all severe, the hair follicles are completely destroyed, with resulting bald patches, and under our present school regulations it would have a splendid chance to spread, doing a vast amount of damage.

Impetigo contagiosa seen occasionally among the children of the poorer classes is often mistaken for eczema or scabies. The only disfigurement that is liable to follow is small scars. In the great majority of cases it follows immediately upon some one of the eruptive fevers, and hence is not often seen in the school room.

Scabies, as even the parents know, is a highly contagious affection,

and once introduced into the class there is practically no limit to its spread.

The fact should not be lost sight of, that it is not every child exposed to these diseases that contracts them, for there must be a suitable soil for the development of the vegetable spores or the animal ova. Neither does it follow that every child exposed to the contagion of the eruptive fevers contracts them. The question is, could not many of these diseases be stamped out by protecting the school room?

In this connection I wish to give the record of three cases of eczema marginatum, a parasitic disease affecting usually the upper portion of the thighs, and rendered more or less obstinate by the heat and moisture of the parts.

*Case 1.*—H., a professional gentleman aged thirty-five, of sedentary habits, plethoric, has had eczema marginatum for years. He had inveterate constipation. A large number of homœopathic remedies had been employed in vain, as well as various local applications which afforded temporary ease. *Nux vom.* 30 was prescribed, and the patient ordered to cover the affected parts with adhesive plaster to prevent the nightly scratching during sleep of the diseased surface. A speedy cure was the result, to our surprise.

*Case 2.*—An Englishman consulted me for a gonorrhœa which he had contracted some weeks before. I discovered that he was also troubled with eczema marginatum, for which he had been treated for a number of years. He said he had been under the care of the best dermatologists in London, and that they had only afforded him comparative relief from time to time. The disease had almost disappeared on several occasions, but always grew worse after a short interval. I told him to paint the parts with acetic acid while under treatment for the gonorrhœa. *Sep.* 30 was administered, and when the specific trouble left him, the eczema had also disappeared and has not again returned. The acetic acid was ordered because he claimed that this always gave him some relief. In Case I. acetic acid never afforded any decided relief.

*Case 3.*—A stout florid gentleman, who had taken much exercise during the hot weather, complained of an itchininess about the thighs and scrotum, for which some simple remedy was prescribed. Two or three months later he returned with a well marked case of eczema marginatum. The itching was excessive, especially after undressing, and at night in bed. He had used all sorts of cooling applications with only momentary relief. He had noticed that in cloudy and wet weather the itching was greatly aggravated. On account of these symptoms, and owing to the fact that he was an old rheumatic

patient, I gave him *Rhus. tox.* 30, and ordered him to bathe the affected parts with vinegar. In a very short time he reported that the eruption had disappeared.

Dermatologists are now debating the question of parasitocides, and have about come to the conclusion that there are no such things; for any substance of sufficient strength to destroy the parasite, is strong enough to destroy or damage the organic elements they inhabit, and hence demonstrate the truth of the homœopathic law, that internal remedies should be employed to alter the character of the soil.

**PTYRIASIS VERSICOLOR, TINÆ VERSICOLOR. (CHLOASMA OF WILSON).—**BY W. S. GEE, M. D.—*Case 1.*—September 3, Mrs. W., æt 25, applied for relief from an eruption on her chest. She suspected it to be of a contagious character, for she had seen a similar eruption on a visiting nurse-girl a few days before. The spots were dark-brown or fawn colored, and although small at first several coalesced and formed irregular patches varying from the size of a gold dollar to twice that size. The development had been gradual, and the presence of the eruption gave her more distress of mind than of body, as there was no itching except when heated from exercise. The eruption first appeared on the upper part of the chest and extended downward and outward by the appearance of new isolated patches. Thin scales appeared, and on their removal the spots were very slightly reddened. The disease had not appeared on other parts of the body. As no constitutional symptoms could be elicited upon which to select a remedy, the character and course of the eruption pointed to one remedy and *Nat. ars.* 30th was given her. As she was very anxious to have the trouble removed in the shortest possible time, she was instructed to use locally strong vinegar whenever the itching appeared. She reported one week later, stating that the local application did no good as the spots still remained. An examination, however, showed that no new spots had appeared and she was instructed to take of No. 1 (*Sac Lac*), three times a day, and of No. 2 (*Nat. ars.* 30), only on local evidence of the progress of the disease. After a few days the trouble gradually disappeared.

*Case II* was the nurse-girl above mentioned, who gave a similar history, and the eruption had the same features. For some constitutional symptoms she was at first given *Nux vom.* and although those symptoms were removed the eruption remained the same, and she, too, was cured with the *Nat. ars.* 30, the highest then obtainable. In this last case no local application was used, giving us stronger evidence of the efficacy of the internal remedy.

These cases are reported for several reasons:

First. To show that even parasitic diseases result from dynamic influences, just as weeds grow only when the soil is suitable, and that

the remedy which corrects that disturbance, changes the soil, cures the disease, as the weeds cease to grow.

Second. *Tinea-versicolor* is comparatively a rare disease, but one which we may meet frequently, and it is well to refresh in our minds its distinctive features.

Third. To call attention to the marked homœopathicity of *Nat. ars.* to the leading peculiarities of this disease. Its skin symptoms read: "Squamous eruption, scales thin, white, and when removed leave the skin slightly reddened. If scales remain they cause itching, worse when warm from exercise."

*Discussion.*—DR. HOYNE—The Doctor takes the same view as I do; if the soil is not suitable the plant will not grow. If it were not so we would have this skin disease every time a case of *tinea tonsurans* is shown to the class, and I touch it, look at it and stir it up. What is to hinder it from spreading through the whole class except the fact that it cannot grow upon a healthy skin. The proper treatment is to give the indicated remedy internally.

Dermatologists have about made up their minds that there is no such thing as a parasiticide, for any agent strong enough to kill the parasite will destroy the organic tissue upon which it is lodged.

DR. ROGERS—What renders the soil suitable?

DR. GEE—Constitutional miasm, perhaps the scrofulous, syphilitic or gonorrhœal. Even our respected allopathic brethren have said that many skin diseases depend upon the condition of the nervous system rather than upon local causes.

DR. E. M. P. LUDLUM—I fully endorse the point made by Dr. Hoyne, that children affected by contagious skin diseases should be kept out of the public schools just as much as if they had scarlet fever or measles. In regard to these skin diseases arising from nervous causes, I cannot believe it. As for scarlatina, I am averse to the use of warm water, in almost every case, to bring out the eruption. If the rash is tardy in coming out, and you cannot bring it out with your remedies, then perhaps it is beneficial. I also object to the use of oil. I think the pores of the skin should be open and not smothered up in oil or any application.

DR. CANFIELD—I, for one, am in favor of warm baths in this disease, especially in patients to whom baths are a rarity when in health.

SCARLET FEVER CASES.—BY DR. SARAH W. ANDREWS.—November 16 I was called to see a girl aged fourteen years. Found the pulse 100, the tonsils enlarged, the right side of the throat reddened, the left side of a brownish hue with a small ulcer. The girl was very restless, had pains all over the body and the limbs; surface of the body hot, but not burning hot. *Aconite* was prescribed to be given until moisture of the skin resulted, and then to be followed by *Bryonia* and *Belladonna* in alternation. I called eight hours later and found her covered with a scarlet rash. *Merc. jod.* and *Ars.* were prescribed in alternation.

November 17.—Throat and tongue scarlet red and moist.—Continue the medicine last prescribed.

November 18.—Tongue brown and dry; lips dry and parched; skin of the body moist; the eruption fully out all over the body; very restless; very thirsty for small quantities of water at a time. *Rhus.* and *Ars.* were given. The pulse was 105 to 110.

November 19.—Tongue again red; she had been delirious in the night; the eruption still out. *Bell.* and *Rhus.* were prepared for her.

November 20.—The tongue is coated white; very nervous; pulse 100; sordes on the teeth and lips, and the lips are parched; great restlessness. At 4 P. M. more quiet, but wanted large quantities of water to drink; the eyes are slightly congested; dark look about the face and head. Gave *Cuprum*, to be followed by *Bell.* and *Bry.* The pulse is 98 but not so full. I was called again at 5 P. M. on account of epistaxis. The face was at first red, but in half an hour after a dose of *Bell.* it became deadly pale. *Carbo-veg* and *Hamamelis* were prescribed. By raising the arms above the head and applying hot water to them the epistaxis was arrested. Her pulse did not grow weaker; her eyes were like two balls of fire. She died at 7 P. M., two hours after I was called. Dr. Leavitt was present in consultation. The body of the patient was covered with blue spots.

November 22.—In the same family, three more children were taken sick, aged two, four and nine years. The youngest had a slight rash all over the body but soon rallied and recovered. Milk diet in all. The second one, aged four had a profuse rash, and to all appearances was doing nicely. On the 23d Dr. Leavitt saw the case with me and we gave *Ars-jod* and *Belladonna*.

November 24.—The child was apparently doing well up to within two hours of death, when the eyes became greatly congested. It died at 7 P. M.

The remaining child of the three that were taken sick at the same time was doing well every way. Dr. Leavitt prescribed for this one from the first day of its illness. After I left at 1 A. M. on November 26, slept an hour quietly, awoke with slight delirium, asking for her mother. She complained of her head, said she was going to die and breathed her last at 5 A. M.

November 25.—On this date the fifth child member of this family at 8 A. M. said he did not feel well, that his throat was a little sore. On examination there was a small red spot in the throat; the tongue slightly coated white. He said he felt tired. The pulse was eighty-five and weak. He went to breakfast with the rest of the family. I decided that I would not prescribe for this child but put the case in Dr. Leavitt's charge. Dr. L., an hour later found a very quick and feeble pulse and prescribed *Ars.* and *Bell.* An effort was made to have the family leave the house, but with one dead and two others sick, no one in the neighborhood would take them. However, two of the patients were taken upstairs. At 4 P. M. Dr. L. and myself went there again. The patient had coldness of the cheeks and *Verat-alb.* a few doses were given, afterward *Ars.* and *Bell.* He died at 11 P. M. This child was prostrated with fright from the beginning and just before death the skin was black.

The house where so much sorrow and suffering has been experienced stands upon a lot which after having once been excavated was filled up with all sorts of rubbish and filth from the city. I believe these deaths were due not so much to the disease as to the local surroundings. There was no sewer connection with the street.

*Discussion.*—DR. W. S. GEE—The house was a frame cottage built upon a lot that had been filled in with all sorts of refuse and rubbish. There was no connection with the common sewer, but there ran from the house to a catch basin outside, a wooden box drain of such loose construction that waste from the house readily escaped into the soil, and it is probable that this and the made-up ground were the main sources of the trouble. It seems to me that the remedy for these cases was *Ailanthus*, the drug that Dr. Wells, to his sorrow and our good, discovered and made public.

DR. T. S. HOYNE—I thought at the time of *Ailanthus*, and the first thing I asked Dr. Andrews when I saw her, was whether it had been used.

DR. LEAVITT was very busy and ran in to see the case and prescribe for it as best he could; at the same time they both seemed to have overlooked *Ailanthus*, which was undoubtedly the remedy, and probably would have saved the second, third and fourth child, provided, of course, that they had been removed to better sanitary surroundings.

A CLINICAL ANALYSIS OF ENURESIS\*—BY C. E. LANING, M. D.  
—*Treatment.*—To arrive at anything definite or positive in the way of treatment of this troublesome affection, the physician must

\*Continued from page 346.

most carefully interpret all morbid phenomena, which are outgrowths of the lesion or lesions, giving rise to the incontinence.

As we have seen in treating of the pathological side of the question, atony of the bladder is one of the causes of enuresis, upon our ability then to cure this, will depend our success in removing the most prominent and disagreeable symptom connected with it, viz.: incontinence of urine. The real, or true pathology, varies in every case in which the curative remedy differs. While there is no doubt that some cases of atony are entirely free from any nervous complication, that is to say there is no real paralysis, but rather degenerative changes of the muscular fibers of the bladder, still we must often admit that it is a difference without a distinction.

Therefore in giving the therapeutics of this lesion, I shall not attempt at present to draw a sharp line of distinction between those cases in which atony in the strict sense of the term is present, and those in which atonic symptoms make their appearance as a result of paresis or complete paralysis of the motor nerves of the detrusor urinæ. We shall, however, make a distinction between those cases in which a frequent or almost constant passing of urine takes place, due on the one hand to a paretic condition of the sphincter alone, and others in which it occurs as a result of weakness of the detrusor, the sphincter becoming affected secondarily.

In cases in which a paralytic or paretic condition is present, the symptoms of said condition will not be, or cannot be, confined to the bladder alone. The commissural fibers connecting the various spinal centers or cells, are so short and so highly conductive, that a lesion of a given center will invariably be transmitted to one or more adjacent centers, the degree or manner in which it affects the various cells to which it is transmitted, depending upon the character and intensity of the original lesion. The symptoms present therefore in a given case would show to us, if we had the requisite knowledge, just what nerve cells were affected, and how they were implicated. Lesions, which are totally different in character, may, and often do, produce one or more symptoms which, so far as we can judge, are identical, but all of the symptoms which arise from any two distinct lesions, are never the same. Therefore, while a number of remedies may cause paresis of the sphincter vesicæ, or detrusor urinæ, they each do so in a special manner, and while they all must needs act upon the same nerve or nerve cells, they do so each in its own peculiar way. Thus various remedies paralyze a given group of motor or sensory nerves, and yet there can be no question as to the fact that the actual changes produced in the nerve cells differ in the case of each remedy, although the result, so far as paralysis is concerned, is the same. If we look further, however, we shall observe that there are other evidences of drug action to be seen, which prove conclusively that each drug has acted in a special and specific manner upon certain tissues. While in the case of any two or more remedies, they

each may act upon the same nerve centers, the reflexes arising will show that the said center or centers have been affected differently by each drug.

A lesion in the lumbar medulla of the nature to cause paresis of the sphincter vesicæ, will reflexly affect other centers. This point requires to be fully understood before entering upon the differentiating symptoms of certain remedies. Under a given drug certain centers are more susceptible to its influence than others, indeed we may say that only special centers can be or are involved. In a perfectly healthy individual, out of all the tissues acted upon by a drug, certain ones there are which are primarily acted upon. In diseased conditions the nerve centers which in health are secondary centers may become primary ones, that is to say, those upon which the drug acts first may not be involved at all. For, let the idiopathic lesion be in the lumbar center of micturition, the irritation or morbid force evolved from it may be transmitted through a number of healthy centers, until arriving at one which, in the individual case, is susceptible, it gives rise to whatever symptom or symptoms such center is capable of causing under the influence of the special irritation transmitted to it.

In each individual as the result, from as yet, some unknown cause, certain, or rather uncertain centers are specially susceptible. Hence, it is plain why a different group of reflexes may occur in different cases, all having the same pathological basis. It must not, however, be thought that simply because the center of micturition is affected in such a way as to produce paresis or paralysis of the sphincter vesicæ, that the pathological conditions are the same in all cases. The actual, real pathology, cannot be got at in some patients, but there can be no question as to the fact of its differing in various cases.

The centers, which become reflexly affected in a given case, do not become so simply because an irritation is conveyed to them, but for the reason that a certain definite kind of irritation has acted upon them. Thus a single sensory nerve may convey to the brain sensations of heat, cold, of smoothness, roughness, hardness, softness or other sensation, just in accordance with the character of the idiopathic lesion as the substance or agent which gives rise to the sensation may be considered.

We are now prepared to take up the study of the drugs causing and curing the various lesions, which give rise to enuresis.

*Agaricus muscarius*.—This remedy is certainly of use in some cases of atony of the bladder. In such cases the lesion is almost entirely a nervous one, the muscular changes being secondary. There is a paretic and also a spasmodic action, as is characteristic of this drug. The sphincter vesicæ is in at least a paretic state and as a consequence the urine dribbles away almost constantly. At the same time the detrusor acts but feebly and spasmodically, as is shown by the fact that the patient has to strain to pass the



urine and that even then the flow is not regular, stopping and starting in an uncertain way.

If the sphincter has become paralyzed before the detrusor is involved, while atony of the last named muscle may take place later on, certain of the subjective and objective symptoms which would appear if the reverse order of things had taken place, are absent. Thus if the sphincter becomes involved first, it being either constantly relaxed or in such a weakened state of contraction as not to permit of any considerable accumulation of urine in the bladder, that viscus does not become distended or dilated, but atrophied rather from disuse. The urine not being retained for any length of time, but virtually passing directly through the bladder, does not undergo the fermentive changes which it usually does in cases of atony of the bladder. It is clear then, that the subjective symptoms which arise in this lesion from the cause mentioned, must be absent.

The nervous phenomena developed by this drug are not confined to the region of the bladder by any means. A spinal lesion great enough in size and intensity to affect the organ under discussion will as has been stated before radiate out to other centers. The manner in which said centers are involved, rather than the bladder, will be the guiding indications for the remedy; in short they complete the pathological picture. While in a given case a certain definite group of symptoms will make their appearance, their number and character will vary in each case, as has been explained above.

In addition then to the bladder symptoms given under *Agaricus* more or less of the following may be noted: Twitching of various muscles, generally those of the lower extremities, especially the glutei. This shows that reflexly the motor cells in the anterior cornua from which spring the superior gluteal nerves, are affected in such a manner as to give rise to the symptom quoted. If other muscles are involved we can locate the lesion by knowing the origin of the nerve or nerves supplying them.

The muscles of the lower extremities may not be alone involved, indeed not affected at all, but for reasons already given, the reflexes may be noted in the upper portions of the body. Twitching of the eyelids and eyeballs is specially liable to be present. The motor cells are not alone attacked, but also the sensory ones, as is shown by pain in the limbs, which is generally made better by motion, so that infants sometimes kick and move the limbs frequently and seem to get relief therefrom, as the cries which precede this act cease after a short time.

In addition to these evidences of sensory disturbance there are others, which result from a derangement of the sensory and trophic cells of the cord in such a way as to give rise to a sensation of burning and itching, accompanied by redness and swelling of isolated patches of skin, resembling very closely a "frost-bite." Again we may observe that the coats of veins are relaxed, causing them to become swollen, resulting in more or less marked stasis of blood.

And this condition readily leads up to the symptom "slight blows cause ecchymosis."

Thus we see that in a given case, all or nearly all of the morbid phenomena, which make their appearance, should be observed and properly interpreted in order to select understandingly and scientifically the curative agent.

*Rhus toxicodendron*.—This remedy is of undoubted use in atonic conditions of the bladder, both in the case of strict atony, where the muscular fibers are at fault, and when only the nerves are affected. We might, to distinguish these conditions the one from the other, designate them as paralytic-atony, and atonic-paralysis, according as one or the other of these factors is predominant. The *rhus* will, as we have seen, correspond to both conditions, or to any combination of the two which may arise.

There is no doubt that *rhus* acts upon the trophic cells in the anterior cornua of the cord in such a way as to produce muscular atrophy. If then the lesion be so located as to affect the cells controlling the nutrition of the detrusor urinæ, the result must be obvious. It is equally certain that this drug acts upon the multipolar cells of the anterior cornua, from which the spinal motor nerves have their origin in such a way as to cause paresis or complete paralysis of the same. Its action is not, however, limited to this region of the cord, but it also exerts an influence upon the cells of the posterior cornua, which give rise to the spinal sensory nerves, and, as a result, we observe various indications of sensory disturbances.

A careful study of the morbid phenomena arising from a lesion involving the centers referred to, will enable us to select *rhus* with almost unerring precision.

As indications for *rhus* in atony or paresis the following symptoms are to be considered:

Retention of urine.—The patient is restless and uneasy, and if old enough to express himself often complains of backache, which is generally located in the lumbar region. The restlessness in such cases is, as in all instances where *rhus* is indicated, not of the nature to impel the patient to constant movement, but the child seems uneasy if he remains in one position long, and obtains more or less relief, temporarily, by motion. There are certainly two factors at least, which are to be considered as causes of this peculiar and very characteristic symptom. Back of all, an impression has been made upon the sensory nerves of such a nature as to cause them, when irritated, to give rise to the uneasy restless sensation just described. The cause of this irritation is, I believe, to be found in mere mechanical pressure exerted through the vascular system. It may be that a certain undue accumulation of carbonic acid gas adds to the difficulty, for warmth so modifies the vascular derangement, that the nervous phenomena, which are proximately the outgrowth of it, are temporarily held in abeyance.

The urine is voided slowly, this shows that either the fibers com-

posing the detrusor are in an atonic condition, or that there is a parietic state of the nerves supplying said muscle. If the reflexes, of which we shall directly speak, point to *rhux* as the indicated remedy, it practically is of no import which condition is present, as we have seen that *rhux* covers both. We can generally differentiate, however, by the use of drugs in the manner already explained.

Thus if the tardy flow is due alone to the parietic state of the efferent nerves, or of the afferent or *both*, a few doses of *Strychnia*, 2x, 1 gr., will so stimulate the motor cells, as to hasten though spasmodically, the contractions of the bladder, while if the muscular tissue alone is affected it will not produce such a result.

Under *rhux* the urine is of a nature to indicate a catarrhal condition of the bladder, viz.: milky, muddy, opaque, with white sediment, or dark, becoming turbid. These conditions, of course, can only be observed in children a few years of age. "Urine involuntary at night and while at rest. Frequent urging day and night, with increased secretion." This group not only points to a bladder lesion, but also to a renal one; the renal difficulty tending, as has been already explained, to increase or aggravate that of the bladder. We see here that the involuntary urination takes place at night, and when at rest. Here, undoubtedly, the circulatory derangements previously referred to came into play. Not only does the idiopathic lesion tend to produce involuntary micturition, but the additional irritation resulting from stasis of blood increases the tendency; in fact it seems to be the proximate cause, and only when present, during rest in the day time, or the quiet of slumber, does the incontinence occur.

When we remember the anatomical arrangement of the vessels of the cord, we can readily comprehend how an increased blood pressure may take place. Nature evidently knew that a stasis of blood in the spinal cord would result in greater or less injury; therefore ample means have been provided for the egress of blood from that structure, inasmuch as there are four veins for every artery. This very mechanism, however, which, while a source of safety, if in a normal condition, very readily works injury if deranged, for it is easily seen how an increased blood pressure will rapidly occur if anything interferes with the venous current, and if the spinal cells in the region where it takes place are already diseased and sensitive, the result is obvious.

It will of course be understood that the symptoms given are not all by any means the outgrowth of atony of the bladder, but rather that atony is only one link in the chain of pathological conditions which may be caused and cured by *rhux tox*.

*Hepar sulphur*.—This drug is of use in atony of the bladder, only when the atony is secondary to paresis of the motor nerves of that viscus. The *rationale* of its action is as follows: The motor impulse sent to the detrusor being diminished, that muscle contracts slowly and feebly. It requires more of a stimulus to cause it to con-

tract than is the case in a normal state. This means that a greater accumulation of urine is necessary to excite it to contraction than should be, and this in turn causes over-distension. The atrophy of muscular fibers of the bladder does not necessarily mean atrophy of the bladder in the sense of diminished capacity. Any muscle will become more or less atrophied if its motor nerves are in a paretic state; this is the case with the detrusor under the action of *Hepar*, the trophic cells being little, if any, affected, so far as the muscle under consideration is concerned.

As we have previously stated, the nerve centers controlling the function and nutrition of the bladder, cannot be involved without other cells or centers which are closely related to them becoming affected, either as regards function, in which case they may be, so far as space is concerned, widely separated, or on account of their immediate proximity.

As regards the trophic lesions which are most apt to accompany the bladder difficulty, they are for the most part made manifest through the skin, eruptions on the scalp, or in the bends of the elbows or in the popliteal spaces are very liable to be present. About the genitals there is often observed a more or less decided erythema. The eruption on the head is generally humid in character, with a tendency to formation of large scales or scabs, and the entire surface affected is exceedingly sensitive, as indeed may be the whole scalp, though there be no external or visible evidence of disease.

As I long ago pointed out, the action of *Hepar* upon all the mucous outlets of the body is very similar. It is due in each case to a paretic condition of the fibers passing from the automatic centers of the cord, and not due to an effect upon the cerebral tissues. Thus there is the difficulty in evacuating the bladder, the rectum and the bronchi; and, even though the stools be fluid in character, it requires an effort to evacuate them, and though the bronchi be filled with a semi-fluid mucus, which can be heard to rattle during each cough, or even during respiration, it is nevertheless, almost impossible to expectorate it. This combination of symptoms would, of course, point strongly to the selection of *Hepar*.

In addition to the above, the gastro-hepatic symptoms must be taken into consideration.

The drug acts upon the vascular system of the liver as well as upon the secretory fibers of that gland, so that quantitative and qualitative changes take place in the bile. This is made manifest in two ways at least. The stools often are clayey or white in color, showing an imperfect bile. The child, if old enough to eat of a varied diet and express its preferences or dislikes, will crave sour things, and show an aversion to fats. The reason for this is evident. The condition of the liver referred to, causes a stasis of blood in the gastric vein, and of necessity a more or less marked gastric catarrh.

The catarrhal secretions are alkaline in character, therefore the acidity of the gastric juice is lessened or rendered *nil*. To overcome this acids are craved and introduced by way of the mouth. The aversion to or inability to appropriate fats, is due to the biliary derangement. The ability of the villi to absorb fat depends largely upon the presence of a proper quantity of bile in the intestines. This as we have found is absent, shown principally by the light-colored fetid stools. In nursing infants, emaciation is apt to take place, for the reason that the fatty principle of the milk cannot be absorbed, nor can the casein be digested on account of the lessened acidity of the gastric secretion.

This is of course not the only combination of symptoms which may occur, but one which unerringly indicates *Hepar*. Do not attempt to divorce one part of a case from the other, and therefore see, apparently, reason for alternating.

*Secale cornutum*.—This drug has a powerful influence upon all the hollow muscular organs of the body. Symptoms indicative of its action upon the bladder are as follows: Unsuccessful urging to urinate; retention of urine; ischuria paralytica. In conjunction with these symptoms evidences of gastro-intestinal lesions are frequently present. Malnutrition of parts or all of the organism is a condition to be looked for under *Secale*. Imperfect digestion, colic and diarrhoea occur in the same patient. There is generally much bloating, the bowels being painfully distended with wind. There are more or less frequent and violent contractions of certain portions of the intestinal tube, causing rumblings of the gas, and at the same time pain, as the result of an undue accumulation of gas in a circumscribed portion of the intestine. The stools are almost always offensive, watery, slimy, greenish or yellowish, they are expelled suddenly and forcibly, or later, there is a paretic state of the sphincter and of the muscular fibers of the bowel in general, so that the stools pass away involuntarily, but without much force.

The child, as a result of the digestive disturbances which so frequently occur, together with the vaso-motor and trophic lesions caused by this drug, generally becomes emaciated, or at least loses its freshness and plumpness. The skin is dry and unhealthy looking. Seldom, if ever, if we observe closely, do we find the evidence of disease confined strictly to the bladder. More or less well defined muscular twitchings are to be seen. Most frequently the facial nerve is affected, and more frequently than otherwise, the portion supplying the muscles of the mouth, so that involuntary movements of the lips take place. A drawing down of the left angle of the mouth often occurs, in which not only the depressor anguli oris is thrown into action, but also the platysma myoides.

The flexors of the wrists are often affected, or rather the median and ulna nerves which supply them, in such a manner, as to cause spasmodic flexion of the hand upon the forearm, or flexion of the fingers

and thumbs. Occasionally the musculo-spiral is involved so that the extensor-communis-digitorum is affected in such a way as to cause extension of the fingers. At times the hands are very pale and cold, owing to the action of *Secale* on the vaso-motors.

This group of symptoms will almost invariably be removed by the drug under discussion.

I have not the time to give an analysis of the action of the various other drugs which are of service in the case of atony. I will therefore pass briefly over the remaining more important ones.

*Belladonna* produces atony of the bladder by primarily causing paresis of the motor nerves of that viscus. It gives rise at the same time to hyperæsthesia of the sensory nerves of the hypogastric region, as is made manifest by any pressure there, or jar acting upon that region. The urine is voided with difficulty, and many times is accompanied with more or less pain. The congested state of the bladder, and the hyperæsthetic condition of the nerves distributed to it, readily accounts for this.

The child frequently has to strain to void the urine; this causes redness of the face for there is present that condition of the vaso-motors, so characteristic of *Bell.*, which causes, or at least allows of, the ready dilation of the arteries and arterioles on the slightest provocation.

*Arnica* is a remedy occasionally of use in the treatment of atonic conditions of the bladder. It can almost invariably be found that there is a history of traumatism somewhere in the case; a blow, a fall, or a straining of the muscles of the bladder, as the result of over distention. As of course would be expected, there is difficulty in getting the urine to flow; the patient has to wait, and strain. There is often pain, the condition of the venous capillaries under *Arnica* undoubtedly gives rise to this. The tissues of the bladder are affected, as are the other tissues of the body, when they are all under the influence of *Arnica*, or some similar acting cause, feeling sore, as if bruised and very sensitive to any pressure or motion. Infants often scream out when voiding the urine, the contraction of the bladder causing much pain. As a further result of the venous stasis, and not improbable resulting ecchymosis, there is a more or less constant feeling of fulness of the bladder, causing a frequent and continuous desire to evacuate it. The distended vessels cause a pressure upon the afferent nerves in a manner similar to a quantity of urine in the bladder, hence the sensation of fulness and constant urging.

I can, in addition, refer only to some of the remedies which are frequently of service in this lesion.

*Laurocerasus*, *Sepia*, *Plumbum*, *Cicuta*, *Nux. vom.*, *Hyoscyamus*, *Gelsemium*, *Causticum*, *Opium*, *Silicia* and *Zincum*, all cause atony secondarily, it being the outgrowth of paresis.

It will be readily seen that to give indications for all these remedies would cause me to far exceed the limits of this paper. I have yet to treat of the other lesions giving rise to enuresis, among which will be found the most frequent causes of it.

## Hospital Notes.

### THE MEDICAL CLINIC.

#### SERVICE OF PROF. HAWKES.

**RHEUMATIC PARALYSIS.**—*Case 13111.*—Barney B——, aged fifty-six. Rheumatism began a year ago while working in a freight-yard continually exposed to changes of the weather, and seemed to be a result of taking cold. The first marked symptoms, as he remembers them, were weakness in limbs and back, with numbness of the legs, more or less pain, which is worse at rest and when beginning to move, but which is relieved by continued gentle motion. A sense of trembling and weakness compels him to sit down very soon, however.

He is very restless at night, especially between 11 and 1 o'clock, being obliged to turn and toss, and change position very often. He is also much worse before a storm, which he can predict twenty-four hours. Uncovering even so much as an arm or hand at night aggravates perceptibly the pain. While his pains are worse before a rain storm, they are relieved when the storm begins. He has great difficulty in sitting down or rising from his chair; must get on his knees to get into and out of bed; can't seem to straighten his legs. He walks with the utmost difficulty, owing to stiffness, weakness and lameness.

October 1, 1885.—Prescribed *Rhus tox.*

He reported better at his next visit, one week later, and continued to do so each week until October 29, receiving no medicine after the first week during that time.

October 29, he received a few powders of the 200th of the same remedy. Each week thereafter till November 19 he reported steady improvement. Since that date no report.

**ICTERUS.**—*Case 13130.*—James W., aged 34. Has been sick six weeks. He has had a cough for seventeen years, with pain in right side of chest. Poor appetite, marked yellow color of the skin and sclerotics, presenting a perfect picture of jaundice; urine high colored; great weakness. The jaundiced condition caused, probably, by catarrhal obstruction of the bile duct. He cannot sleep before 12 o'clock at night. Is irritable and cross. Stomach deranged, food sours and lies uncomfortably in stomach.

November 5, gave him *Nux vom.*

November 12.—He showed marked improvement in color. Said he felt better; still quite ill-natured. Gave him no medicine.

November 19.—Color natural. Patient well.

**RHEUMATIC LUMBAGO.**—*Case 13131.*—Fred Hulst, aged forty-three. Hurt his back by over-lifting a year ago, and while still suffering from the effects of the strain, took cold. He has, also, pain in his chest, which existed previous to the cause of the back-ache. This "aching" in the chest is now quite troublesome; has occasional headache, and complains of great weakness after eating. All his aches and pains worse before a storm. The pain in the chest awakens him at night, when he is very restless, tossing from side to side. Lumbago quite annoying when sitting down or rising from the sitting posture, but continued motion relieves. Constipation.

November 5.—Received *Rhus. tox.*

November 12.—Reported less headache, pain in small of back does not come so often, and is not so severe, food does not cause so much distress, pain in breast about the same, sleeps much better, and is generally encouraged.

November 19.—"Felt well enough to go to work on Monday, and did so in a damp, cold room, when he took a violent cold, and has been sick ever since." When he went to work Monday he felt better than he had for three years previous. Monday night he was delirious, with most violent headache. He has now no appetite, and is very weak. Gave *Belladonna* for two days, to be followed with placebo the balance of the week.

December 3.—All the symptoms very much better; lameness felt only occasionally now; pain in breast, which had been much aggravated by the cold taken, is now less than before; bowels regular. *Rhus tox.* in a higher potency than at first was prescribed. No further report.

I would call attention to a clinical fact that I have several times unmistakably observed, that is to say, constipation often accompanies rheumatic affections when *Rhus* is the remedy, and when such is the case that symptom disappears with the rest under the action of the remedy.

**SUPPRESSED AGUE.**—*Case 13132.*—Andy Osborne, aged twenty-seven. About two months ago was attacked with chills and fever. Chill and sweat almost together about 3. P. M., with no intervening heat; chill continued fifteen minutes, and was accompanied by great weakness. Scanty high colored urine, and no thirst.

Has had a feeling of general weakness now for two weeks. Has weakness of the legs, with stinging pain through the hips. "*Stinging*" is his own voluntary description of the pain, and he sticks to it. Pulse 104, strong and regular; was taken suddenly to-day



before noon with violent palpitation of the heart, but had no chill. He was greatly alarmed, and *felt as if he could not breathe again*.

*Apis Mel.* wrought a marvelous change in a week, so that he considered himself almost well. The guiding symptoms were the time of chill; scanty urine; absence of thirst; stinging pains, and the feeling that he could not breathe again. This latter symptom in heart troubles, dropsy, etc., is reliably characteristic of *Apis*.

INTERCOSTAL NEURALGIA.—*Case 13133.*—Diagnosis by Dr. Crawford in physical diagnosis sub-clinic. Miss Barbara H., aged twenty-five. Has been ill more than a year; pain in both sides of chest. She was confined to bed with this trouble for several weeks; difficult breathing; much cough; must stop to take breath when walking; heart beats very fast; easily frightened; at one time she raised blood with no cough or effort. Headache continual; worse in base of brain and forehead; better when she lies quietly with the head low; no appetite until 10 A. M.

October 29.—She received *Bryonia*.

November 5.—Reported better in every way; less pain, less headache; better appetite. No medicine given.

November 12.—Report still improving.

November 19.—Much better in every way than last week. This was the last report. She received no medicine after the first week.

DYSPEPSIA.—*Case 13134.*—Mrs. Colgen, aged fifty-four. Very stout in appearance. Her great complaint is on account of the immense quantities of water which "runs out of her mouth in streams." Has been troubled for six years, and during that time has taken great quantities of medicines. Sour stomach, with belching; food lies heavily; frequent ineffectual urging to stool; has had rheumatism during the greater part of the time, which began in the feet and ascended. She was ill in bed with rheumatism a year ago. *All her symptoms* including the salivation, are worse before a storm, which she can predict twenty-four hours. Her rheumatic pains and the salivation are worse at night and when at rest; and are relieved by motion. She "must get up and walk about, because it relieves her."

November 12.—Gave her *Rhus tox*.

November 19.—She reported very much better. "The water-brash is nearly cured." Bowels move once a day; rheumatism troubles her scarcely at all; stomach more comfortable. No medicine.

December 3.—She says all her old troubles have returned, "because the last medicine was not the same as the first!" To ascertain how much imagination had to do with the "aggravation" placebo was given in the same form as the *Rhus*.

The guiding symptoms in this case were the marked aggravation before a storm, and at night, and while quiet; the marked relief from motion; *Nux* or *Mercurius* would otherwise have been selected.

I again desire to call attention to the stomach and bowel symptoms; and especially to the intense salivation, all of which were so greatly benefitted by *Rhus*, when indicated by the very characteristic symptoms to which I have called attention.

**ASTHMA—Case 13135.**—Michael White, aged forty-nine, had malarial fever two years ago, when he took quantities of quinine; has not been well since; no record of asthma in his family history; is now extremely weak and short of breath; continual rattling of mucous in the chest, even after coughing up a quantity of tough, yellowish, lumpy mucus. This sputa is so hard, he says, he could make bullets of it. Low vitality, no energy, takes cold very easily, perspires easily, experiences more difficulty in breathing if bowels, which are quite regular, become constipated. He has had both pleurisy and pneumonia. He is weak and depressed, and is nauseated when coughing; thin white coating on tongue. November 12 gave him *Tart. emet.*

The guiding symptoms being the continual rattling of mucus; the weak, sweaty state; nausea; thin, milky, white coating on tongue. No report has been had from this patient.

**CHRONIC HEADACHE—Case 13136.**—Miss Emma A., aged twenty-three, has had headache twelve years, at intervals; the attacks becoming more frequent, and the paroxysms more severe. She was confined to her bed with it yesterday. Frontal headache of a throbbing character, better when she lies quietly with the head high. Face and eyes become very red; pain in the eyes; nausea without vomiting during paroxysms; pain much aggravated by stooping, bright light and noise; wants to be quiet in a dark room; menses regular, but scanty; bad taste in the mouth in the morning; barring bad effect of motion she feels better in the open air.

November 12, gave her *Belladonna*. No report.

**SUPPRESSED AGUE—Case 13118.**—Mrs. Brumbage, aged forty, had fever and ague terribly fifteen years ago, when she consumed "quantities of quinine" for a long time, which had the effect of changing the character of and partially suppressing the paroxysms.

A chill now awakens her about 3 or 4 A. M., and lasts from a half hour to an hour. There is no regular shake with the chill as was the case formerly; she is simply cold and unable to get warm; then follows a suffocating feeling about the heart, which seems to go up

and around to the shoulder ; she gasps and then the heat rushes all over her. She then rises and remains up ; feels like going to bed and sleeping about 6 o'clock, but is prevented by duty. The menses ceased nearly a year ago.

She has fearful vertex headaches, with great heat ; these affect her eyes ; she awakens frequently at night, and always feels better and refreshed on waking. She complains of faint feelings, and must then have something to eat. Appetite variable ; can't bear clothing tight about the abdomen ; hot flashes. The terrible feeling about the heart distresses her most.

October 15.—Gave her *Sulphur*.

October 22.—She reports the distress about the head and shoulder better ; the chills and hot flashes not so marked. Chills now come during the day, and not at all at night as formerly ; nor do they last so long. Sleeps better ; vertex headache much less severe. Faint, gone feelings remain the same. No medicine.

October 29.—Reports better ; sleeps all night ; pain about the heart up to the shoulder gone ; has had no headache for one week ; has taken cold, but notwithstanding this she is better. No medicine.

November 19.—Not so much improvement during past two weeks, but is some better, is stronger generally, and "feels more like living." Gave *Sulphur* in a higher potency.

December 3.—Better in every way. Still has an occasional chill, but they annoy her very little ; some oppression about the chest remains.

This patient, though suffering so long, is practically cured in less than two months.

The guiding symptoms were hot, vertex headache, hot flashes and "weak spells," with gone feeling, which impelled her to eat for relief.

I would here ask members of the profession who have or know of chronic cases of fever and ague, or of any other chronic ailment, traceable to an attack of intermittent or other such fever, and which was treated with quinine in any of its forms or compounds, to endeavor to have such come to this clinic during the college term.

Fever and ague has long been the *bête noir* of homœopathy. Directly the opposite should be the case ; for, if there is any one disease more than another promptly amenable to *homœopathic* treatment, it is fever and ague. Instead of dreading the appearance of such cases before the class, I am glad when the patient reports a case of this kind, in no matter what condition it may be. They can all be cured.

## THE WOMEN'S CLINIC.

## SERVICE OF PROFS. LUDLAM AND BAILEY.

THE TREATMENT OF UTERINE DISPLACEMENTS.—At his lecture, December 8, Prof. Bailey said: There are two important points that I wish to emphasize in the treatment of the displaced uterus. They concern the proper position to which the uterus is to be returned, and the methods of doing it. It is to little purpose that we have taken the time to describe so minutely the intrinsic and extrinsic causes that result in uterine deviations if by reason of this study we can not discern the underlying principles which suggest a rational treatment, having for its end both relief and cure. While in general it may be stated that there is absolutely no exact standard by which to determine the proper position for the uterus in all women, yet it is a fact that in each individual there is a place or plane which the uterus does occupy in a state of health. I apprehend that the position of relative height at which this organ should be maintained in the pelvis is the one least thoroughly studied or understood. Versions and flexions can be made out by the physical signs, but the most painstaking examination is necessary to determine in a given case where the health-line is in respect to drag or to ascent. It is important not to replace a prolapsed uterus too high in the pelvic cavity. In such a case the disturbing causes have been only relatively changed, for while the one was too low the other is too high, as compared with the health-line. These distinctions of place are not fanciful nor arbitrary as to their importance. You will remember the references that I have made to the peculiar distribution of the blood vessels that are supplied to the uterus. At the plane of normal distribution the blood flows to and fro without obstruction. If the prolapsus be extreme the symptoms that lead a patient to seek advice will be found to depend very largely upon mal-nutrition from an obstructed circulation and its immediate results. I know the common idea in the profession is when discovering a displaced uterus, especially if it be downward to the second or third degree, to replace it by lifting it well up, and maintaining it by some mechanical force. The impulse is to correct one extreme by going to another. There would be no reasonable objection to this procedure if it were curative, but clinical experience teaches that in such cases, where the uterus is sustained too high in the pelvis hypertrophy, hyperæmia, venous and capillary congestion and cervical erosions, with accompanying symptoms, are distinctly traceable to this also faulty position.

The conditions that are curative in such cases are best met when the displaced organ is simply returned to its normal plane. It is at this point or place where the normal circulation and nutrition is again restored, and it is thus made possible for the proper tone of the peri-

uterine tissues to be again maintained. Two reasons may be assigned for the popular idea of replacing the uterus in the manner just referred to; one is that the farther within the pelvic cavity the uterus is compelled to stay, the better the chances of health restoration, and the second is that for a long time the instruments that have been made for repositing the uterus required the application of an upward force, so as to necessitate giving this abnormally high position. This is especially true of very many of the instruments that are designed to reduce flexions and versions.

Among the various instruments before us, popular, according to their adaptability, and simplicity, none have equal merit with the one I show you—known as Ludlam's Uterine Repositor. I say this from the standpoint of practical results. The ease and thoroughness with which versions and flexions can be manipulated, and the absolute freedom from the baneful result of creating another mal-position in the correction of the existing one, are among its chief recommendations. Its simple mechanism, and its wide range of utility, which many if you have seen thoroughly demonstrated in our sub-clinic room, will commend it to the most thoughtful, or even to the most captious.

As to the methods of curing cases of uterine displacements, many that you hear of are faulty in theory and pernicious in practice. Some are good, as far as they can be made to apply to individual cases. There is much that will be required of you as practitioners in this age, and especially in this department to be well equipped with a proper understanding of causes, conditions, and remedial means and measures will be rigorously required of you as public benefactors.

OVARIOTOMY. — RECOVERY. — November 25 Prof. Ludlam called attention to a case of which the following is a synopsis:

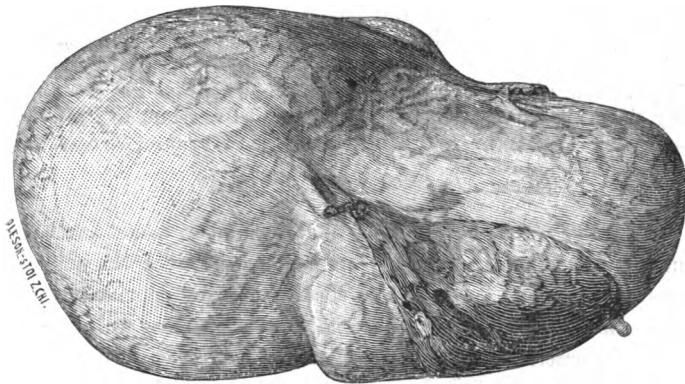
*Case.*—The patient was first sent to him by her physician, Dr. F. W. Gordon, of Sterling, Ill., in October, 1883. She is the mother of one child, now six years old. She had occasional pains in the region of the left ovary, but in the summer of 1881 first observed a slight enlargement in the left inguinal region. The menses were regular. The case was pronounced to be ovarian dropsy, but it was thought best, all things considered, to try the effect of internal remedies for a time at least. The trouble increased, however, and in the fall of 1884 she came to me again. I then decided that extirpation offered the only chance of a radical cure, but, as she was still able to look after her household, consent was not obtained. The growth increased, she had pain and discomfort, difficult breathing on lying down, dysuria, and finally dyspepsia. She repeated her yearly visit in October, 1885, when its multilocular form was made out, and the most serious reasons given for its removal without delay.

The operation was made at the patient's home in Sterling, November 17, my assistants being Drs. F. A. Gordon, of Sterling;

B. L. Reynolds, of Chicago; G. W. I. Brown, of Dixon, and C. N. Hazelton, of Morrison. The details of the operation were not different from those common to most ovariectomies. She re-acted well, flatus was passed on the second day, on the third day there was a slight epistaxis, and a slight vaginal hemorrhage. The urine was voided naturally on the third day; and, although she took chloroform as an anesthetic, there was no nausea or vomiting.

December 9.—At the end of the third week she is well again, eats and sleeps well, and there are no symptoms. The menses appeared on the ninth day, one week too early.

The tumor, which at its removal weighed twenty-five pounds, was then shown to the class, and explained as affording an excellent illustration of a multilocular growth in which the compartments had remained separate. The lower, or parent cyst-wall, was very much attenuated, and might readily have burst and destroyed the patient's life. The upper one was the larger and much the firmer of the two. The point of separation of the pedicle is very nicely shown in the specimen, but the rounded outline of the two cysts would have been more satisfactory if they could have been more fully inflated.



**EPITHELIOMA OF THE UTERINE CERVIX.**—After operating upon a marked case of this kind, sent to the hospital from Cheyenne, Prof. L. expressed his preference for the blunt curette, and advised the greatest caution not to penetrate the peritoneal cavity with the instrument. This caution was especially necessary where, as in this case, what remained of the posterior lip of the cervix was eroded nearly to the summit of the corresponding *cul-de-sac*. During the operation the hemorrhage was readily controlled by hot sponges. The subsequent treatment consisted of *thuja* internally and locally.

## Miscellaneous Items.

The CLINIQUE is under obligations to Dr. H. E. Beebe, secretary, for a copy of the Transactions of the Twenty-first Annual Session of the Homœopathic Medical Society of Ohio; ditto to Dr. Nichol for a pamphlet report on Lacerated Cervix, by Dr. W. T. H. Emory; ditto to a friend for the Third Annual Report of the Homœopathic Free Dispensary Association of Washington, D. C.—Cleveland has a new journal, the *Clinical Review*, Dr. C. L. Cleveland, editor.—Removals for the month include that of Dr. B. M. Hughes to Pecos, Tex.; Dr. J. S. Bell to Canton, Dak.; Dr. F. S. Troyer to Waupun, Wis.; Dr. W. O. Sylvester to 42, Thirty-first Street, Chicago, and Dr. D. H. Brien to Delta, Idaho.—Dr. William M. Davison, formerly of this city, was married October 27 to Mrs. Lucy West.—Molesworth's Acme Dilator and Intra-uterine Syringe, elsewhere advertised in this issue, is a new and valuable instrument.—The *Revista Homeopatica Catalana* of Barcelona, Spain, publishes a translation of Prof. Small's paper on "Cardiac Affections" from our journal.—The *Prescriber*, by Dr. John H. Clark, of London, an excellent little book, comes through Boericke & Tafel.—Dr. R. Ludlam has bought an elegant residence on Michigan Avenue Boulevard, and will therefore rent his old home and offices.—Dr. J. Watry, class 1883, having just returned from Europe, where he has been studying since his graduation, has been appointed assistant to Prof. Vilas.—The class in the "old Hahnemann" is very large, earnest, happy, hopeful and industrious.

VALEDICTORY. — The issue of this number closes another volume of the CLINIQUE. Six years have passed since the publication was begun, and it has enjoyed a steadily growing popularity with the profession, for which its friends and the management feel very grateful. Its practical and clinical character have been maintained and fully appreciated. It only remains for us to thank its subscribers and contributors for their generous and hearty support, and to remind them that in future its course will not be changed. It will appear promptly on the 15th of each month, freighted as heretofore with the kind of information that will be most useful to its readers, leaving to other journals the task of furnishing the theoretical and partisan papers and excerpts for which there is always a market. With the compliments of the season, we also beg to remind our readers, that *this is the time to renew their subscriptions.*











UNIVERSITY OF MICHIGAN



3 9015 07043 0577

