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THE
NEW ENGLAND
MEDICAL GAZETTE

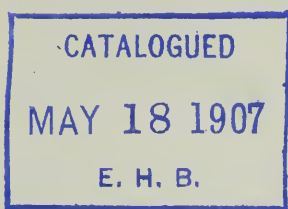
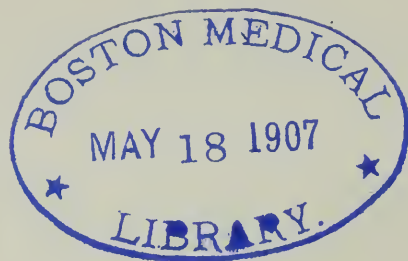
*A Monthly Journal of
Homoeopathic Medicine*

THE GAZETTE ASSOCIATES
Editors

“Die Milde Macht Ist Gross”

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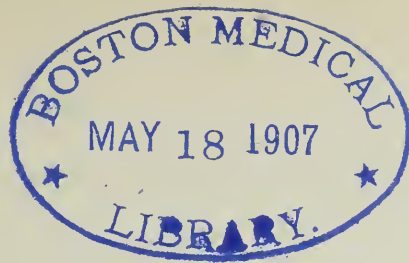
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Conrad Wesselhoft

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THE NEW ENGLAND MEDICAL GAZETTE

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JANUARY, 1905.

VOL. XL.

ORIGINAL COMMUNICATIONS.

THE FAUCIAL TONSIL.

BY GEORGE B. RICE, M.D., BOSTON, MASS.

[An elaboration of a paper read before the Massachusetts Homœopathic Medical Society, Oct. 12, 1904.]

A consideration of this subject has been undertaken for the following reasons:

First. The function of the tonsil is so little understood that a discussion of the different theories of physiologists on the subject cannot but be of interest.

Second. The pathological changes are widely varying, and a differential diagnosis of the diseased states is not always easy.

Third. In the past few years the instruments for operation on the diseased tonsil have greatly improved, and, therefore, the methods of operating have changed.

Fourth. It is important that a differentiation should be made between those cases amenable to cure by homœopathic medication, and those which must be treated by other methods.

By the faucial tonsil is meant that portion of Waldeyer's ring which lies between the anterior and posterior faucial pillars (see Fig. I). At birth the tonsil is partly or wholly covered by a fold of mucous membrane, the plica triangularis, reflected from the anterior faucial pillar. Above is the supra-tonsillar fossa, and the gland is attached to the inner surface of the subconstrictor muscles of the pharynx which separate

it from the internal carotid and the ascending pharyngeal artery. It arises from an invagination of the hypoblast in the sinus tonsilaris; this diverticulum subdivides and lymphoid tissue is formed in the primitive crypts. In the normal child of healthy ancestry these formations of lymphoid tissue are not to be seen on gross inspection of the throat, and they gradually disappear as "an incident in the physiological life history of the animal body" approaching maturity.

Its normal structure consists of connective tissue in which are imbedded lymphoid tissue cells. The gland is irregular in shape, containing numerous crypts, and presents puncture-like blind orifices called follicles. The interior of these follicles, according to a recent authority,¹ is composed of endothelial cells, but this is not a constant condition,² for, in quite a large proportion of children, nothing more is found than a small aggregation of lymphoid bodies covered by oral mucous membrane, and containing no visible follicles or crypts.

As had been intimated, the physiology of the tonsils is imperfectly understood. Numerous theories have been advanced regarding their function. Burnett³ of London says, "They are placed on either side of the fauces for the primary purpose of lubricating the food as it passes down the gullet, and, again, the tonsils lie at the top of the digestive tube, and whenever certain parts or portions of the body have to deal with something harmful, the same is passed along the circulation to the tonsils to be cast out, and the tonsils thus act vicariously for said parts from elsewhere." He further states, "The tonsils are capable of curing phthisis by the formation of series of abscesses each going through the various stages of heat, swelling and bursting, and that the tonsils are capable of sacrificing themselves on the altar of the economy by ulceration till nearly or quite all of the tonsilar tissue is gone."

¹ *Annals of Otolaryngology and Rhinology*, November, 1902, p. 694.

² *Medical Review of Reviews*, April 25, 1902.

³ "Enlarged Tonsils Cured by Medicine." By Dr. J. Compton Burnett, London, Eng.

These theories are quoted not because they deserve serious consideration, but because they illustrate the extreme views adopted by many of Dr. Burnett's particular school. It is obvious that these theories are not the result of scientific research or observation, but are simply vagaries of a fanciful imagination, founded upon a small basis of previously discovered facts.

Wright¹ of New York, one of our best authorities, says, that while certain lymph nodes exist normally between the faucial pillars, yet we cannot insist too strongly upon the correctness of the view, that the tonsils are pathological when they can be demonstrated clinically.

Fry² asserts, that the tonsil is a retrograde structure and has no function in man. Knight, in his recent book of "Diseases of the Nose and Throat," states, that the function of the normal tonsil is still a matter of speculation and that whatever the function might be they would seem no longer capable of exercising it when hyperplastic and diseased.

Ingalls³ suggests, that the structural relation of the tonsil to the general lymphatic nodal bodies, makes it possible that they may, like the so-called ductless glands, have an internal secretion of their own.

Kyle⁴ thinks the tonsil to be no more than a large lymphatic gland and infers that it has a similar function.

Packard of Philadelphia, believes that investigation has demonstrated that healthy tonsils can be invaded by micro-organisms but that they can quickly rid themselves of these sources of disturbance. This author thinks that their function is to offer a barrier to the entrance of micro-organisms into the deeper tissues.

Two years ago, Bosworth⁵ stated before the New York Academy of Medicine, that this mass with its lacunæ traps,

¹ Jonathan Wright, *New York Medical Journal*, April 7, 1900.

² "Yearbook of Nose and Throat," 1901.

³ "Diseases of the Nose, Throat and Ear," p. 538.

⁴ "Diseases of the Nose, Throat and Ear," p. 381.

⁵ *Medical Review of Reviews*, April 25, 1902.

should be considered a diseased body. He says, "Twenty years ago I observed in a London Medical Society meeting, that there are no tonsils in the healthy throat." This observation was received with jeers and laughter. After twenty years of additional observation I am disposed to repeat the same remark.

One could go on almost indefinitely quoting theories, but the consensus of opinion seems to be as follows: The normal tonsils are very small bodies of fibrous and connective tissue and lymphoid cells. They are capable of secreting mucous from the membrane lining the crypts thus aiding, to a very limited extent, in the lubrication of food. They have the power of absorption of toxins and micro-organisms, and probably¹ do assist in the formation of lymph cells and their distribution into the blood, that is, the function in this respect is identical with that of lymphatic glands.

The tonsils are subject to many diseases and an attempt will be made to enumerate most of them and to describe and illustrate from practice some of the most interesting.

The acute inflammatory diseases are as follows: acute superficial tonsillitis; cryptic, follicular or membranous tonsillitis; rheumatic tonsillitis; herpetic tonsillitis; peritonsillar abscess; suppurative tonsillitis.

The chronic affections are: hypertrophied tonsils; caseous tonsillitis or chronic follicular tonsillitis (a condition where the crypts are very much enlarged and become pockets for the deposit of particles of food and broken-down epithelial cells); cholesteatomatous tonsillitis (perhaps identical with the first named); chronic abscess of the tonsil; atrophy of the tonsil; mycosis; keratosis.

Besides these affections we occasionally meet lipomatous and papillomatous formations, as well as malignant growths, both the epitheliomatous and sarcomatous variety. Tuberculosis and syphilitic chancre of the tonsil are exceedingly rare, though the finding of the bacilli of the former disease in the follicles and crypts is not uncommon.

¹ "Kirk's Physiology" (nineteenth edition), p. 315.

Of the acute affections mentioned, the conditions caused by the streptococcus and staphylococcus infection present quite varying types, and should be further considered. The most common forms of these manifestations are given by the synonymous terms, membranous tonsilitis, fibrinous tonsilitis, benign fibrinous angina, pseudo-membranous tonsilitis, acute follicular tonsilitis, and acute cryptic tonsilitis.

The disease is characterized by the formation of a distinct membrane which is very similar to the diphtheritic membrane in its early appearance. The most common form shows single exudates forming over the mouths of the follicles. The deposit is white or yellowish white, the tonsils are swollen, and the mucous membrane is reddened. More rarely the exudate takes on a membranous appearance due to coagulation¹ necrosis of the surface membrane of the tonsils as well as of the lining of the follicles. As a rule the membrane can be readily dissolved with H_2O_2 and does not leave a bleeding surface if forcibly removed. The infective process may progress involving the deeper structures causing ulceration. Some authorities^{2 3} make two diseases, follicular tonsilitis and membranous tonsilitis quite distinct, but from a clinical and bacteriological viewpoint there is little difference between them, the general symptoms depending upon the amount of tissue involved and the absorption of toxins, and the vital resistance of the patient. In the acute follicular form there is usually more swelling and inflammation of the tonsils and the general symptoms and discomfort are greater. Figs. II and III give a general idea of the appearance of the throat under the two conditions.

It should be noted in connection with streptococcus infection of the throat that occasionally the bacilli are exceedingly virulent, and in the very old or young or when developing in the throats of those whose vital forces are weak that profound

¹ Kyle, "Diseases of the Nose and Throat" (1904 edition), p. 395.

² Grunwald, "Atlas of Nose, Mouth and Pharynx."

³ Kyle.

and rapid toxemia may result. A case in point is the following. The writer was called in consultation by Dr. M. of a neighboring city. The patient, a gentleman of seventy years, had two days previously complained of soreness of the throat, he had at the same time a severe chill followed by rise of temperature and hoarseness. The swelling of the tissues increased until swallowing was extremely difficult, involvement of the lymphatics of the neck took place, and although respiration was not noticeably impeded, yet it became very audible to one in an adjoining room. Loss of strength was rapid, heart's action progressively weak, and death occurred on the afternoon of the third day from the initial chill. In this case the laryngeal tissues were principally involved without membranous formation.

Herpetic tonsilitis is not a common disease. It is associated with lowered vitality, disordered digestion and a disturbed state of the nervous system. In some cases the general health is perfectly good, the herpetic manifestations being simply an expression of nervous irritability of a functional character. As found elsewhere in the body¹, two conditions are always present, *viz.*, the vesicle and the characteristic grouping of the vesicles. If the throat is examined during the vesicular stage the diagnosis is easy, but after the vesicle has broken down and formed an ulcer the disease may be easily confused with apthæ, or mild follicular tonsilitis. The disease is sudden in its onset, occasionally accompanied with chills and fever and a burning, pricking, stinging pain. More often the general symptoms are absent. The duration is uncertain. Lumbye² reports the disease affecting an old man of seventy-eight and lasting two years. Usually the condition lasts but a few days.

Peritonsillar abscess; circumtonsillar abscess; quincy sore throat are used synonymously.

For a common disease it is less understood by the general practitioner than any affection of the throat with which he

¹ "Walker's Dermatology."

² Shirley, "Diseases of the Nose and Throat," p. 74.

comes in contact. It was for years, and is at present, thought by many to be an abscess of the tonsil proper. For this reason the tonsil was frequently incised, and as this rarely gave relief, but on the contrary increased suffering, such treatment quickly fell into disrepute.

As the name indicates, peritonsillar abscess is a disease of the tissues surrounding the tonsil. Lenox Brown¹ in an exhaustive study of the causation of the disease comes to the conclusion that, "First, by the circumstances that in almost all—if not all—of the patients who are attacked there exists a strong predisposing factor in the shape of tonsillar hypertrophy—faucial, pharyngeal, and even lingual."

Second. That the epidemic is very apt to be regulated by certain meteorological variations.

Third. So far from one attack conferring immunity against a second, as is more or less the case in all infectious fevers—influenza perhaps excepted—each invasion of tonsillitis leaves the subject more liable to another. And this tendency to recurrence may often be altogether overcome, and immunity secured, by the removal of the tonsillar structures implicated.

Fourth. From a clinical point of view it is at present impossible to agree that any one of the many varieties of nonspecific tonsillitis is more responsible than another for the infection, for in every epidemic all forms of inflammation are represented.

Many of the best authorities believe that rheumatism is a strong predisposing cause, but this diathesis is not often sufficient alone to produce the disease. Hereditary² influences probably have a part in the etiology of the disease.

The onset of the disease is manifested by a chill, fever, general pains and sensitiveness on swallowing, usually unilateral. On examination of the throat the tonsil on the affected side will give evidence of follicular or parenchymatous tonsillitis. These conditions instead of going through the

¹ "The Nose, Throat, and Their Diseases" (1899 edition), Lenox Brown, p. 332.

² Bosworth, "Diseases of the Nose and Throat," p. 105.

various stages to recovery are soon accompanied by swelling behind and above the tonsil with increased pain and fever; at about this time also the soft palate frequently becomes involved, the uvula edematous and the glands of the neck indurated.

Recurrences are common, in fact, an attack adds to the predisposition. A few years ago an interesting case of repeated recurrences came under the observation of the writer. The patient was first seen Dec. 11, 1896. She brought with her a written record of having had from November, 1891, to Dec. 5, 1896, forty-eight abscesses, the attacks lasting on an average, five days from the beginning of the inflammation to the rupture of the abscess. In another case Mr. D. gave a history of having had seven severe attacks in the two years preceding his visit to me. Fig. IV represents the appearance of the throat at about the time of pointing of the abscess. The bulging of the tissues it will be noticed is above the tonsil. In true suppurative tonsilitis the tonsil is the seat of the degenerative process. The formation of the abscess is usually evidenced by slight soreness of the throat and swelling, without marked constitutional symptoms. Spontaneous rupture occurs in a few days followed by relief, but within a short time a recurrence of this process takes place until finally the pockets discharge a small quantity of pus without appreciable cessation. Fig. V illustrates this condition, microscopically.

Hypertrophied tonsils present many types, the two extremes being the large soft varieties usually found in strumous children and the hard fibrous form in older children and adults. In the first case the lymph nodes largely predominate, in the other the tonsil consists almost entirely of fibrous and connective tissue cells. This variety has usually a broad base, is adherent to the faucial pillars, and interferes with the muscular movements of the soft palate. Calcareous deposits are sometimes found in these hypertrophies and may be so large as to become encysted and form tonsilitis. Pus pockets are not infrequently associated with this type of lymphoid degenera-

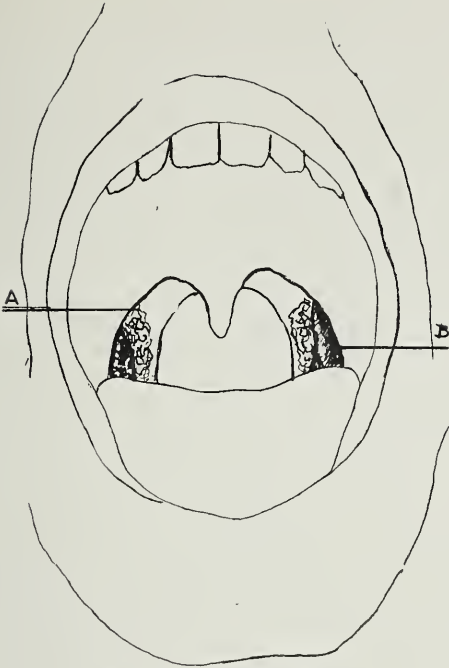


Fig. I. (Diagrammatic.)

A.—Entrance to Supratonsillar Fossa.
B.—Plica Triangularis.



Fig. II.

Follicular Tonsillitis. (Grünwald.)

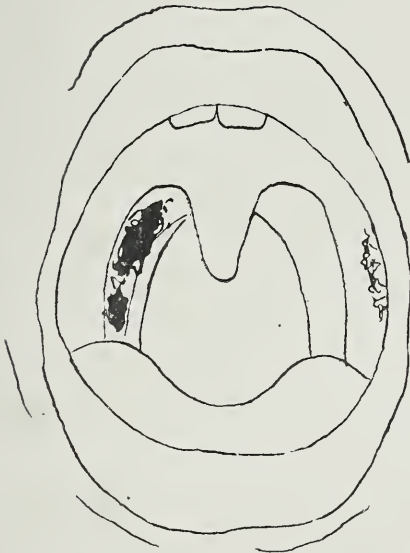


Fig. III.

Membranous Tonsillitis. (Grünwald.)



Fig. IV.

Peritonsillar Abscess. (Bosworth.)
A.—Point of Opening.

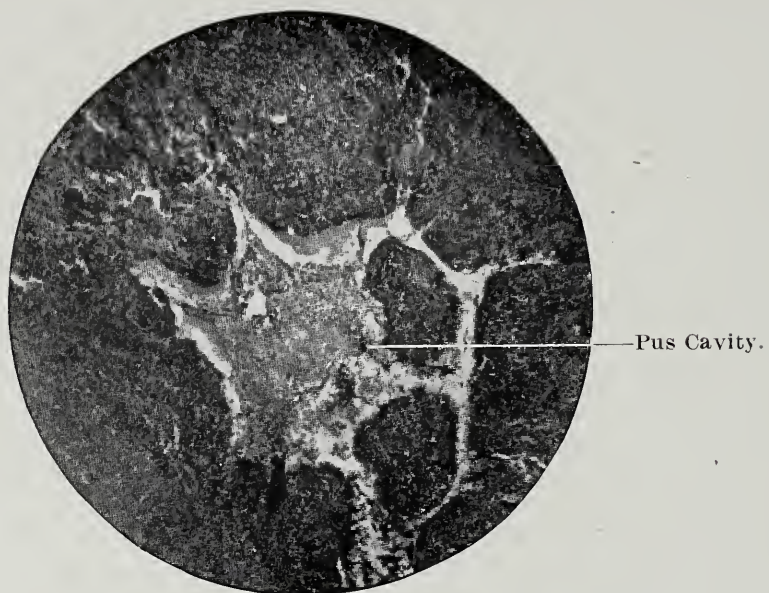


Fig. V.
Author's Specimen.

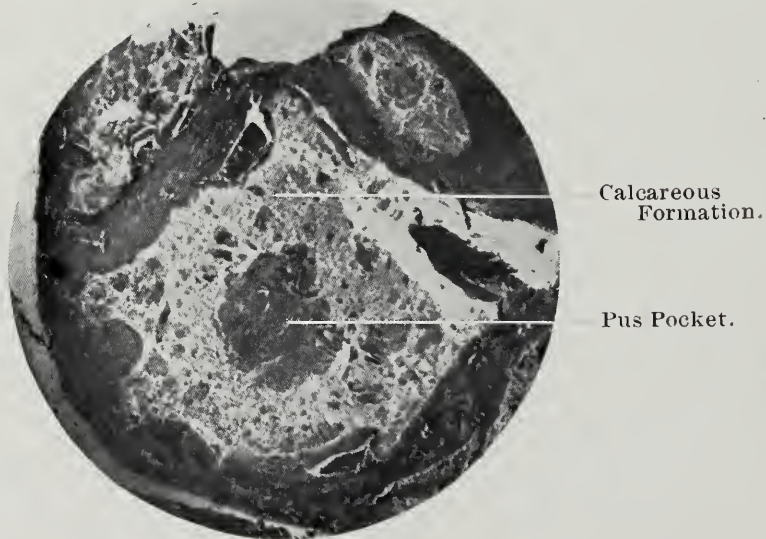
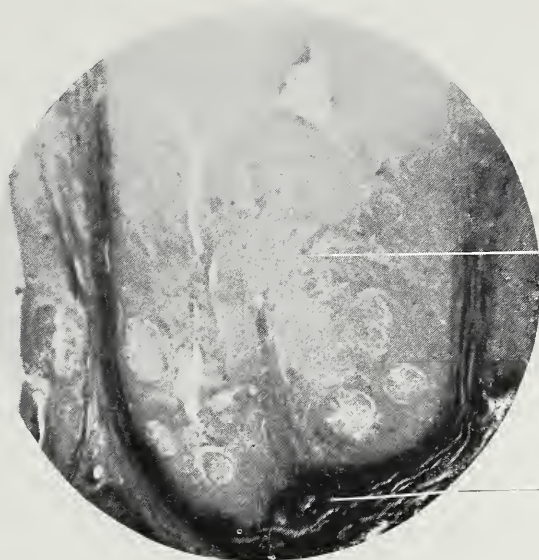


Fig. VI.
Author's Specimen.



Lymphoid
Tissue.

Fibrous Tissue

Fig. IX.
Large, Soft Tonsil.
Author's Specimen.



Large Cell
Hyperplasia.

Fibrous and
Connective
Tissue.

Fig. X.
Hard, Flat Tonsil.
Author's Specimen.

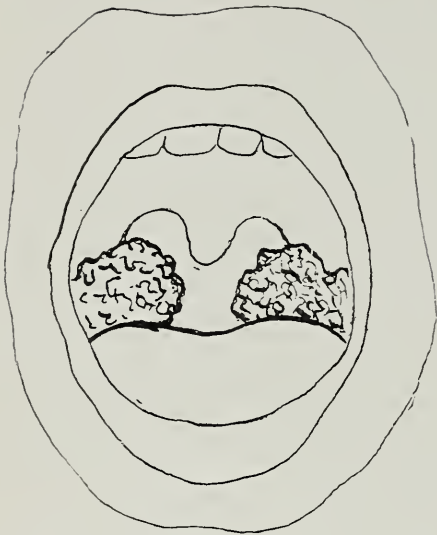


Fig. VII.
Large, Soft Tonsils. (Author's Case.)

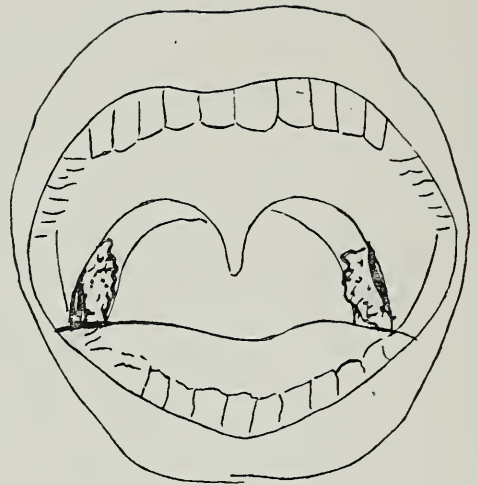


Fig. VIII.
Hard, Flat Tonsils. (Author's Case.)



Fig. XI.
Mycosis Pharyngeus. (Author's Case.)



Fig. XII.
Leptothrix. (Brown.)

tion, as shown in Fig. VI. The accompanying drawings and microphotographs (Figs. VII-X) illustrate the types of hard and soft hypertrophies just considered.

Mycosis pharyngeus is a term applied to a fungoid deposit in the mouths of the follicles of the tonsils frequently spreading over the surface of the mucous membrane and involving the tissues of adjoining parts. It is caused by the deposit of the spores of the leptothrix bucallis (see Figs. XI and XII). Indigestion and an impaired state of the health or any conditions causing a loss of tone to the oral and pharyngeal mucous membrane are predisposing causes. Patients complain of itching in the throat, or of a sensation of roughness. Sometimes there is pain and difficulty in swallowing and frequently cough. The membrane may present two¹ forms, the diffuse and the circumscribed and involve extensive areas. The deposits are detached from the mucous membrane with difficulty and tend to reproduction. Cases of pharyngomycosis are quite rare. The author, in a somewhat extended experience, has seen but four or five undoubted cases where the leptothrix bucallis was demonstrable.

Keratosis² of the tonsils is somewhat similar in appearance to the above disease, but is found only in adults. Its cause is not known. The constitutional and local symptoms are less marked than in mycosis. The mucous surface is not inflamed as in the first-named disease; it does not affect other than lymphoid tissue, and the leptothrix spores are not always present.

Kyle³ finds from microscopical studies that the disease begins in the subepithelial structure and then extends upward to the surface. The exudate consists of white, tough, horny tufts firmly adherent to the mucosa. Its marked distinction from mycosis is in the absence of inflammatory action.

(To be continued.)

¹ *New York Medical Journal*, February, 1889.

² Knight, "Diseases of the Nose and Throat," p. 266.

³ Kyle, "Diseases of the Nose and Throat" (1904 edition), p. 456.

REMEDIES IN SOME DISEASES OF INFANCY AND CHILDHOOD.

BY MAURICE WORCESTER TURNER, M.D., BROOKLINE, MASS.

[Read before the Massachusetts Homœopathic Medical Society.] -

Your chairman has asked me to give something from my experience and to avoid "book indications," and I trust this will explain my frequent use of the personal pronoun.

In this paper I shall not test your patience with long reports of cases, but will confine my remarks to the presentation of a few points, which, in nearly every instance, I have verified a number of times.

There are three matters of which I wish to speak: the *first* one being in regard to some remedies in disease of the respiratory tract in children.

We all know that cases of capillary bronchitis, or bronchopneumonia, in children, are frequently not seen by the physician in the early stage. When he is called, in a case which is fairly well advanced, the selection of the remedy may be difficult. In such cases the routinist usually gives antimonium tartaricum, often alternating with aconite, paying little regard to the symptoms present, and forgetting that if exudation has taken place aconite is contraindicated. Of course antimonium tartaricum is *not* a specific for this disease, and unless symptomatically called for will not be beneficial, so that the patient is left to the tender mercies of vis medicatrix naturæ, and, considering the high mortality rate in this disease, nature is not so potent in healing after all.

There is a remedy, however, which is often called for, and which has served me well; whose symptoms are readily distinguishable from those of antimonium tartaricum,—I refer to ipecacuanha. We are told that it depends on the *stage* of the disease as to which of these two medicines, ipecacuanha or antimonium tartaricum, is indicated; that ipecacuanha is useful early and antimonium tartaricum later. This is probably true, but unfortunately at the same time misleading and unreliable as an aid in deciding between the two drugs, as

there is no sharply drawn line differentiating the stages of any disease. There *are* signs which enable us to distinguish between the two remedies with certainty, so that we need not depend on the equivocal indication of *stage*.

The symptoms calling for ipecacuanha, in broncho-pneumonia, are in many ways like those of antimonium tartaricum; there is the same rattling in the chest, also difficult spasmodic cough with sweat on the forehead, with or without expectoration, though there is the sound of much mucous in the chest, and, lastly, vomiting. Of course under either remedy there is present, more or less, the characteristic symptoms of the disease, but in differentiating between them only the individual symptoms of the sick person are useful. The distinctions, which I try to remember, are not many.

First, there is, under ipecacuanha, the mental state of peevish irritability, with sleeplessness.

Antimonium tartaricum has somnolence predominately with mental dullness; the child clings to its mother, wants to be carried (like the chamomilla and mercurius babies), cries and whines when you go near it or try to examine it (which is similar to the condition under antimonium crudum, cina, iodium, sanicula).

With ipecacuanha the tongue is clean, whilst the antimonium tartaricum tongue is thickly coated white with reddened papillæ and red edges, or a red streaked tongue, or a tongue which is very red but dry in the middle. Either remedy may or may not have thirst.

Ipecacuanha has vomitus more often bitter with $>$ after vomiting.

Antimonium tartaricum, vomitus especially sour; vomiting brought on or $<$ by any position except lying on the right side, and followed by drowsiness and prostration. With both the nausea is often continuous.

I have not spoken of the expectoration for the reason that it is infrequent in young subjects, but should it occur and blood be present, of the two remedies, ipecacuanha alone is indicated by this one symptom.

Both remedies have pale, often bluish, face. The ipecacuanha condition coming in winter, but especially after warm moist weather; that of antimonium tartaricum following or being < by cold damp weather; or as we find in the "Guiding Symptoms," "After a change in temperature during the fall coughs with children get worse."

If these points are borne in mind, especially the mental condition, there will be no difficulty in making the selection, and when ipecacuanha is exhibited with these symptoms present one need not fear for the result.

I have found that ipecacuanha either precedes or follows antimonium tartaricum well, but in capillary bronchitis it especially precedes; antimonium tartaricum becoming useful if the symptoms change, the patient getting drowsy, and the cough less and less frequent. In some of my cases, after ipecacuanha, lycopodium or sulphur or kali carbonicum has followed well.

Lycopodium I have used when, after the exhibition of ipecacuanha, the following condition develops: the rattling in the chest continues and is especially marked in the right side; the child is cross on waking from sleep; is restless; lies on the back; is inclined to uncover, and, if old enough to express its wishes, desires the air in the room cool. There is aversion to any cold food, must have everything warm, but eats very little. Practically no thirst. Then the cough is especially marked in the late afternoon and evening—four to eight o'clock—it is surprising how close to those hours the < keeps. As to the oft-repeated symptoms of red sand in the urine, and gastrointestinal flatulence, they may or may not be present.

Sulphur follows ipecacuanha or antimonium tartaricum or lycopodium, and helps when there are fever flushes; the patient drinks much water and has no appetite. There is rattling throughout the chest < left side. Skin hot without sweat. Mentally the child may be growing more stupid, with sordes on the teeth and lips, but this is not always present. Something that can be depended upon is the aggravation that

comes shortly before noon each day—11 A.M.—and on falling asleep there is sudden jerking of the arms and legs. Constipation or the early morning acrid diarrhea.

In regard to kali carbonicum, the following outline of a case will give the symptoms best.

The child had improved under ipecacuanha so that the stage of resolution had begun, but there it stopped. Ipecacuanha was repeated, but without benefit. Fever was slight, but still there was considerable exudate, and much bubbling and rattling through the chest. There was a distressing cough, without expectoration, and every morning a severe paroxysm of coughing occurred somewhere between two and four o'clock. Breathing was difficult so she could hardly drink, and sleep was much interfered with by the dyspnea, and, also, by the rattling in the chest. Stitching pains were not present. After the exhibition of kali carbonicum she rapidly improved.

Second, in regard to cases of cretinism and myxedema.

It seems to me too sweeping an assertion that they all improve after the exhibition of thyroid extract; certainly some do not. But those which are benefited are seldom restored to health, in the full sense of the term, as the thyroid must be taken more or less frequently for years. We should make a distinction between cases which are palliated in this way, and those which can be cured. It has occurred to me that patients who are helped by the thyroid, may be carried still further toward a full restoration to health if we attenuate the remedy. In fact if an attenuation be used from the beginning of treatment, better results may be obtained.

Perhaps I might call this a preliminary statement in regard to a case. I hope to say more about it in the future.

Lastly, a word about the diet in infantile marasmus. A case will explain most easily.

A child, bottle-fed, had thrived on cow's milk and Mellin's food,—this was prepared without sterilizing, and made fresh at each feeding,—until she was about four months old. She

did not have that abomination which is so commonly added to a baby's milk—lime water.

When she was between four and five months old she began to fail, and lost flesh rapidly so that in about six weeks she was little more than a skeleton. Several changes of food and medicine were made without benefit. There was frequent vomiting, diarrhea, constant moaning and insomnia. The gums were not discolored, neither was there pericosteal swelling.

As a last resort I put her on an antiscorbutic diet of meat broth, potato soup, orange juice. Improvement was rapid, she became plump; later dentition was uneventful though a little late, and she remained well.

This was several years ago and I have since used the same diet successfully in a number of cases, all desperate ones, in which other means had failed. In none of the children was there evidence of scurvy. This method of feeding these severe cases has been more satisfactory than the use of the patent foods, and I cannot but feel that if ordinary articles of food were oftener used with infants, and patent foods and lime water avoided, that it would be much better for the little patients. Very likely this way of feeding is not new, though I have not been able to find a diet of this kind recommended in infantile marasmus, except that sometimes the use of the fruit juices is advocated. I do not wish to be understood as saying that these cases are scorbutic, but I do think they are closely related to scurvy.

Such a diet, for an infant, upsets all of the rules;—that the meat juices would be too stimulating and the starch difficult of digestion until the teeth and salivary glands were developed;—and reminds us of Hamlet's words,—

“There are more things in heaven and earth, Horatio,
Than are dreamt of in your philosophy.”

DISCUSSION OF DR. TURNER'S PAPER, BY F. A. HODGDON, M.D., MALDEN, MASS.

In the main I am in full sympathy with all Dr. Turner has said. Unless we reach a case of broncho-pneumonia early it is lost time to give aconite, but in the early and congestive stage I believe we have no remedy more potent for good. After exudation has taken place we must look for other remedies for a cure.

Of all that has been said of antimonium tartaricum and ipecacuanha I fully agree, they both have a place in the successful issue of many cases. I think for ipecacuanha I would transpose the symptoms and put nausea first instead of last; I would have it first, last and all the time. No trouble for which I would prescribe ipecacuanha could fill the entire picture unless nausea was the guiding symptom.

I have been accustomed to give antimonium tartaricum in the chest symptoms where a paralysis is present, or at least an impaired action of the chest was an important symptom, where to raise the sputum seemed very difficult, exhausting the patient beyond all reason.

With cretinism and myxedema I have had a very limited experience. I will speak of only one case. A boy sixteen years of age, son of a traveling salesman, had all the appearance of a boy of six or seven years of age, both physically and mentally. A small head, small but brilliant eyes, shriveled features, small hands and feet. I put him upon the thyroid extract powder in capsules. The effect was marked and sudden, both mentally and physically; the patient improved for a period of nearly two years, after which time I lost track of him. The remedy acted to me more of a nerve and brain stimulant, for at intervals we discontinued the remedy and the patient would relapse into his old lazy and indolent ways again, but upon its renewed use the patient would revive and improve for many weeks. This observation coincides entirely with the views of the author, and I am glad to add my mite to so interesting a class of cases.

Infantile marasmus I have come into contact with frequently. It is a disease of starvation confined to artificially fed babies, or accompanied by a catarrh of the mucous tract so that there is a decided malnutrition. In this disease the food is either too limited in quantity, is indigestible, or else is unbalanced in its component parts. A child may be doing well and some intercurrent disease disturb the digestive organs, and we must look for a change of food in the treatment of this class of diseases. The treatment is essentially a dietetic treatment. If the child is nursing we must analyze the milk for cream and curd. If bottle-fed the most painstaking care must be exercised in the milk and its preparation. Meat juice, with milk and orange juice is the very best diet to the exclusion of all else, and has done more in my hands than all other foods combined. Cream and water may be used, as the patients of this class need fat, which must be supplied in some form.

Inunctions of sweet oil, cod-liver oil, cocoa-butter, lard, lanolin, have been used to good advantage after the bath, the child to be then wrapped in warm blankets and kept quiet until the next feeding.

OPERATIVE TREATMENT OF BENIGN UTERINE TUMORS.—The indications for operation are: a growing tumor, regardless of its size; hemorrhage at or between the menstrual period; pain and pressure symptoms, and the coexistence of a pyosalpinx. The size of the tumor should not deter surgical treatment, but rather encourage it, for the danger of the operation undoubtedly increases with the size of the tumor, the age of the patient, and the reduction of vitality by repeated hemorrhages.—*Pacific Coast Journal of Homœopathy.*

THE HYGIENE OF PUBERTY.

BY ELLEN H. GAY, M.D., BOSTON, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

The ideal hygiene of puberty would require a radical modification of existing customs and institutions having to do with the care and education of children.

At puberty the parents often lose the child as heretofore known, and find in his or her place an erratic stranger. The quiet child becomes noisy; the noisy, quiet; the quick tempered becomes patient, and the lovable, ugly in disposition.

The emotions are on the surface, the soul is awakened and the spirit most impressionable. Mental instability manifests itself and the child is restless under restraint; has longings for adventure; dreams of romance; questions motives and realizes less his moral responsibility; attempts anything that promises excitement.

There is marked dissimilarity between the boy and girl during puberty.

The ordinary girl begins to mature at thirteen, the boy at fifteen. Observation shows that the year before puberty apparently begins, is really the most critical time. For girls puberty is the most persistent period of nerve and vascular excitement, and the highest tension immediately precedes the sanguineous flow, a fact not generally appreciated by physicians.

Anatomical differences between the sexes at this period are most marked. According to statistics compiled by Dr. Bowditch, at thirteen or fourteen girls are for a period of two years both taller and heavier than boys of the same age, but before and after that period the reverse is the case. A much greater percentage of boys have long heads after puberty than before. In girls this difference is not marked. Among both boys and girls the percentage of broad heads decreases after puberty. A larger percentage of girls having long heads show intellectuality; the reverse is true of boys.

Girls are less sensitive to heat than boys.

At puberty both boys and girls grow in height faster than in chest girth. Since the chest contains the organs most important to life, and since the body during puberty should have the best care, conditions that affect unfavorably the relative proportion of body and chest girth must be avoided.

Girls gain their weight at seventeen, boys at twenty-one. Up to twelve in girls and fifteen in boys, the gain in stature is by leg growth. From fifteen to eighteen boys continue to increase by leg growth, while girls increase in trunk growth. Girls have markedly longer trunk growth than boys in proportion to length of leg.

In sense of pain, boys are less sensitive than girls after the age of fourteen.

The wrist and arm lift is greater in boys at fourteen than in girls, at nineteen it is twice as great.

Lung capacity is much greater in boys than girls. Girls reach their maximum of lung capacity as early as thirteen.

Boys fatigue less quickly than girls.

During puberty the pulse is more rapid, especially in boys.

In mental ability, dull children are duller from ten to fifteen years of age. Girls are brighter than boys at this age. A queer anomaly is that lung capacity of dull children increases from ten to fifteen.

In sensation of color girls excel boys. In muscle sense boys are superior.

Tests where quickness and accuracy are involved, are affected in a most marked way by puberty, making it probable that puberty has a greater effect on the mental than even on the physical nature. This effect is much greater in girls than in boys. In general the brighter the child, the more accurate is the sense of time. Girls learn much more quickly than boys, especially in the high school.

With such marked differences, one recognizes that different treatment is called for in the development of the boy and girl at this most critical period of their lives. One naturally turns toward the physical education as the most important help

to ideal development at puberty. This period of life is practically ignored in gymnasiums for both sexes, and school and college athletics have become such an abuse instead of blessing that the institutors themselves admit that in less than ten years all athletics in our educational institutions will need defenders. School athletic fields are battle-grounds where temporary and permanent injury is daily sustained, as there is no examination of physical fitness. In practice, games are continued for as many hours as the players choose with no supervision by teachers. They are allowed to hire a coach whose only care is to secure as much proficiency as possible from the team. There is no real fun, no good time in all this as one would naturally suppose who has only a theory on the subject. It is hard work carried to the complete exhaustion of mind and body. The present games are not conducive to correct development. It is the larger muscles that are called into action. But the greatest injury is done to the heart, and in the girl to both the heart and reproductive organs, and an alarming state of affairs is found when examining our girls and boys in the high schools. These athletic contests are usually indoors where the air cannot be pure. Artificial light, music and crowds of spectators add to the excitement. The moral nature is corrupted by the accompaniments of competition. Each contestant plays for victory at any cost, imagining anything is justifiable to win.

Our present school system is absurd, unscientific, baleful in influence mentally and physically, and leaves the youth unprepared for life. Combe criticises especially any school plan which does not consider the difference between the sexes, as contrary to nature, for it makes at this time the same requirements of girls and boys. Weissenburg says that from facts already known, school life exercises a bad effect in this respect on the development of the body. The Greeks withheld even their boys from school until ten years of age. We start both sexes in infinitely more pernicious surroundings, at the age of four. Vacation should begin by the 1st of June.

Children grow from March to August, from August to February the growth is about stationary, for that reason the months of growth should be spent out of doors as much as possible.

Self-abuse is the great corrupter of youth of both sexes. It prepares the way for illicit indulgence, excites the sexual appetite and debauches the imagination.

Procreation and nutrition are the two dominant instincts of animal life. The one is just as natural as the other. That volumes of knowledge and lifetime of study is given to nutrition, while procreation is a subject to be whispered, is the reason prostitution flourishes and divorce courts are crowded. The generative act is at some time an absolute mystery to all persons. It has a personal interest that impels inquiry. The result is to direct an emotional attention upon the sexual organs, at the very time when their normal and gradual development should occur. The physiology and hygiene of the reproductive system should be taught in our schools. The child first of all needs a thorough knowledge of himself and herself. Parents shamefully neglect to instruct, and the boy and girl gain their sexual knowledge from any and every source, naturally very eagerly. They should be talked with as equals, on such matters, discussed not as morbid subjects but as recognized matter-of-course conditions. Give them a moral armor that will make them noble men and women, rather than licentious wrecks and sexual neurasthenics.

Let the boy and girl live generously, work carefully, with sleep prolonged by early hours. Give more outdoors, more relaxation, more of nature, more individualizing, and more chance to the child so often weakened by heredity, environment and customs.

The boy at puberty needs instruction morally no more than the girl. He needs watchful care over his reading, associates, games, food, sleep and study, and so does the girl, but puberty means to the girl so much more than to the boy. The boy goes through a process of development, while the girl is

changed apparently in her whole being. In the girl the period is much shorter, more marked and the last stage reached earlier than in the boy. It is influenced by social surroundings and mental status. The wealthy city-born girl is more susceptible than the poor or country girl. Country-bred girls menstruate at 14.3 years; high-class working girls at 14 years; high-school girls at 13.8, and college girls at 13.5 years. Neither birthplace nor parentage influence as surroundings and mental stimulus.

There is great depression at the age of puberty. Each menstrual period shows the same nerve activity preceding, followed by depression, then resumption of the normal at the close. Normally the pulse is less rapid lying than standing, but when menstruating the pulse is the same lying and standing. Mental strain and application increase the frequency of the flow. Change of conditions and surroundings retard the flow. Hence there is amenorrhea among freshmen at college and emigrants, while during mental examination and cramming, there is increase of frequency of flow. Midyear examinations are especially influential in causing frequency of flow, with more pain. Fifty per cent. of college girls are so affected. Exhaustive investigations by Engelman, show that there is more suffering, irregularity and frequency of flow, in college and in the department stores where the girl is restricted in motion, and endures severe mental strain. Fifty to eighty per cent. of all women suffer from menstrual abnormality. Functional disturbances begun at puberty increase in college.

In the freshman year sixty-nine to seventy per cent. suffer, while eighty per cent. of the higher classes suffer. At the close of the spring term menstruation averages every fourteen days. The majority date functional difficulty from age of fourteen, the time of puberty. These data are taken from statistics gained by Engelman from the College Alumnae Association. General health deteriorates 19.6 per cent. in college girls and 10.6 per cent. in the working girl. The menopause is later when puberty is earlier, and *vice versa*.

When we realize the anatomical and physiological differences between the man and the woman, we cannot be surprised at the injury woman suffers when exposed to our present system of education and labor upon a basis of male vigor.

Is it not startling that only forty-six per cent. of women enjoy normal functional life?

Mary Putnam Jacobi says that the ganglionic nerve cells of woman are more easily exhausted, hence prolonged effort requiring prolonged generation of nerve force, is followed far more readily by collapse, than is the case with man, and such collapse of the nerve center acts upon this most vital of all functions, the reproductive function. Hence work which simply tires a man, by the reaction of nerve exhaustion upon the susceptible function, permanently injures woman.

Woman cannot be compared to man because the two are radically different, externally and internally unlike.

In order to secure a normal organism, a healthy woman, the healthy development of this one central function must be secured, and the natural and rightful activity of that function. Engelman says: "The life of woman has ebbs and flows, great life waves of vascular tension and nerve excitement, marked by a heightened activity and susceptibility of her entire being, distinctly indicating that in the woman this periodical activity is not a local process as we have been taught, but one involving the entire female organization."

Shock or exposure at the menstrual and pregnant periods causes lifelong suffering or premature birth; another proof that the reproductive function is the very life of the woman. Dr. Wier Mitchell says: "The American woman is unfit for her duties as a woman."

This is due to the functional neglect, nerve exhaustion, an inharmonious exertion and development of the physical, mental and moral nature.

Weight and constriction about the pelvis is an old subject. The natural waist line is just under the breasts, the style of the first Napoleon. When fashion returns it there, there may

it stay, for beauty, health and comfort. That is the point where fullness should begin to allow breadth of skirt for ease in walking, not now allowed with skirts beginning at the pelvis. If the waist line were there, it would not be possible to constrict the vital organs as in the present mode. The uterus would have full opportunity to enlarge normally at the menstrual and pregnant periods.

It is wise to return to nature, and study her laws as shown by customs among savages. Universally at puberty the young girl rests absolutely for five months; at each menstrual period nine days, and after pregnancy thirty-nine to eighty days. These periods are not only of rest, but also of isolation. The girl or woman goes apart from the tribe to a tent intentionally built so low that it is impossible to stand, and no one, not even a relative, visits her except attendants.

In the races approaching civilization as in the East Indies, a room in every house is devoted to this use. Work of every kind is forbidden.

Is there a civilized nation on the globe that observes any customs whatever at these most vital periods in a woman's life?

Hospitals and institutions are built, chairs endowed, and books written for the female pelvis. Men give their muscle and brains, and women their lifeblood to support them, but there is no thought given the woman herself.

The average woman looks upon herself as a mistake of the Creator. She will not admit her one dominant function, childbearing—that function which is the very essence of her being, in fact the primal reason for her existence. It is to make the girls respect their God-endowed function, and defend their right to be cared for during the establishment of their peculiar organization, that our voices as physicians should be raised. At present for the girl there is excessive brain work and nerve strain, with ignoring of the physical organization in education. In the working girl there is nerve strain, and partial or incomplete muscular activity. For all girls there is neglect and absolute ignoring of functional hygiene, physical

and emotional strain of society, injurious mode of dress and overstimulation of the senses.

Educators, physicians and parents must consider woman's peculiar construction. There must be harmonious development and occupation of nerves and muscles, less brain work and nerve strain, more care and protection and perfect freedom of dress over the abdominal region. The growing girl must be taught self-knowledge and be given care during the menstrual periods. Let nerve strain be varied by exercise out of doors. Give more attention to physical training in its best sense, which must be begun before and continued after puberty. Educators must adapt mental training to physiological possibilities, and regard woman's peculiar organization, remembering that morbidity increases in ratio to increase of hours of study. The keynote and most vital thing is knowledge of woman's functional life, its conditions and requirements, an understanding of its nature by physicians, educators, mothers and the girl herself.

LITERATURE.

"What Our Young People Should Know." Paul G. Wirt.

"The American Girl of To-day." George J. Engelman, M.D.

"The Question of Rest for Women during Menstruation." Mary Putnam Jacobi.

"Experimental Study of Children." Arthur MacDonald.

EDITORIAL.

Books, exchanges and contributions—the latter to be contributed to the GAZETTE only, and preferably to be typewritten—should be sent to the Gazette Associates, 279 Dartmouth Street, Boston; personal and other news items to Dr. A. T. Lovering, 10A Park Square, Boston; subscriptions and all communications relating to advertising, etc., to the business manager, Mr. Chas. A. Boynton, Hyde Park, Mass.

CONRAD WESSELHOEFT, M.D.

March 23, 1834—Dec. 17, 1904.

The very general expression of sorrow called forth by the death of Dr. Conrad Wesselhoeft may be accepted as a sufficient demonstration of the respect and affection in which he was held far beyond the circles of his more immediate friends, patients and colleagues. A man so highly esteemed and so much missed has left a void which time will surely fill, but it can be filled only by one of his own stamp, which is not the common one. It may be said, indeed, without yielding to the promptings of obituary fulsomeness, that men of this stamp are so rare as to make the contemplation of their lives serve to lift us for a moment above the current of our daily thoughts and strivings.

To the readers of the GAZETTE, to whom he has been so long and so intimately known, a brief biographical sketch and a review of his labors and aims will not fail to be of sympathetic interest.

He was born in Weimar, Germany, of a family active in all reforms, a family whose tendencies and ideals he largely inherited. Coming to the United States in 1840 as a boy of six, he speedily absorbed the traditions and habits of mind peculiar to American youth, while preserving a certain soberness of thought and an earnestness of purpose which characterized him throughout life. At the age of fifteen he was sent to Germany, where he entered the St. Thomas Gymnasium, a classical school which counts among its alumni many distinguished men, and still holds a high place as an educational institution. From this he graduated after four years as *primus*, or head scholar, when, in consequence of the death of his father, he returned home to assume practically the posi-

tion of head of his family. Entering the Harvard Medical School he pursued his studies with a zeal and intelligence which attracted the attention of his teachers, and brought him early into that closer relation with men like John Ware, Henry I. Bowditch, John B. Jackson and Calvin Ellis, which is the reward and distinction of serious and receptive students. The many acts of kindness and helpfulness of these large-hearted and truly progressive men, in such marked contrast with the repellent intolerance of others towards the young man already supposed to be tainted with the homœopathic heresy, he loved to recall in his later years as among his most pleasing experiences. The favoring influences coming from these men in the forming of his judgment, and in intensifying his love for the profession in which they bore such honored names, he never failed to recognize.

In addition to the inspirations derived from these teachers he came more directly under the guidance of his uncle, Dr. William Wesselhoeft, a practitioner of exceptional knowledge and skill, whose instruction and example could not fail to arouse in the receptive mind of the young student a genuine enthusiasm for the great reforms inaugurated by Hahnemann, while, at the same time, he was becoming hourly more and more impressed with the best spirit and the best traditions of his chosen calling, the thoughtful spirit and the traditions which, it is to be feared, are not everywhere upheld in the specializing and supposedly practical teaching of the schools.

Graduating in 1856 with the esteem and kindly consideration of his teachers expressed in many ways, he soon settled in Dorchester, then a widely scattered suburb of Boston, and promptly gained the confidence of a large and intelligent clientele. As, however, neither his tastes nor his health fitted him for the exigencies of a country practice, he moved, as soon as he found himself in a position to do so, to Boston, drawn as he was to a more congenial sphere of activity. Here he at once took a prominent part with men like Talbot, de Gersdoeff, Thayer, Chase and others in the affairs of

homœopathy which, at the time, were becoming acute as a result of the increasingly strained interpretation of the medical ethics of the day. He succeeded in so formulating the principles of the Massachusetts Homœopathic Medical Society as to bring them into harmony with the wider principles of advancing science and sound ethical conceptions. His active interest in founding the Boston Homœopathic Medical Society, in establishing the Homœopathic Dispensary and Homœopathic Hospital are well remembered by his older colleagues. With the founding of the Boston University Medical School he was closely identified, and remained to the last one of its most active and representative teachers.

The recent review of his labors in behalf of the cause to which he had devoted his life, given in his own modest words at the banquet tendered him on the occasion of his seventieth birthday, make it unnecessary now to repeat the details. Of more importance is his attitude towards the fundamental principles of homœopathy and the purification of its practice, since the constant effort to set forth these principles in clearest light, to adhere to them wisely in the exigencies of practice in the presence of the ever-changing limitations of different therapeutic measures, and to support them by strictly scientific data, was the ceaseless purpose of his truth-seeking mind.

In his early years of practice, after the death of his uncle, he was strongly attracted by the wide learning, the militant spirit, the provings and other researches of Dr. Constantine Hering, who became warmly attached to the ardent young physician, and soon looked upon him as a future leader in the great therapeutic reform which had for its aim the fullest and most unprejudiced knowledge of drug effects. Under so stimulating an influence, and in fellowship with Carrol Dunham, Wells of Brooklyn, Dake of Nashville and others, men so much his seniors, he labored for the advancement of the American Institute of Homœopathy; an organization in which he ever had the warmest interest and for which much

of his best work was done. He saw in it the largest opportunities for the furtherance of scientific therapeutics in so far as this relates to the use of drugs.

With the strong conservative strain in his liberal mental organization it was impossible, however, for him to follow those among his leaders and associates who based their practice and opinions solely on the results of unsifted clinical experience, or who adopted as their guiding theories those of Hahnemann's hypotheses on which he himself had laid the lesser emphasis. In order to bring directly before his American colleagues the chief sources and principles of the homœopathic method, and at the urgent solicitation of Dr. Hering and the publishers, he set himself the laborious task of re-translating the *Organon*, a task which, although thankless in many respects, was yet without question the means of giving a distinct and strong direction to his convictions. It was the need of mastering and assimilating fully the spirit and meaning of the great reformer for the purpose of rendering these in intelligent language, that led Dr. Wesselhoeft to the point of view for the soundness of which he continued to labor throughout the remainder of his life, though it carried him far away from those to whom he had been bound by the closest personal and professional ties.

In possessing himself of a point of view free from disturbing preconceptions he was inspired to pursue an independent course of exact inquiry along two separate lines. What he demanded for himself and for the reform to which he was devoted, was greater certainty to be derived from evidence in accord with the methods and results of science as evolved since the days of Hahnemann. With such ends in view he undertook original work of a kind most needed not in homœopathy alone, but in all pharmacotherapeutics. He felt impelled to determine, as far as possible, the limits of divisibility of drug matter as prepared by our methods of attenuation, and to study the effects of calculable amounts of metallic and other mineral substances in a state of extreme subdivision,

studies of the utmost practical and scientific importance not alone in consideration of homœopathic practice, but of the light shed in recent years by the foremost physicists of our time on the power of the infinitely minute. These studies so full of promise, so urgent and yet so utterly neglected by the old school he pursued for many years with unflagging zeal through ill health, domestic affliction, and all his numerous professional duties. His microscopic investigations undertaken with infinite pains and every possible safeguard against error, led him independently to conclusions in harmony with those of greater scientists who, commanding the amplest means and most perfect methods of research, together with the widest knowledge, could carry their inquiries far beyond the point attainable by the busy practitioners, who lacked both expert assistance and adequate laboratory facilities. Among his most important contributions to the work of the American Institute are to be mentioned his papers on the Microscopic Examination of Triturated Metals and Other Insoluble Substances; on the Proofs of Drug Presence and Power in Attenuations Above the Sixth Decimal, as Furnished by the Spectroscope; on the Presence and Dimensions of Particles of Metals in Triturations; on the Effects of Trituration on Wedgwood and Porcelain Mortars; on the Trituration of Glass and Copper in Demonstrating Divisibility; Why Prolonged Grinding Makes Triturations Darker—not to speak of numerous shorter papers on allied subjects.

That his conclusions regarding the limits of divisibility of matter should have met with little acceptance on the part of the majority of his colleagues, indeed, that they should have aroused the most strenuous opposition, was most natural in view of the extreme difficulty surrounding the questions at issue and of the general backwardness of knowledge on the subjects involved. But it is most certain that the consideration of these same questions, brought by him into such marked prominence, have tended in a most decided manner to raise the character of the discussions in our leading homœo-

pathic bodies, and to stimulate inquiries both in this country and in England which have by no means reached their final settlement.

The same spirit of exactness, the same deep inward prompting to eliminate error and gain a positive basis for our knowledge of drug power, ruled his efforts in the proving and re-proving of drugs on which he spent no little time and self-sacrificing labor. It was a thought and endeavor worthy to be recorded and to be classed with the best scientific efforts of the day, to compare our accepted provings with others made with absolutely inert substances. Other men like Drs. Hughes and Dudgeon in England, Heinigke and Sulzer in Germany, had subjected the earlier provings to critical scrutiny from what may be called the literary point of view, by studying the original sources and records, and thus casting out what was plainly of an untrustworthy character. But none had attempted actual control provings in order to test the genuineness of countless subjective symptoms without which we recognize that no proving can have value. It was not to exclude these, but to determine in how far they belonged to the positive drug effects, rather than to the self-deceptive observations of unscientific provers, that the work was undertaken. It had its source in the innate honesty of the man who dared to probe to the bottom the beliefs in which he had been reared, and which were so generally accepted among his colleagues as beyond question. His *Reproving of Carbo Vegetabilis*; his *Critical Analysis of Provings of Chininum Arsenicosum, Adonis Vernalis, Lilium Tigrinum and Zinc*; his *Rules and Suggestions for the Critical Analysis of Provings*, and his *Demands of Modern Science in the Work of Drug Proving*, all papers read before the Institute of Homœopathy, not to mention his *Reprovings of Sepia and Hamamelis* with rigid control tests upon himself and a number of well-chosen students, men and women, were strictly scientific inquiries of a character to be placed beside any of which modern therapeutic research can boast and of

incomparably greater value than all the animal experimentation of the pharmacological laboratories.

Here again, it must be said, he met with comparatively little hearty response from those who approved his aims, while he did meet with much opposition even of a bitter and most ungenerous kind from those who held any questioning of existing knowledge to be no better than damnable heresy. His experience in this respect was no other than that which falls to the lot of every man who undertakes the unpopular task of striving to supplant accepted belief by sound knowledge. All acknowledge however to-day, that while he seemed to make no immediate impression on his colleagues by his timely and well-directed efforts to purify our materia medica, the great work of drug proving now undertaken by the American Institute of Homœopathy received its impetus and direction at his hands.

In addition to all these labors must be mentioned as among the most important, and as showing the confidence reposed in him by his colleagues in this country and in Europe, his coeditorship of those most monumental of all homœopathic works, the *Cyclopedia of Drug Pathogenesis* and the *Pharmacopeia of the American Institute of Homœopathy*. To have been chosen to participate in works laying upon their authors such heavy responsibilities, and calling forth such wide and detailed knowledge, was an honor to which few could aspire.

Of his many kindnesses to students and young practitioners seeking for light, his modest and untiring disposition, and his thorough honesty of purpose, all who knew him are now eager to testify. His merit was not that of the brilliant mind working effectively with accepted data and gaining popular applause, but the merit of the scientific thinker and investigator whose sole aim is to approach the truth and who seeks it unremittingly through the countless discouragements of feeble health, care, sorrow, loss of friends, and the opposition of those for whom his best energies are expended. His per-

sonal qualities, his active interest in all the burning questions of the day, his interest in and devotion to his patients, will soon be forgotten. His labors and results will endure until therapeutics enter upon a new phase in which all that is now held to be good shall be cast aside.

LETTER TO THE EDITOR.

BOSTON, Dec. 5, 1904.

EDITOR NEW ENGLAND MEDICAL GAZETTE,
BOSTON, MASS.

Dear Doctor: Will you kindly allow me to correct the title of my paper as printed in the GAZETTE,¹ and which was read before the last meeting of the state society? As I am wholly opposed to the use of buried sutures for perineal repair, I am unwilling to go on record, even by title, as practicing, or advocating that method.

The title of my paper should have been, "Perineal Repair by the Use of Buried Removable Sutures."

Yours fraternally,

JAMES B. BELL.

¹ Secretary's Report of the October Meeting of the Massachusetts Homœopathic Medical Society," November GAZETTE.

SOCIETIES.

BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

BUSINESS SESSION.

The regular meeting of the society was held at the hall of the Boston Society of Natural History, Thursday evening, Dec. 1, 1904, at 8 o'clock, the president, J. Emmons Briggs, M.D., in the chair.

The records of the last meeting were read and approved.

The resignations of Fred. S. Piper, M.D., of Lexington, and Winslow B. French, M.D., of Boston, were accepted.

Voted: That Conrad Smith, M.D., and Benj. T. Church, M.D., having declined to be candidates for the offices of associate secretary and auditor, respectively, the nominating committee are requested to fill these deficiencies.

Voted: That the Boston Homœopathic Medical Society approves the idea of a municipal hospital to be established and maintained by the city of Boston, for the care of *tuberculous* patients, especially in the advanced stages of the disease.

SCIENTIFIC SESSION.

PATHOLOGICAL SPECIMENS.

Dr. Horace Packard exhibited a gall-bladder with calculi. The specimen in itself was stated to be not of particular pathological interest, but suggestive of recent progress in gallstone surgery.

"Up to a recent date," said Dr. Packard, "we have felt our duty done, in removal of gallstones and leaving the bladder just as it is. Often there exists incident to gallstones, an abscess of the gall-bladder. Permanent drainage, of course, must be established when the gallstones are removed. Not infrequently such an abscess cavity never ceases to drain, and the patient as a result is troubled with a sinus discharging mucus and pus for years afterwards. The gall-bladder never regains its normal condition. The removal of the gall-bladder

with the cystic duct, at the same time that the stones are removed, reduces the length of convalescence. The last patient upon whom I operated in this way is seventy years old. At the present time, ten days after the operation, she is thoroughly convalescent with perfect healing of the wound, which closed without drainage."

Dr. J. H. Sherman: Is the gall-bladder necessary?

Dr. Packard: I think it is fully accepted and has been satisfactorily demonstrated that the gall-bladder is unnecessary. Patients from whom it has been removed maintain excellent health and do not seem to miss it at all. Its removal under modern methods of surgery entails shorter convalescence than the older form of operation involving removal of gallstones only.

PROGRAM.

1. Diphtheria in the Middle Ear. F. W. Colburn, M.D. Discussion opened by Conrad Smith, M.D., O. R. Chadwell, M.D.
2. Can X-rays be Used Homœopathically? An illustrative case. John P. Sutherland, M.D. Discussion by F. P. Batchelder, M.D., W. Wesselhoeft, M.D., F. B. Percy, M.D., B. T. Loring, M.D.
3. A Few Cases Treated by Radium. Henry E. Spalding, M.D. Discussion by Samuel H. Spalding, M.D.
4. Hyperchlorhydria a Cause of Puerperal Convulsions. Lucy Barney-Hall, M.D. Discussion opened by Charles T. Howard, M.D.

DISCUSSION (DR. COLBURN'S PAPER).

Dr. Klein: I think in some of these cases it might be wise to isolate the patient in the beginning, as very often diphtheria might come in the middle ear or eustachian tube and we know nothing about it. There is said to be very little infection in the middle ear, but later indications show there is considerable infection. We know that infection goes from the nasal duct up to the eye, why should it not go to the mid-

dle ear from the nose and throat? I know in some of the hospitals of Europe the first thing in diphtheria cases is to carefully disinfect in the ear. Diphtheritic patients should have the ears examined very often, especially little children, who compose the majority of diphtheria cases. In these cases the ear is neglected altogether, because the child is turning the head from one side to another, putting the hands to the ears, and it is difficult to make an examination. Infection does not show itself in the meatus, but the disease extends through the opening into the mastoid cells and proceeds to make trouble. One cause of the trouble is the indiscriminate use of dry boracic acid by physicians and aurists, and this, in my opinion, has done a great deal of harm. I have had cases where there was a boracic acid sediment in and the ear, forming a crust, which allows suppuration to go on prevents the discharge going through the opening and it passes into the mastoid cells. For that reason, I have been very careful in the use of boracic acid. This crust is very hard to wash off, therefore it is better to use the acid in an alcoholic solution, not as a powder, because the solution is more effective, enters the cavity better and affects the bacillus more. I have had many severe cases of diphtheria, but have used very little antitoxin, in two instances only. The same way with opium and morphine. In a practice of twenty-two years I have never used more than two grains of morphine.

The earlier we operate the better it is, but do not plug the ear with boracic acid, which I think is the cause of mastoid diseases. If the cavity is properly cleansed, you will have less mastoid disease than ever before.

Dr. Colburn, in closing: I would like to mention one series of cases reported by Wreden. In twelve cases out of eighteen there was paralysis of the facial nerve, in one case bilateral, showing destructive effect of the diphtheritic process upon the tympanic structures.

DISCUSSION (DR. SUTHERLAND'S PAPER).

Dr. Loring: I have been very much interested in hearing about this case, though the subject is not a new one to me.

Several years ago when my hands were suffering from a slight attack of X-ray dermatitis, I noticed that in appearance they resembled very closely a case of eczema of the hands that was rapidly improving under exposure to the X-rays. The subjective symptoms were also very similar, and the thought at that time occurred to me that, so far as eczema was concerned, the curative effect of the rays was apparently homœopathic. Not long afterward I had two cases in which an eruption that had every appearance of *acne vulgaris*, appeared on the areas exposed to X-radiance and nowhere else, in persons with a clear, fair skin. When, one by one, reports were published of epithelioma, carcinoma and precancerous keratitis on section diagnosed as epithelial carcinoma, appearing in persons continuously exposed to X-rays, my previous thoughts were more forcibly recalled, and some little time given to considering whether or not the law of similars was the law by which the X-ray cured. Some months later, when several cases of enlargement of the thyroid gland were under my care, the right lobe and isthmus of the thyroid of a patient being treated for tubercular cervical adenitis of the right side of the neck, became considerably enlarged, but subsided quickly on stopping the X-ray exposures. This, added to my other cases, seems to me to warrant the conclusion that the chance of all these cases being coincidences is very small indeed. At the time of the Boston meeting of the American Institute of Homœopathy I read a short paper upon the subject before the electro-therapeutic branch, and wish to quote from that paper a section giving in parallel columns the symptoms which I had seen caused, and the similar diseases which I had seen relieved by exposure to the X-rays.

CAUSED.	RELIEVED.
Papulo-pustular eruption.	Acne vulgaris.
Local dilatation of small blood- vessels.	Acne rosacea.
Itching, burning, redness, cracking.	Eczema, acute and chronic.
Dry, white, scaling eruption.	Psoriasis, acute and chronic.
Indolent, painful ulceration.	Lupus vulgaris.
Epitheliomatous growths.	Epithelioma.
Thyroid enlargement.	Simple and exophthalmic goiter.
Pain in area exposed.	Pain relieved for several days following exposure of pain- ful areas.

These symptoms and results have been within my personal observation.

Regarding this case so ably reported by Dr. Sutherland, it is wonderful that one which has so far progressed can be relieved without opiates. While it is usual for some measure of relief of pain to be felt for some days following each X-ray treatment, in few cases is the relief absolute. Where circumstances will permit, I think all such cases should be treated just as this one was while under the care of Dr. Sutherland.

Dr. Watters: During the discussion of this paper, it has occurred to me that ten years ago we heard of tuberculin in the treatment of tuberculosis and its curative effect in that disease. We know that it will cause the spread of tuberculosis. In some cases, instead of stopping the disease, it will stop the symptoms but will disseminate the disease through the body. Would not this be possible in the treatment of cases of internal carcinoma by the X-rays? Dr. Sutherland saw evidence of one large tumor. After X-ray treatment, the microscope showed that it was broken down and disintegrated. In some of these cases, especially if deeply seated, would not disintegration of the tumor have a tendency to start growth in other places?

Dr. Southwick: The possibility of the X-ray being a starting-point or indirectly the cause of secondary formation has been discussed for some time. As the result of a very large experience and observation of cases, both during prolonged courses of treatment and also seeing many cases abroad, I feel that this is not possible from a physiological or pathological standpoint. In these cases secondary growths are characteristic of the disease, and are usually found post-mortem. They belong to the usual clinical history of the disease and are not produced by X-rays. There seems to be something in an early recurrent growth if it is small, which makes it more susceptible to treatment than the primary tumor. The smaller nodules will oftentimes yield earlier than nodules of longer duration. The primary growth breaks down, and secondary growth occurs long before we know it, and these secondary growths may degenerate and yield to X-rays. All nodules about the primary growth are under the influence of the X-ray during such treatment unless protected by a screen. I think we must consider the presence of broken-down secondary growths due to the effect of treatment on them. The X-rays tend to arrest all growth, and are destructive of new growth rather than a cause of dissemination.

The anodyne effects of the X-ray are superior to those of opiates. Were I to choose between opium, and any preparation of opium, and the X-ray, I should certainly select the X-ray, because I know of nothing which will so generally give relief as the X-ray, though it is not always successful. The X-ray and electricity are worthy of much more extended use, though not specifics for all diseases. Electricity, especially the high-frequency and sinusoidal currents, applies to a large number of chronic diseases; it promotes elimination and increases cellular activity, and does not interfere with other remedies. An instrument is now made which measures the current passing between the coil and tube. It is possible to measure the current producing X-rays so exactly that

another operator can reproduce the same conditions in another tube by measuring the electricity passing through the tube. It marks a great advance in exact work.

When an electric spark is discharged, nitrous acid is formed and thorough ventilation is very important. There is enough acid in the air to produce marked corrosion of metals, especially nickel-plated fixtures in the room. It is very injurious to breathe such air for a length of time.

Dr. Sutherland (in closing): I would like to take advantage of the opportunity to emphasize the great therapeutic value of X-rays. As far as the dose is concerned even if we decide we are using something analogous to a mother tincture, I do not see that this interferes with the homœopathicity of X-rays. The "dose" I have always considered of secondary importance. Just as long as we are using a dose that is not capable of producing an aggravation, I think it is all right whether we use a tincture or a potency. I am not one who claims that all cures are wrought on a homœopathic basis; for instance, I do not think that diphtheria antitoxin is homœopathic to diphtheria, for antitoxin has never produced a pathogenesis. It can be taken in large doses without producing any symptoms. When first used it was thought to produce a rash, which very likely was not due to the antitoxin itself, but to the preservative that was made use of; being incapable of producing a pathogenesis, it cannot act as a similar.

Vaccination has been referred to, but the ordinary use of vaccination is not in the least degree homœopathic, because the person who is vaccinated is not ill. To vaccinate a person ill with smallpox, would be resorting to a homœopathic measure. In the X-ray pathogenesis we have a wonderfully close parallelism to the condition X-ray cures, a much closer parallelism than we get in most of our prescriptions.

DISCUSSION (DR. H. E. SPALDING'S PAPER).

Dr. Southwick: We should differentiate carefully between the French and the German preparations of radium; the former is eight times the stronger for the same unit strength, as the French unit is based on pitchblende. French radium is not now manufactured, and it is almost impossible to get German radium of over 1,000,000 units. When I was in London last summer, I was shown ten milligrams, which was said to be the only radium of that strength in the city. The price was about \$250.

It is therefore not likely to be used very extensively, and if not handled carefully, it deteriorates. One physician, who prided himself upon his radium, found it had vanished when he wished to treat a case of cancer of the tongue the second time. It has not proved all that was expected, and it is used chiefly for those cases where the X-ray cannot be used as well. One million units of strength burns easily, and the burn is very painful. One case of epithelioma of the upper lip, which did not respond to the X-ray, did immediately to radium, and recovered last spring. The patient was in my office recently and seemed absolutely well. A slight scar showed the site of the epithelioma. In his case the cure was due very largely to the use of radium.

Dr. H. E. Spalding (in closing): The radium I used I purchased as being the French. It is supposed that the rays of radium correspond to the X-rays, but, after all, this is pretty difficult to prove from the fact that radium will do work that X-rays fail to do. Dr. Southwick has suggested, and others report, that there seems to be some difference between the two, because better results are obtained when the two powers are alternated than when either is used alone.

Owing to the lateness of the hour and at the request of Dr. Lucy Barney-Hall, it was voted to defer her paper on "Hyperchlorhydria a Cause of Puerperal Convulsions" until a future meeting.

Dr. H. C. Clapp presented a petition, to which he wished to

secure the signatures of as many of the members of the society as lived in Boston, requesting the city of Boston to establish a hospital for consumptives.

Adjourned at 9.45 o'clock.

B. T. LORING, *Associate Secretary.*

BOOKS AND READING.

Medical, literary and scientific publications will be reviewed in this department. Books and journals should be marked *NEW ENGLAND MEDICAL GAZETTE*, and sent to the Gazette Associates, 279 Dartmouth Street., Boston.

A TEXT-BOOK OF CLINICAL DIAGNOSIS BY LABORATORY METHODS. By L. Napoleon Boston, A.M., M.D. Illus. Philadelphia: W. B. Saunders & Co. 1904. pp. 549. Price, \$5.00.

The author gives emphasis in the very beginning to a most important fact, the need of the physician thoroughly understanding the microscope as an instrument in order to obtain the best results from it.

The chapter on blood is fairly well written, some of the definitions are somewhat obscure and the paragraphing leaves much to be desired.

A full list of parasites found in the blood gives added value to the chapter.

That part devoted to urine seems to give undue prominence to some less important tests at the expense of more valuable descriptions of those methods of more general use to the physician. Interpretation of results obtained is treated indifferently.

The gastric contents and examination thereof receive careful attention and are treated in a satisfactory manner.

Parasites of the skin are described in a more satisfactory manner than by any one of the recent texts.

The value of the book over many others already in print is the thoroughness with which animal parasites are treated, all the recent advances of the past few years being carefully noted and short descriptions of the various forms being given.

W. H. W.

ABSTRACTS FROM BOOKS AND JOURNALS.

RADIO-ACTIVITY IN RUSSIAN MUD.—Professor Boardman has found that specimens of mud in several parts of Russia possess radio-activity power. In one instance it was found that this mud would inhibit the growth of bacteria. More recently it has been found that the waters of Zuxton and Bath in England as well as several other waters are also radio-active. It is not improbable that radio-activity will be found to be a factor of considerable importance in hydrotherapeutic practice.

Red Cross Notes.

THE PERSISTENCE OF THE KLEBS-LOEFFLER BACILLI IN THE THROAT OF CHILDREN WHO HAVE HAD DIPHTHERITIC ANGINA.—B. Auché sums up his conclusions as follows: (1) In cases of diphtheritic angina, the Klebs-Loeffler bacillus may persist in the throat three and even four weeks after the disappearance of the false membranes. (2) In general, it is transformed, and becomes shorter and less virulent in proportion to the length of time that it remains in the throat. (3) It may, however, grow again, and cause a relapse, or be transported to the throat of another person, and give rise to an acute attack. All such chances should be avoided. (4) The only way to prove the time of disappearance of the bacilli, is to make cultures on gelatinized serum. The patient should be isolated until the culture gives a negative result.

Gazette Hebdomadaire des Sciences Médicales de Bordeaux.

FREE TREATMENT BY THE MEDICAL FACULTY OF THE UNIVERSITY OF MICHIGAN.—The regents of the University of Michigan have ruled that the medical faculty of the University of Michigan must grant gratuitous medical and surgical treatment to everybody applying therefor, whether rich or poor. This has led the Wayne County (Michigan) Medical Society to pass resolutions declaring that such a ruling deprives the medical citizens within the radius of the influence of the University of Michigan of part of their rights in an unwarranted manner, and is harmful to the state as well as to the medical profession, and calling upon the Board of Regents of the University of Michigan

to rescind its ruling concerning the indiscriminate free medical and surgical treatment of those who apply for treatment at the University clinics.—*Medical Record*.

PAY PATIENTS IN HOSPITALS.—Ought patients in a hospital to pay according to their ability for medical or surgical treatment? The regulations of many hospitals prohibit the payment of fees by any of the patients lodged within their walls, whether occupying a private room or provided with a bed in a ward. Some others allow the medical attendants to collect fees from occupants of private rooms. As a rule, ward patients are not allowed to recompense their medical attendants for their services. The result is that an injury is done to the profession and to a large class of patients whose self-respect is hurt by such a course. A member of a family whose income is from twenty to thirty dollars a week can rarely afford to occupy a private room at twenty-five dollars a week. If it is necessary for such an one to seek treatment in a hospital, he secures accommodation in a ward. The charges for this service, however, do not in a great many cases exhaust the possibilities of the patient; in addition to the bill for board, lodging and attendance, he could pay something for professional services. For such cases the regulations of hospitals should make provision. The present conditions are demoralizing to the laity and unfair to the profession. We can go further and say that those who can afford a private room should pay at least something for the services of the physician and surgeons. A patient whose financial possibilities stop at the private-room rate, say twenty-five dollars a week, ought to accept ward accommodations at the regular charge and pay the balance to the medical attendant. Hospitals were first planned for the treatment of the sick poor. To-day hospital attention and care are among the luxuries purchasable by the rich. The great middle class of society is still unprovided for except at the cost of a species of pauperism and an injustice to a profession that already does more than its share of philanthropic work. The *North American* views as a step in the right direction the following motion passed by the governors of a county hospital:

The committee shall have power to admit patients requiring

surgical treatment, who are able to pay the whole or part of the cost of such treatment, such cases to be admitted only on the recommendation of a medical practitioner and when, in the opinion of the committee, they require assistance.

North American Journal of Homœopathy.

DIETETIC TREATMENT OF SKIN DISEASES.—Lassar (*Dermatologische Zeitschrift*) states that dietetic measures are of the greatest importance for the cure of various cutaneous affections. Psoriasis, for instance, is unmistakably benefited by refraining from meat. Cheese is liable to aggravate certain skin diseases or possibly induce them. The subject must learn what articles of food he must avoid, and should strive to eat at regular intervals and in small amounts. A single hastily eaten meal when he is overfatigued, overheated or irritated, may affect him like ingesta containing ptomaines. In case of prurigo the nervous system must be soothed and sleep restored. Eczema frequently develops after the prurigo, and both may be avoided by keeping the bowels in good order, avoiding excess of bread and potatoes, and all other causes tending to induce flatulence. Prurigo patients are usually constipated, with hard stools. The tendency to furuncles and phlegmons in diabetic and gouty subjects may be combated by putting the patients on a sugar-starvation diet. So soon as all substances are avoided that form or become transformed into sugar, the tendency to furuncles subsides. The excess of sugar in the tissues affords fine culture media for the pyogenic germs. When this excess is avoided the germs cease to colonize in them, irrespective of whether the elimination of sugar is physiologic or pathologic. The same reasoning and conclusions apply also to uric acid in gout. Any intoxication may affect the skin and reduce its resisting power. He defines scrofula as a lessened resisting power due to inherited weakness and insufficient nourishment or care, and insists that everything which tends to enhance the resisting powers aids in curing the local affection. Obese subjects should diet to reduce their weight, and by this means avoid cutaneous lesions from friction between folds of the skin, etc.

FUNERAL OF DR. CONRAD WESSELHOEFT.

Funeral services for the late Dr. Conrad Wesselhoeft, who died at Newton Centre, Dec. 17, were held at the Church of the Disciples, Boston, Tuesday afternoon, Dec. 20. His colleagues met in the vestry at 12.30 for a memorial meeting, Dr. J. P. Sutherland, dean of Boston University School of Medicine, presiding. The faculty of the school, with which Dr. Wesselhoeft had been connected from the beginning, were present, and representatives from the Massachusetts Homœopathic Hospital, Massachusetts Homœopathic Medical Society and Boston Homœopathic Medical Society. It was a large and impressive gathering of leading members of the profession.

Before the platform rested the body of their late associate in a gray coffin on which were several wreaths of white hyacinths, roses, violets and maidenhair ferns. Words of appreciation of their late associate were spoken by Dr. Sutherland, Dr. E. P. Colby, Dr. F. P. Batchelder, Dr. J. Emmons Briggs, Dr. F. B. Percy, Dr. H. P. Bellows, Dr. Horace Packard, Dr. H. B. Cross, Dr. H. L. Chase, Dr. Baker Flint and Dr. Herbert C. Clapp, who read the following address prepared by Dr. J. P. Sutherland:

Friends and Colleagues: This is not an occasion when there is call for many words; certainly not for formal or ornate speech. For the man, whose passing from our midst we meet to mourn, was not a man who was himself given to flowers of speech, or who cared for them in others. Conrad Wesselhoeft was, above all things, simple, direct, straightforward. His life went straight to its aim; and that aim was efficient service. That aim he achieved. Along how many lines he served mankind, and helped forward that branch of science with which he was for nearly fifty honorable years so closely identified, it is our duty and our privilege in this hour to bear our testimony. How he served our school of medicine as a teacher and a counselor; how he served our medical societies as a pioneer and an instructor; how he served the community at large as a physician, winning its affectionate confidence not only for himself but for the cause of homœopathy whose banner he upheld with a never-faltering hand—these several services we are met to severally recall and acknowledge.

To what the man himself represented to us, as comrade and friend, each of our hearts bears deep and silent witness. It cannot but comfort us to-day, to know that we did not wait until to-day, to express our love for him. Last spring we met with him to celebrate his seventieth birthday, and we told him that we loved him; and he was very happy in his certainty that this was true. In the last hard days of his passing, the loving-cup we gave him was always within sight of his eyes and touch of his

hand; and we know that the thing it stood for, upheld and gladdened his heart, when the shadows were growing thick, in the twilight of this our mortal day. We do not mourn for him; we mourn for ourselves, that we must miss the good, cheerful, faithful companionship that has blessed us so many years. For himself we cannot mourn. He passes in the fullness of his honorable years; in the completion of great and fruitful service. He has laid down, with what content only the sick and weary can know, what was to him so really, in these last suffering months, the burden of the flesh. We

“ . . . mourn no blighted hope nor baffled plan,
In him whose life stands rounded and approved
In the full growth and stature of a man.”

To him who stood at a chieftain's height, we may say, in sober cheerfulness and founded hope, Hail and farewell! For he was of those who

“ . . . never turned the back, but marched straight forward;
Never doubted clouds must break;
Never dreamed, though right seemed vanquished, wrong could
triumph;
Held, we fall—to rise—are baffled, to fight better;
Sleep—to wake!”

These resolutions were then presented and unanimously adopted:

Whereas, in the Providence of God, our teacher, friend and fellow-worker, Conrad Wesselhoeft, has been called from this earthly life, in the fullness of his years, and in the completion of a full and most honorable record of service to science and devotion to the welfare of humanity;

Therefore be it resolved, That we, his fellow-workers of the faculty of Boston University School of Medicine, hereby record our grief in the loss of his presence among us; and our deep appreciation of his lasting and most worthy service to the school with whose teaching force he was so long connected. That, as a teacher, Dr. Wesselhoeft was painstaking and convincing. He spoke of that whereof he knew; and his teaching was the fruit of sound scholarship, of patient original research, and of profound personal conviction of the value to humanity of the scientific truths it was his function to impart. That, as a supporter of the school, in its broadest needs and interests, he was indefatigable in earnest and well-directed effort. That we extend to his family the assurance of our deep and lasting sympathy in their loss of that daily companionship which daily more endears such a character and personality as were his.

At 1.30 P.M. the body was borne into the church followed by a long procession of physicians to all intents and purposes serving as honorary pallbearers. The religious services were conducted by the Rev. Charles G. Ames, minister of the church, and the Rev. Mr. Stearns. The burial took place at Cedar Grove Cemetery.

PERSONAL AND GENERAL ITEMS.

DR. WILLIAM H. BIGLER of Philadelphia, a member of the faculty of Hahnemann College and well known as an authority in children's diseases, passed away suddenly Dec. 9, aged sixty-four years.

IT has been estimated that ten to fifteen thousand lives could be saved in the United States every year from death by typhoid fever if proper local and general sanitary measures were adopted and enforced.

FOR SALE.—Strong-Ovington Static Induction and High-frequency Electric Apparatus, bought of Otis Clapp & Son, used one month, sold for no fault; price, \$250. Address High Frequency, care of NEW ENGLAND MEDICAL GAZETTE.

WE regret to announce that, owing to ill health, Dr. W. B. French has given up all professional work, and severed his connection with the Massachusetts Homœopathic Hospital, Boston University School of Medicine, and with most of the medical societies of which he was a valued member.

THE many friends of Dr. J. Wilkinson Clapp will undoubtedly be greatly pleased to learn that his health, which had been impaired by long and close application to business, has been completely restored, and that he has resumed his active connection with the firm of Otis Clapp & Son. We are authorized to make this announcement to the profession, to whose congratulations we desire to add those of the GAZETTE.

DR. THOMAS DARLINGTON of New York, commissioner of health, has made the following statement: "Estimating the value of a single life at \$1,500, not necessarily a high estimate, and taking only those lives between sixteen and forty-five years, the loss of life in this city alone from tuberculosis mounts up to the startling sum of \$23,000,000 annually."

THE EDINBURGH ROYAL INFIRMARY is the largest in Scotland. The medical college is next to it and has 1,400 students, so they are making doctors in Scotland as well as America, only the course is five years to be a bachelor of medicine, for a full-fledged doctor of medicine the time is seven years. The "Jubilee" portion is modern, but the rest is quite old. There are five surgical operating rooms and the wards are very conveniently arranged. About ten thousand hospital patients are treated a year, two-thirds of them being surgical.

ONE of the most novel schemes in the treatment of insane patients ever tried in Maine bids fair to be utilized another summer, by which the convalescent patients of the Bangor and Augusta hospitals will be given a summer outing on Widow's Island, sixteen miles east of Rockland.

At the time of the Spanish-American War the federal government built a fine brick structure on this island, intending to use it as a marine hospital should occasion arise. It was never furnished and it is now at the disposal of the state should the state care to use it.

The building is large enough to accommodate from fifty to seventy-five patients in good shape. It is advocated that parties of convalescents be taken to the island during the summer months and given an outing after their long months of confinement in the hospitals.

The island is a barren affair of five or six acres and an ideal place for the purpose.

THE NEW ENGLAND MEDICAL GAZETTE

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VOL. XL.

ORIGINAL COMMUNICATIONS.

PRESIDENTIAL ADDRESS.

BY FREDERICK W. HALSEY, M.D., BOSTON, MASS.

[Delivered before the Massachusetts Surgical and Gynecological Society, Dec. 14, 1904.]

Members of the Surgical and Gynecological Society: In addressing you this evening, allow me first to express to you my sincere appreciation of the honor you have done me, in choosing me to preside over you for the year past. It is an honor, in my judgment second to none, in your gift, for is not this society more democratic, more cosmopolitan and more enjoyable than any other to which you or I belong? We have had and still number among our members some of the most dexterous and skillful men and women, not alone in Massachusetts or New England, but in the whole world. While some of the pioneers—some of the boldest and bravest of them—have gone before, their influence for good must go on indefinitely, and it is certainly stimulating to feel that much is expected of us.

Presidential addresses are usually built on prospective or retrospective lines; and the effort to say the same things which have been said before (and often better said), becomes a bit hazardous, if it escapes being tiresome. If altogether retrospective, many things are said which often cause regret and sorrow; and if mainly prospective, events may be forecast which we feel sure will never happen. Our course then lies "between Scylla and Charybdis," painful in a measure in either

case. On the principle that children are often encouraged and guided in the right path better by picking out their good qualities and fostering these, than by lying in wait for an opportunity to point out their weaknesses and faults, and correcting such by a constant harping on the don't, would it not be well to have a little love feast, as it were,—a sort of praise meeting, as our Methodist brethren would call it,—touching on the qualities which go to make up the good physician, some of which pertain to all of us, and all of which pertain to some of us.

Our scientific session for the year having come to a profitable end, the inner man being at peace with the world, what better ending than to hear a few good things said about ourselves!

As the years roll by, why do we congratulate ourselves that we belong to the medical profession? Is it not because we feel that nowhere on this green earth can we do more for humanity than in this our chosen profession? Are the heroic deeds of life mostly done in the heat of battle and while the blood is hot?

Look back through the past ages, through the scourge of pestilence and famine,—ravage a thousand times more fatal than war,—and we find heroes for every emergency, who, for the sake of their fellow-man, knowingly and willingly lay down their lives. Let your minds go back a few years to that memorable morning in the amphitheater of the Massachusetts General Hospital when the first test for the use of "sulphuric ether" as a general anesthetic was to be given. Dr. Morton had used ether in his dental work so successfully that he believed it could be safely used in a more prolonged surgical operation,—he did not know it; he simply believed it, and was willing to make the supreme test. If successful, a new epoch would be created, and one of the greatest blessings ever given to mankind would be bestowed; if the test failed, as every one was prepared to have it, a life would, without doubt, be sacrificed, and Dr. Morton would be held deeply culpable.

At the time appointed Dr. Morton had not appeared. Dr. Warren, who was to operate, said, with a tinge of sarcasm: "We expected to operate this morning under the influence of an agent called ether; Dr. Morton not having arrived (and I do not blame him), the patient may be prepared as usual, and we will go on with the clinic." Before they were fully ready, Dr. Morton, pale but determined, arrived, and proceeded to anesthetize the patient. In a short time word was given that everything was ready, and the surgeon began his work. Instead of the usual shrieks and groans, the silence of death hung over the room as the operation proceeded; a pungent unknown odor filled the air. For some the strain was too great; one fainted and was removed from the room. The operation finished, the ether was discontinued. For once the surgeon occupied second place, the intense interest being centered on the patient. Not a groan had been uttered and scarcely a motion made during the entire operation; to all intents and purposes, the patient was dead. Slowly the signs of life returned; first of motion, then of speech. When it became a certainty that the patient had survived, Dr. Warren raised his hand, his voice shaking with emotion, and said: "Gentlemen, *this is no humbug.*"

Like many another hero, as we know, Dr. Morton went down to death poor, unhonored and unsung, and future generations must do him reverence. It was from the results obtained from this morning's work that the great achievements which have been made in modern surgery have been rendered possible, for up to this time little but emergency work was attempted. Following such a discovery by an American, it seems eminently fitting that so many of the notable advances along surgical lines should have been made by Americans.

In serious fractures of the long bones, extension by broad bands of adhesive plaster, thereby preventing ulceration, was first suggested by Dr. Josiah Crosby of New Hampshire. Out of this came the extension apparatus, with weight and pulley from the foot of the bed, by Dr. Gordon Buck of New York.

Plaster-of-Paris dressings for fractures do not date back so very far, and were first used by Dr. James Little of New York, and while attending a post-graduate course in New York I witnessed Dr. Little give several demonstrations of his method, which was then considered a great novelty. It was only done at that time after all swelling had disappeared. Dr. Sands of New York afterwards applied extension, and put up the limb in plaster immediately after the fracture, with good results. Dr. Lewis A. Sayer of New York first showed the possibility of curing Pott's disease by plaster-of-Paris jacket applied while the patient was swinging from the head. Dr. James A. Wood of Philadelphia obtained great success in bone surgery, particularly in the reproduction of the same.

Dr. A. M. Phelps was the pioneer in the successful treatment of clubfeet. Dr. I. T. Talbot was the first in this city, and, as far as recorded, the first in this country, to perform a successful tracheotomy. Dr. Horace Green was the first to demonstrate the possibility of passing an instrument into the larynx, but he reaped nothing but reproach from the profession in consequence. It remained for Dr. Joseph O. Dwyer to perfect a set of tubes which could be used for intubation of the larynx, rendering unnecessary, in selected cases, the operations of laryngotomy and tracheotomy. Dr. S. R. Beckwith was one of the first to successfully amputate a leg at the hip joint. Aspiration of the pleural cavity was first demonstrated by Dr. H. I. Bowditch of Boston. Dr. Ephraim McDowell of Kentucky performed the first ovariectomy known to have been done in the world. This operation and some other abdominal work was done after this, but until the discoveries made by Sir Joseph Lister of England in the field of antiseptics, such operations were followed by doubtful success. Dr. George D. Beebe of Chicago performed the first successful anastomosis of the intestines on record, the operation being done for strangulated hernia, four feet and six inches of the jejunum was removed, and the operation was successful. Dr. Valentine Mott of New York has been credited by Sir Astley Cooper, the

eminent British authority, with having oftener and with greater success ligated large arteries than any other surgeon in the world. Dr. Alonzo Boothby of Boston was one of the first to successfully remove a kidney. Drs. Theo. A. McGraw of Detroit and W. S. Halstead of Philadelphia, were pioneers in the operations on the liver and biliary passages.

Dr. N. Schnider of Cleveland, Ohio, was one of the first, if not the first surgeon, to enter the cranial cavity and attack a neoplasm at the base of and behind the orbit. The growth was attached to the dura, pressing on the brain, and was successfully removed.

Dr. J. Marion Simms was first to advocate the opening of the abdomen for gunshot wounds, and has been called the father of modern gynecology. Dr. Horace Packard of Boston introduced the administration of etherized air by a special apparatus of his own invention, reducing the amount of ether used to produce anesthesia, and lessening the unpleasant after-effects of the drug. Decapsulation of the kidney was first suggested by Dr. George M. Edebohls of New York for the relief of Bright's disease. To Dr. Frances M. Markoe of New York is credited the first successful removal of the spleen. While all honor should be given to these pioneers in their special work, due credit and praise must not be withheld from the men who have followed, who are bearing with them the heat and burden of the day,—men in our own city, whose brilliant work will compare favorably with that of almost any others in the world,—men like Warren, Emerson, Scudder, Porter, Hayward, Richardson, Cabot, Bell, Mixter and Monroe; and were we to go outside of Boston, the list could be enlarged almost indefinitely, for since the introduction of ether and the adoption of aseptic measures, the progress in surgery has gone on by leaps and bounds. Not an organ in the body but has been invaded, and it almost seems that advances of the future must be in the line of added dexterity in operating, rather than in discovering new operations. These are all men who have done something, and of whom we have a right to feel proud; more than a fair sprin-

klings of them, New Englanders, and some of them members of this society. What has animated the spirit and courage of these men? What has been the driving force or motive of their work? Is it the love of gain or the unqualified commercial spirit which dominates them? We know it is not.

Unfortunately for humanity, and the individual himself eventually, we see examples now and then in our profession of the pure, unadulterated, commercial spirit overshadowing all other traits in the character. When we see such instances we deplore them, but the cases are usually hopeless. Many a shrewd merchant or clever broker is spoiled in the making of an indifferent physician. It is an old truism that the average doctor is a poor business man. Many successful physicians who have amassed quite a little wealth resent this, but it is true nevertheless, and necessarily so. If in the pressure and stress of the busy physician's life, rushing from one case to another, carrying the responsibility of life and death with him much of the time, any of his work is neglected, it is apt to be his bookkeeping. This is particularly true of the general practitioner in country practice. With many this failing is so pronounced as to become actual shiftlessness; then the doctor and his family are serious sufferers. Those of us who have had much country practice, who have ridden over the hills and through the valleys, who have felt the physical fatigue, in consequence, at the end of the day's work (if the end ever came), can sympathize with, and readily forgive the shortcomings of such a man. I have in my mind's eye a man something after this type, whose whole life has been spent in doing good. Well equipped by education and training for his work, his opportunities have been almost without limit. Given by nature a vigorous body and large capacity for work, he has never shirked it. With tender sympathy toward his patients, he has endeared himself to a degree not often seen; never so tired or so hurried but he could make the one more call needed; never so busy but that he could listen to the troubles and worries of his patients; never maligning or backbiting his profes-

sional brothers; a ready friend and counselor to the young physician, and by no means confining his friendship to mere words, as many who have been in sore straits and have been helped by him could testify; always upholding the honor of his profession,—his success has been conspicuous. Of money he has accumulated only a moderate amount (nothing commensurate to his work); and yet so unconscious is he of filling the picture I have drawn, that were I to call his name to-night, were he present, he would doubtless say, "Humbug." This is the type of man who does honor to our profession, and whom we may well strive to emulate. Nor is the type so very rare, for ours is a profession which ought to stimulate and bring out our good qualities, if we have any. Our intimate association with the trials and tribulations of the flesh,—with the shadows of life, so to speak,—must make us more or less thoughtful, if not sympathetic. This need by no means make us gloomy or morose, for nothing is so depressing as such a physician. In an after-dinner speech given by our lamented colleague, Dr. Heber Smith, speaking to the younger members of the profession, he said: "Cultivate a spirit of cheerfulness. In the morning, when you start out, resolve that you will have a good time all day,—as good a time as you ever had in your life. If you succeed, you will communicate your good spirits to every one with whom you come in contact, for good spirits are contagious." The remark made quite an impression on me and will bear thinking over. It has become quite the fashion among writers in our daily journals, and indeed within our own profession to look on our surgeons and compare them to raging lions going about seeking whom they may devour. Scarcely a medical meeting passes but some well-meaning but misguided doctor tells of the numerous cases he has snatched from the surgeon's grasp and rescued by purely medical means. He forgets, and they all forget, the main point: that the thing, above all others, which has gone to make the successful surgeon, is his ability to recognize a truly surgical case; and having so recognized, to bring such case to a successful issue. He for-

gets the tremendous responsibility resting on the surgeon when he gives his decision for or against operation. He forgets he is not dealing with chairs or tables needing repair, but with human lives. He puts the commercial side to the front and argues that the surgeon is influenced by this side of it. Thank heaven there are few such, and they never become really great surgeons. If the surgeon appears at times a trifle overzealous, what shall be said of the general practitioner who does not believe in surgery for his patients? Listen a few moments to a brief editorial in the November number of the *American Journal of Surgery and Gynecology* on neglected operations: "There has been much—too much—said about unnecessary operations (especially by our esteemed friends, the neurologists), not enough about the neglected cases,—patients sadly in need of operation. Think for a moment, dear reader. How many neglected cases have you in your own field of work? Verily the woods are full of them. Hemorrhoids without number literally aching to be ligated or burned; hernias by the hundred straining at their trusses, vainly waiting for the curative knife that comes not; varicose ulcers of the leg, without limit, crying for surgical relief; lacerated perineums yawning in hopelessness for scissors that cut not; tumors of every region growing, growing (and some of them cancerous), without the one word of encouragement from the trusted family doctor needful to secure extirpation,—all these and more. Doctor, are you doing your full duty to your patrons in neglecting these chronic cases, and especially of semicharity character? Reflect and act."

Jealousy, avarice, cupidity and dishonesty we have had with us since the world began, and probably will until the end, but I believe we have less of these vices in the rank and file of our profession than in any other I know. The absolute trust and confidence imposed in us by our patients, the close and confidential relation into which we are brought with our families, entering into the home life as no other profession does, is apt to inspire in us a feeling of trust and confidence toward

others. By no other chain of reasoning can I understand the fact that the medical profession is considered legitimate prey by a certain class. Notice the childlike simplicity with which we listen to the hard-luck story of the man just out of the hospital and in need of temporary assistance. Notice the courtesy with which the alluring agent of the gold, silver or copper mine is received. This field must be a prolific one, or it would not be so well worked.

In some things we learn only by experience,—a little expensive at times, but likely to be effective.

What of the women in our profession? Handicapped by the prejudice of centuries, by the mannishness and aggressiveness of the pioneers in the field, by the attitude of their own sex in distinct opposition to them, they have persevered and demonstrated to us and the world that a woman may become an expert physician and surgeon and still retain all those attributes we most admire in them as a sex. Surely ours is a profession of self-sacrifice from beginning to end. We never attain the point of being our own masters, however much we may desire it. We are ever subject to the favor and caprice of a fickle public. There are no prizes awaiting us; no reward for any achievement or invention we may make. There can be no secrets kept from each other and used purely for the purpose of enriching the individual. Human lives are too sacred, and the advance of general knowledge too important, to allow of such traffic. This we know as a part of our ethics when we begin, and we accept such and are content. The opportunity for exceptional reward for exceptional skill is not equal, as between the legal and the medical profession,—the legal having the decided advantage of us. Fortunately for us the large majority of our patients in these days survive our treatment, either medical or surgical, and live to do us honor. What held the medical profession together in the days of Rabelais, when a call for the doctor was synonymous with a call for the undertaker, is beyond our ken. Enthusiasm in our ranks, the thirst

for new discovery, the satisfaction of a well-fought fight, spurs us on.

Fortunate for us we have no definite goal; our work is never ended. Year after year we go on, scarcely realizing that nature can ever call a halt with us; striving ever to do the best that is in us; happy and content in our work; not realizing that we, too, are coming back to nature.

How apt at this point are those beautiful lines of Longfellow:

“As a fond mother when the day is o’er
Leads by the hand her little child to bed
Half willing, half reluctant to be led,
And leave his broken playthings on the floor,
Still gazing at them through the open door,
Nor wholly reassured and comforted
By promises of others in their stead,
Which though more splendid may not please him more;

“So nature deals with us, and takes away
Our playthings one by one, and by the hand
Leads us to rest so gently, that we go
Scarce knowing if we wish to go or stay,
Being too full of sleep to understand
How far the unknown transcends the what we know.”

FERRUM PHOS. IN INCIPIENT COLDS.—We possess a patent, powerful remedy in combating acute, active inflammatory conditions. It is ferrum phos. For incipient colds it is worth its weight in gold. If, on exposure, you will give your patient a dose every hour for four hours, your cold symptoms will have disappeared in a very short time. Try it if you have not already done so.—*North American Journal of Homæopathy.*

THE TREATMENT OF MAMMARY CANCER.

BY GEORGE R. SOUTHWICK, M.D., L.R.C.P.LOND., M.R.C.S.ENGLAND, BOSTON, MASS.

The primary cause of cancer remains to be discovered, but one fact is of great clinical importance and prophylactic value. Benign growths in the breast are liable to become malignant, and it is a serious error of judgment to allow an apparently harmless growth to remain year after year without removing it. Many of these tumors can be cured without operation; some cases require it. No woman should be subjected to the necessary mutilation of the operation for malignant disease if she has only a benign tumor, nor on the contrary will the usual operation for the removal of a benign tumor suffice for a malignant one however small. Painstaking skill and accuracy in the clinical diagnosis are of the utmost importance. To neglect clinical evidence founded on a sound anatomical basis, and to refer to the microscope only as our safe guide is a confession of ignorance. The possibility of inoculation with cancer has been proven, and care must be taken in handling such cases. • All soiled dressings must be burned.

Kelling's theory of the origin of cancer published in a recent number of the *Münchener Medizinischer Wochenschrift* is ingenious and of immense importance, both from the standpoint of prophylaxis and from that of early diagnosis which he finds possible by the precipitation of certain nucleins from the blood. He is of the opinion that embryonal cells from animals other than man gain access to the human body, lodge there and develop into tumors. He states that he has injected triturations of early chick embryos into dogs, and has produced tumors having the gross and microscopic appearances of malignancy. If further investigations confirm his opinion cancer may yet be classified among the preventable diseases. It has been shown, however, that embryonic tissue, as that from the embryo of the pig, can be transplanted and made to grow in living tissue, but the experimenter demonstrating this fact found that the embryonic tissue continued to

reproduce itself and did not produce a malignant growth. Further investigations are awaited with interest.

The operative treatment of cancer is a time-honored rule, but a sharp line must be drawn between past and present methods. Few surgeons have had a larger experience than the late Dr. Samuel D. Gross of Philadelphia or the late Dr. Hodges of this city, and both have recorded the failure of the ordinary operation as a curative measure.

The modern operation is based on early diagnosis and the removal of the entire breast, the pectoralis major muscle, and sometimes the minor, and all of the adjoining lymphatics which are the chief carriers of materials causing metastases. Special care must be taken to clear the space beneath the pectoralis minor, and between it and the clavicle. It is a common site of a very painful recurrence when this precaution is neglected. The final results of the operation do not depend so much on the mere size of the cancer as on its metastases and the probable extent of lymphatic invasion.

Statistics are notoriously misleading, and those of the ultimate results of operation for mammary cancer are among them. As high as fifty per cent. of cures has been claimed for the modern operation, but this was based on the three years' limit, and the assertion that cancer developing after three years was a new infection and not a return of the original disease. More recent statistics show that about one-third of the favorable cases complete the three years' period without recurrence.

The disability which so often follows the modern operation has been a serious objection to it. The operation is one which requires thorough anatomical knowledge, and a high degree of surgical skill for its proper performance. It has been the privilege of the writer to see a large number of these cases the last few years, and the difference of the usefulness of the arm varies much with different operators.

It is unusual for the best of the English surgeons to have many cases where patients two months after the operation cannot stand erect, place the hand on the back or on the head

and dress their hair even after very extensive operations, but such freedom of motion has been the exception rather than the rule in the cases seen by the writer in this country. Happily this disability can be prevented in most cases, and every effort should be made to preserve a useful arm. Patients complain bitterly of a useless arm, and few of the most recent works on surgery give directions for the preservation of complete motion.

Some cases of mammary cancer refuse operation, some permit it, some come too late and a few may not require it. The treatment of mammary cancer is one of the great questions of the day. There are a few cases of small or quite superficial cancer, especially in the aged, which grow very slowly and which can be treated successfully without operation, but these are to be considered as the exceptions which prove the importance of the operative rule for those cases where every trace of the malignant disease can be removed. When this can be accomplished the conditions for subsequent treatment are much simplified, and the danger of metastases forming during treatment is eliminated.

Allusion has been made to the theory of an infecting agent or a parasite as a cause of cancer. It is interesting to note here that in a number of authentic cases cancer has developed in X-ray burns, which seems to indicate that cancer is not produced either by a germ or a parasite. It is a demonstration of the great power of the X-ray for both good and evil, and should be a warning that the operator exposed more or less continuously to the rays is in far more danger than the patient. The statistics based on the theory of infection and three years' freedom from recurrence as a cure do not fully represent the facts. A study of the ratio of recurrence to the time it takes place after operation has given results of practical value. It is most common about one year after operation, but in those patients who survive free from cancer three years after operation the chances are seventeen to one against recurrence, according to Cheyne, and the tendency for the growth to recur

diminishes progressively, *i.e.*, the chances for a permanent cure improve steadily after the third year. In other words, if we can carry the patient through this period nature comes to her aid, the tide turns and her life is likely to be saved. A case of mammary cancer should receive the most careful attention and treatment throughout the entire period of three years from the very day of operation. Everything which can be done to improve the nutrition of the patient, to relieve her mind from worry, and to save her from actual fatigue increases her resistance. The modern operative treatment under favorable conditions marks the beginning of treatment. The term, beginning of treatment, is used advisedly. Too often the operation is the end of all serious effort to cure the patient, and she is abandoned to nature and to opium. The writer wishes to make an earnest protest against such a course. Innumerable reports from reliable sources have demonstrated that many of these cases are amenable to treatment. The X-ray and other forms of electro-therapeutics have proven invaluable in the treatment of mammary cancer, especially the recurrent form. The earlier the treatment is begun the better are the results, and not a few cases of advanced recurrent cancer with extensive ulceration have been apparently cured.

Cancer returns within a year in nearly two-thirds of the untreated cases and soon causes death. Contrast this fact with another that early recurrence is treated successfully in the majority of cases by nonoperative treatment. With these facts before us why wait for visible signs of recurrence? Why not anticipate it? Why not make every effort to prevent it?

The X-ray is valuable for the early post-operative treatment of particles of malignant tissue which may have escaped the knife. It is equally valuable for the treatment of the microscopic beginning of such a growth, and who can tell when it first begins?

It is not reasonable, with an effective remedy at hand, to wait for the visible growth of recurrent cancer which almost surely reappears, and it is of vital importance to tide the patient

over the three-year period. There are some cases so malignant or widespread that all our present methods of treatment may be only palliative, but the results that have been accomplished lead us to expect that larger experience, better apparatus and improvements in technic, in other words, expert work, will save the lives of many such cases.

It is not possible here to enter upon the consideration of details, but the following suggestions based on a very considerable experience and observation in X-ray work may be useful.

The apparatus used must saturate the subdermal tissue with X-rays without burning the skin, and the tube must maintain a fairly even vacuum during the treatment. There must be a large volume of rays which penetrate the tissue without too much absorption by the skin. The skin may be severely burned without affecting materially the structures beneath it. Treatment of this kind is of little use.

Another point of great importance is the necessity of an occasional X-ray treatment for a long period after all physical signs of recurrence have disappeared. This treatment should be given from time to time throughout the three-year period, at varying intervals according to the circumstances of the case.

The writer can state in a general way from his experience and from a conservative viewpoint, that, in the great majority of cases of early mammary recurrence, all signs of the disease disappear with treatment. Two years and more have elapsed in some of these cases without reappearance, and only time can tell the final result. Recovery has taken place in some cases apparently hopeless, and in others the relief from suffering and the prolonging of a useful life in comparative comfort has been most gratifying.

Phototherapy has come to stay as a priceless possession of both the physician and the surgeon, but like other remedies it has its limits and its indications.

The subject cannot be passed by without reference to other forms of treatment which are used independently or as

adjuncts to X-ray treatment. Radium of 1,000,000 units is sometimes useful, especially in locations where the X-ray cannot be used to advantage. The high-frequency current is one of the most important of these agents, either for general or local treatment.

The effect of a large, soft effleuve, which will spark gently without causing a painful sting, and a current which shows on the milliamperemeter the actual measurement of not less than 500 milliamperes has a wonderful effect in promoting healing of open ulceration whether malignant or not. An electrical discharge of this kind is rich in violet rays, which destroy pathogenic microorganisms. The low vacuum glass electrode is also useful, but as no ultraviolet waves pass through the glass the beneficial effects must be due to the ionization of the tissues and the liberation of oxygen. The successful use of the X-ray and ultraviolet light for the treatment of carbuncles and boils is a good illustration of their effect on suppurative processes.

The success with which the new single phase and polyphase sinusoidal current is being used for chronic diseases associated with deficient metabolism, such as diabetes, gout, chronic rheumatism, neurasthenia and muscular weakness from various causes, leads us to expect that it will be valuable in building up the patient, and restoring the various functions of the body to a healthy condition.

Our old friends arsenic, conium, phytolacca, rumex crispus and some other remedies should not be laid on the top shelf.

Good results have been reported in a recent number of the *Medical Press*, London, from the hypodermic use of chian turpentine. Five minims of a twenty per cent. combination of chian turpentine with olive oil gradually increased by five minims up to sixty minims were injected on alternate days. The writer had the pleasure of a long conversation with Dr. John Shaw in London regarding the hypodermic use of this and other remedies. Turpentine in the past has been a feature because of the way it has been used, and its being regarded as

a specific. The following case reported by Dr. Shaw, illustrating its successful application, is briefly quoted. The patient was first seen early last August. A hard, solid, inoperable tumor filled the abdomen, and extended almost to the ensiform cartilage. The right leg and thigh were enormously distended. There had been hemorrhage from the bladder several times. He was not able to retain solid food. X-rays had not arrested the growth. Wonderful improvement followed the use of chian turpentine. The leg became softer and smaller. The appetite returned, and he could eat, retain and digest solid food. The tumor diminished to a great extent and to the level of the umbilicus. The distension of the abdomen disappeared, and the walls became supple. This improvement was maintained at last accounts in the middle of last October.

Iodopin is another agent which has been found very beneficial for recurrent growths involving glandular structures, and can be used hypodermically.

Dr. J. H. Webb of Melbourne, Australia, holds the opinion that the development of cancer is due to the lack of some element necessary for the complete growth of the cell, and that if such a substance can be supplied cancer will not develop. He thinks there may be defect of soap in the biliary secretion permitting the separation of cholesterol from the living cell. He states that he has used successfully for the treatment of inoperable cancer solutions of superfatted soap. Commencing with five minims of a one per cent. solution, Dr. Shaw has gradually increased the dose to sixty minims every fourth day. Amelioration was obtained in all cases, chiefly in the direction of decrease of the tumor, diminution of fetor and discharge, and cessation of pain.

Dr. C. A. J. Wright has reported some remarkable results with the cinnamate of strontium used by cataphoresis, with the high-frequency current. The new use of the sinusoidal current promises to be even more valuable for cataphoresis.

Dr. Wright uses the cinnamate of strontium suspended in three parts of glycerin to five parts of distilled water.

Dr. Bell, formerly of Glasgow but now of London, advocates the use of thyroid tablets and large doses of salicylate of soda, but the former remedy has been tried previously without much success. The serum of Schmidt has failed, and that of Doyen is doubted in spite of the reputation of that distinguished surgeon.

There is ample and increasing clinical evidence to show that cancer is not incurable to the extent formerly believed. It is still the sphinx of modern medicine, but the number of cases apparently cured is increasing. What has been done encourages us to expect more can be accomplished. The X-ray is still the remedy *par excellence*, but it is one which can be aided and supplemented by other treatment.

The writer would summarize the important points in the treatment of mammary cancer as follows:

I. The early and skillful performance of the modern operation in suitable cases and the preservation of complete motion of the arm.

II. The early and persistent use of suitable X-ray and other apparatus.

III. The employment of drugs locally and internally.

IV. The early treatment and diagnosis of all mammary tumors.

THE FAUCIAL TONSIL.

BY GEORGE B. RICE, M.D., BOSTON, MASS.

Continued from the January number of the "Gazette."

Syphilis, malignant disease and tuberculosis of the tonsil, in many instances, present similar characteristics, and should, therefore, be considered consecutively.

Primary syphilitic infection of the tonsil is not very often recognized, but a few well-authenticated cases have been recorded; none having come under the observation of the author. The local manifestation is similar when the tonsil is the seat of the infection, as elsewhere, the character of the tissue and the malignancy of the infection determining the form of the sclerotic process.

Fig. XIII shows a primary ulcer of the right tonsil from Grünwald.¹ It will be seen that the tonsil is much indurated and is covered with necrosed tissue. There is swelling and redness of the surrounding tissues, with involvement of the cervical and supraclavicular glands of this side. Pain was not a prominent symptom. About six weeks after the local appearance, a roseola eruption appeared over the entire trunk of the body.

Thorner² reports an interesting case, and Parloff³ reports two cases in men, and one in a young woman. In the latter case the induration of the tonsil was extreme, and the corresponding submaxillary gland was as large as a hen's egg.

In addition to these cases, sixty-nine others have been recorded in medical literature to the author's knowledge.

An erosion of the mucous membrane is usually considered essential to syphilitic infection, but Bosworth⁴ thinks that the tonsil may become infected from the lodgment of the poison in a crypt, thus insuring a certain permanency of contact. In some of the above-recorded cases the infection was conveyed by

¹ "Atlas of Syphilis and Venereal Diseases," Plate XI.

² *Laryngoscope*, October, 1897.

³ *Journal of Laryngology and Rhinology*, September, 1890.

⁴ "Diseases of the Nose and Throat," Vol. II, p. 262.

impure practices, but in the majority it arose from kissing, the use of drinking-vessels, pipes, nursing-bottles, etc.

An hypertrophied cryptic tonsil would naturally favor infection; hence, although the chancre presents the usual appearance, it is usually more extensive, and gives rise to a wider range of symptoms.

Secondary and tertiary manifestations of the disease are more frequent in the oral cavity and fauces and tonsils, with the possible exception of the skin, than in other portions of the body. A mucous patch of the tonsil may be confounded with diphtheria, because the inflammation which gives rise to the mucous patch may result in the deposit of a false membrane. The mucous patch is ordinarily film-like, slightly bluish white, and apparently lying on a healthy membrane. It is similar in appearance to an area after having been superficially cauterized with silver nitrate or glacial acetic acid. On one occasion the author saw a mucous patch assume the appearance of the deeper tertiary ulceration with extensive induration of the surrounding tissues.

Occasionally the inflammatory infiltration of the tonsil may persist for a long time without the formation of any ulceration or fibrinous deposit. The tertiary or deep ulceration is always preceded by the gummatous tumor, and is the result of disintegration of this induration. The depth and extent of the ulceration, then, depends entirely upon the amount of tissue involved by the gumma.

The tonsil is frequently the site of such a deposit, which comes on suddenly, lasts from a few hours to a few days, and then breaks down and forms an ulcer. One well-known authority¹ states, that the more frequent site of the ulcer is the posterior wall of the pharynx, next the soft palate and faucial pillar, and lastly the tonsil. The author's observations would lead him to place the soft palate and faucial pillars first in frequency, then the tonsils if inflamed and hypertrophied, and

¹ "Diseases of the Nose and Throat," p. 275.

lastly the posterior wall of the pharynx. The appearance of the ulcers,—depressed, surrounded by sharp, well-cut edges, with circumscribed redness,—are characteristic, but pain is not a prominent symptom. A patient recently consulted the author for nasal obstruction, but no complaint was made of pain in the throat or discomfort on swallowing. An examination of the nose revealed a gummatous swelling of the inferior turbinal of one side of the nose, and a deep ulceration of the septum on the opposite side, while the right tonsil and the corresponding portion of the soft palate was ulcerated, as well as a portion of the soft palate on the opposite side. Destruction of tissue may be so extensive as to involve the tonsilar artery, and give rise to serious and even fatal hemorrhage.

Many cases of malignant disease of the tonsil have been reported, four having come under the observation of the writer. Mackenzie¹ says, that in 8,289 deaths recorded in the Paris registers, that only three were ascribed to cancer of the tonsil. Lenox Browne² thinks the proportion is about one to every five thousand cases of chronic throat disease. Other observers think the proportion is much less. Butler³ says, the most frequent form is sarcoma, but Bosworth⁴ thinks the number of cases reported in current literature would indicate that carcinoma was by far the more frequent.

The following cases from the author's record-book illustrates the onset and course of round-celled sarcoma of the tonsil:

Case I was that of Miss E. H. M., aged fifty-two, seamstress, referred by courtesy of Drs. T. and B. in September, 1894. This patient had suffered for some time from a soft growth in the nasopharynx obstructing nasal respiration, and interfering with air interchange between the middle ear and nasopharynx, but without any further discomfort.

¹ *Journal of Laryngology and Rhinology*, January, 1891, p. 26.

² "Diseases of the Throat," second edition, p. 259.

³ "Sarcoma and Carcinoma," London, 1882, p. 188.

⁴ "Diseases of the Nose and Throat," Vol. II, p. 375.

On examination of the nasopharynx and throat, a soft gray mass could be seen apparently attached to the basilar process of the occipital bone, and an enlarged reddened left tonsil, adherent to the anterior faucial pillar and pushing it forward and inward. This gave the appearance of a peritonsillar abscess, but there was but little pain on swallowing, or from palpating the growth with finger or probe. Involvement of the glands on this side of the neck was marked. A small piece was removed, both from the faucial growth and from the nasopharyngeal tumor as well, for microscopical examination. Dr. F. P. Batchelder, after examination, returned a diagnosis of round-celled sarcoma. During the following two months the tumors increased in size, particularly the tonsillar, and the patient rapidly lost weight and strength until her death occurred on Nov. 24. During the last two weeks two operations with the cold-wire snare were necessary to enable her to swallow food.

Case II. Mr. W. was seen May 19, 1902, through the courtesy of Dr. H. of a New Hampshire village. The patient said that in the previous December he noticed pain and swelling in throat. He consulted a physician, who deeply lanced the swollen tissue. The swelling did not subside, and the incision failed to heal properly, so after some months of treatment he consulted Dr. H., who brought him to Boston for examination.

Examination of the throat revealed marked swelling of the left tonsil, with involvement of the corresponding submaxillary gland. His general health was fairly good, and he did not complain of much pain. The tissue was not very red, but presented a peculiar fold-like series of swellings (Fig. XV), one overlapping another. A probe could be pushed into the swelling without causing very great discomfort, but the bleeding following this procedure was profuse, as in the first case. A piece was removed for microscopical examination, and Dr. Watters diagnosed the growth as a round-celled sarcoma (see Fig. XVI). Treatment was given, local and operative, without avail, for the patient gradually, but steadily, grew worse,

and died on June 4, 1903. At the time of his death the growth filled about two-thirds of the space from one faucial pillar to the opposite side, and the whole soft palate had become involved. The external swelling increased also, and this was finally opened, and a large quantity of pus and broken-down tissue removed. Pain was not at any time a marked symptom, odor was slight, and the bodily condition fairly good, with one exception, until a month previous to his death.

It will be noted that in neither of these cases was pain a prominent symptom.

Bosworth¹ writes, from a study of a large number of reported cases, that the most notable teaching is the striking difference between sarcoma of the pharynx and of the tonsil. In the former disease, quite a proportion recover after operation or remedial treatment, while in the latter, termination is almost invariably fatal. He explains this by calling attention to the rich lymphatic distribution in the tonsil, and its intimate relation to the glands of the neck. This author also calls attention to the noticeable absence of pain.

Carcinoma of the tonsil presents symptoms somewhat different from sarcoma. In this disease, pain is the first symptom noticed. This is at first intermittent, but sharp and lancinating, and as the growth increases it becomes an almost constant symptom, and is localized in the faucial region and ear of the side affected.

Increased flow of saliva is also an early and prominent symptom, which is not the case with sarcomatous tumors; in fact, the symptoms are almost identical with those of an acute peritonsillar abscess. In the one case seen by the author, from the early manifestations until the death of the patient, the above-mentioned facts were exactly demonstrated. Ulceration almost always occurs, and there is then noticeable an increase in the secretions, frequently mixed with blood. At this time, also, the breath becomes offensive, and signs of im-

¹ "Diseases of the Nose and Throat," Vol. II, p. 392.

paired nutrition, shown in loss of strength and emaciation, are prominent features of the disease. The sensation imparted to the finger on palpation of the mass is one of hardness and density, unlike the doughy feel of sarcoma. Rapid extension of the malignant process takes place, until the tonsil, faucial pillars, palate and tongue become an agglutinated inflammatory mass, after which death soon occurs (see Fig. XVII).

Tuberculosis of the tonsil in its active state is believed by most authorities to be due to secondary infection from the lungs or larynx. Primary tuberculosis is recognized, however, and a latent form, called by Mouret¹ "vegetative tuberculosis." Here it is an infrequent disease, and one authority calls attention to the fact, that the frequency with which tuberculosis occurs, diminishes in a marked way as the tissues approach the outer air, but that the severity of the disease increases. The symptoms are: marked and lancinating pain, stiffness of the faucial and palatal muscles, rise of temperature and prostration. After ulceration has begun, the disease may in appearance simulate the syphilitic mucous patch, and, in its later stages, the deep ulceration of tertiary syphilis. In the majority of instances, after such infection, patients fail rapidly, and death soon ends their suffering. One notable exception to this rule has recently come under the author's observation in the case of Mrs. A., who was seen in consultation a number of times with Dr. K. This patient, in January, 1903, went to the Rutland Hospital with tuberculosis of the lungs. She left this institution in six months, somewhat improved, but with a cough. In April, 1904, hoarseness became noticeable, and in May, 1904, tuberculosis of the larynx was diagnosed.

In the following June ulceration of the posterior wall of the pharynx and the right postfaucial pillar was recognized. This increased slowly, the ulceration finally involving the left posterior faucial pillar, and the tip of the uvula as well. Under the continued treatment of Dr. K., these ulcerations were con-

¹ *New York Medical Journal*, Nov. 28, 1896.

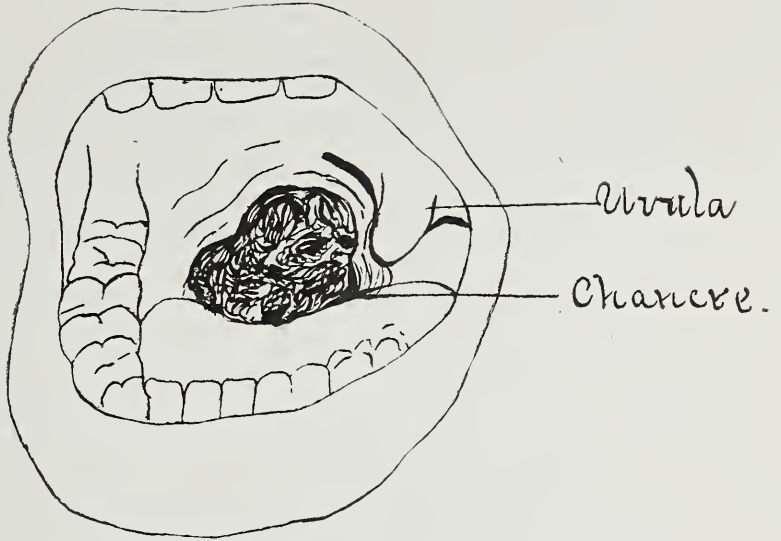


Fig XIII.
Primary Syphilis. (Grünwald.)



Fig. XV.
Round-celled Sarcoma (Early Stage).
(Author's Case.)



Fig. XVII.
Carcinoma. (Grünwald.)

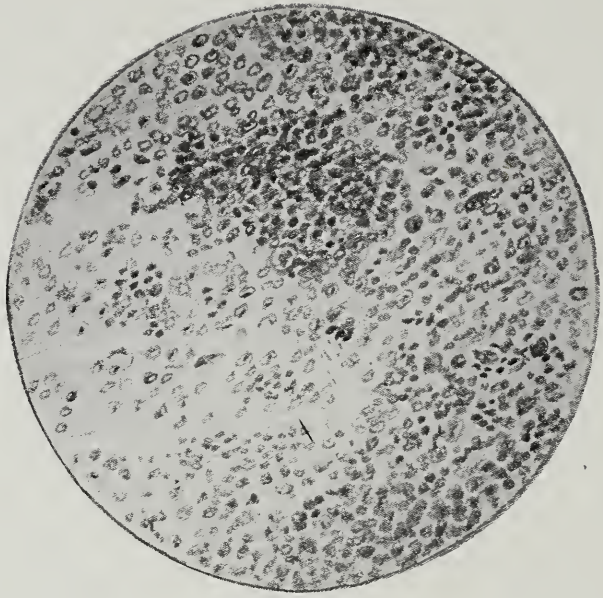


Fig. XVI.
Round-celled Sarcoma. Drawing from Microscopic Image.
(Author's Specimen.)

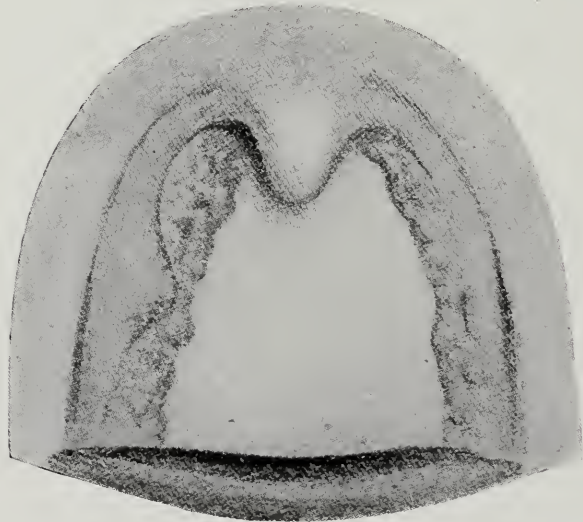


Fig. XVIII.
Primary Tuberculosis. (Chapelle.)

trolled, and the patient, though failing in a general way, is now free from any ulceration, either in the pharynx, fauces or larynx.

Many authorities record instances of finding tuberculous bacilli imbedded in tonsilar tissue. In these cases there is usually no evidence of pulmonary tuberculosis, the infection coming from without. Some writers, on the other hand, deny the existence of primary tuberculosis of the tonsil, while they admit the presence of the bacilli in the tissues. Bosworth,¹ Grünwald,² Mouret,³ Williams,⁴ Chappell⁵ and others have proved conclusively, however, that this is possible. Williams says that primary infection of the tonsils is less rare than is generally believed. He further writes, that tubercular adenitis of children is usually due to infection through the tonsils, and says it is significant that this glandular affection seldom arises, except during the earlier years of life, before the tonsils atrophy.

Chappell⁶ reports a case of primary infection of the lateral pharyngeal walls finally involving the right tonsil (Fig. XVIII).

Lupus is generally regarded as tuberculous in its nature. Its onset is insidious. There is first tumefaction, then hard, smooth nodules appear, massing irregularly together, finally forming an ulcer, with a defined margin and a dry and reddened base. These processes are very slow in development.

Syphilitic and tubercular ulceration may coexist. Such a case recently came under the observation of the writer through the courtesy of Dr. B. Here there existed pulmonary tuberculosis, secondary infection of the larynx, and syphilitic ulceration of the soft palate.

Differential diagnosis of these affections,—syphilis, malignant disease and tuberculosis,—should not, as a rule, be diffi-

¹ "Diseases of Nose and Throat."

² "Atlas of Disease of Mouth and Pharynx."

³ *New York Medical Journal*, Nov. 28, 1896.

⁴ "Diseases of Nose and Throat," Williams, p. 9.

⁵ *New York Medical Journal*, Sept. 19, 1896.

⁶ *New York Medical Journal*, Sept. 19, 1896.

cult. The history, presence or absence of pain, temperature, impairment of nutrition, or no interference with the general health, color of tissues, shape and character of the ulceration, and the rapidity of the destructive process, are valuable guides in diagnosis, and should be carefully considered. Occasionally, in doubtful cases, the effect produced by the administration of mercury and iodine will help to determine the exact nature of the trouble.

Having rather briefly considered these various diseases affecting the faucial lymphoid tissues, the author feels that the paper would have but little value were not definite conclusions deducted regarding treatment (operative) by local medicaments, and by the internal administration of the indicated homœopathic remedy.

We wish to know in how many of the affections can we reasonably expect good results from homœopathic treatment pure and simple. In what class of cases shall we advocate tonsilectomy? and is this operation ever dangerous to health? and what results may we expect from the use of local medicaments?

First, is the removal of the tonsil by surgical means a justifiable procedure? The author is well aware that many able and experienced practitioners of the homœopathic school believe that under no circumstances should the faucial tonsil be removed, although these same physicians may advocate removal of other portions of Waldeyer's ring; namely, the pharyngeal and lingual tonsils.

In the first part of this paper we have considered the function of the tonsil, and have noted that a number of authorities believe that when visible it is pathological and a menace to health. In a paper written by the author in 1902, and to which reference has once been made, the conclusions reached from a microscopical study of about sixty cases of enlarged tonsils were as follows:

1. Where connective-tissue hypertrophy is combined in varying degrees with hyperplasia of adenoid tissue, In this

class the parenchymal inflammatory condition varies with extrinsic influences, but at each exacerbation the connective tissue is added to without a corresponding subsidence, and as it invades the parenchyma it impairs its function more and more until ultimately the tonsil may no longer be adenoid tissue, but a mass of fibrous tissue, whose density depends upon the amount of contraction taken place.

2. Another class is where some influence has destroyed the parenchyma either diffusely or circumscribedly. In this case, the repair which takes place leaves areas of connective tissue, which contract more than does the fibrous tissue in case of class 1. The destruction may be by any infective processes, or by any artificial means which would impair the integrity of the cells. Of course the inflammation in this class may stimulate a general hyperplasia of connective tissue.

3. Hypertrophy of tonsilar tissue may be caused by an infiltration of epithelioid cells, as in tubercular adenitis, and there be no increase of lymphoid cells; on the contrary, a decrease due to necrosis. Finally the variety of the tonsil seemed to exert no influence on the form of hypertrophy, for the same conditions existed in the different varieties, were they lingual, faucial or pharyngeal tonsils.

From these conclusions, together with the reports recorded from other investigations, it would seem that we are justified in considering hypertrophied lymphoid tissue as a foreign growth, and, as such, demanding removal, and that the macroscopical appearance of these hypertrophies does not always serve as a true guide in our estimate of the danger to the health of those patients who come under our care. Again, whatever may be the function of the lymph nodes, that this function is in part, if not wholly, destroyed by the hypertrophic process.

An additional study has been made by the author of a large number of cases from a clinical standpoint, as over two thousand tonsilotomies and tonsilectomies have been performed in the past ten years, and it has been possible in a good percentage of these cases to note the after-effects on the general

health, susceptibility to colds, and to throat infections. Whenever this has been possible, the reports have been eminently satisfactory.

One patient, an adult, writes: "In reply to your note of Nov. 17 in regard to my throat trouble, it gives me pleasure to state that since the operation performed by you in May, 1900, I have been entirely free from tonsilitis or quinsy sore throat. The year you operated was the thirteenth annual quinsy sore throat, from each of which I had suffered the tortures of the damned."

The case of Miss H. was the patient mentioned in the first part of this paper as having had forty-eight tonsillar abscesses. Since 1898, when the last small operation was performed, there has been no recurrence of the trouble, and, in consequence, her general condition has improved in every way.

A third reports recently, concerning an operation on her little boy in May, 1903, for the removal of large soft hypertrophies: "I am thankful every day of my life that the operation was performed." This case is mentioned particularly because the operation was done because of a change in her family physician, the first one telling her that the results of such procedures were extremely unfavorable, and even dangerous. Many more similar instances from the author's record-books and correspondence could be given. This experience is corroborated by almost every physician who has given the subject extensive study and who has had a large experience.

Now the question arises, Do the tonsils reform after removal? Dr. F. E. Hopkins of Springfield, Mass., in a paper read before the American Laryngological Association in 1899, gives the experience of Burnett of Philadelphia, Pa., J. Mason Warren of Boston, Daly of Baltimore, Behrens of New York, Browne, Mackenzie, Semon and Nottingham of London, that recurrences do occur in a small proportion of cases, and that the causes are: imperfect operation, the tuberculous and syphilitic dyscrasia, and an acute inflammation of the stump,—

meaning in the latter case, it is to be presumed, an infection of the stump immediately or some time after the operation.

To obtain the best results, then, the operation must be done thoroughly. Simple removal of the large soft tonsils of children with the guillotine or tonsilotome after separating adhesions to the faucial pillars is usually sufficient, but in the small flat hypertrophies of children, and in the majority of hypertrophies of adults, more thorough methods are necessary.

In some of these cases the use of the right-angled tonsilar knives and the guillotine with counter pressure exerted on the outside by an assistant, and then breaking down adhesions and pockets with the finger, may be sufficient. In others the use of scissors and forceps, and the tonsilar punch, will be found essential. Children should be invariably anesthetized. In adults the operation can frequently be performed more effectively by the aid of a local anesthetic.

The prevention of recurrence, in those patients, particularly children, suffering from dyscrasias,—specific, tuberculous and strumous,—we must treat by hygienic, dietetic and remedial measures. It is impossible and unnecessary in a paper of this character to give indications for the use of a large number of remedies, but three remedies of unquestionable value will be mentioned, with brief indications for their use; namely, *calcareo carbonica*, *calcareo phosphate* and *calcareo iodide*.

These remedies have been proven efficacious over and over again. The *calcareo-carbonica* patients with fair complexion, flabby muscles, excess of adipose tissue and of scrofulous diathesis, are wellknown to every student of *materia medica*, but there are certain finer distinctions to which I wish to call your attention, as indications for its use. The tonsils, if hypertrophied, are very much so. They are pale in color, and soft to the feel. Luschka's tonsil is also soft. It bleeds easily on the slightest touch of probe or finger. The turbinated bodies are pale and puffy. The discharge (nasopharyngeal alone, if the nares are obstructed; both nasopharyngeal and anterior nasal, if the obstruction is not complete) is muco-

purulent in character, at times streaked with blood. This latter symptom is particularly prominent if there is an anterior discharge. It is at times profuse, but often scanty, with a sense of dryness in the nose and nasopharynx. The teeth are late in appearing, and after their appearance decay quickly.

The calcarea-phosphate patient is also of the scrofulous type, but of dark complexion, of thinness of flesh, and of firmer fiber. The tonsils, if hypertrophied, are smaller, and offer greater resistance to the probe. The enlarged Luschka's tonsil is also more resisting, and both the faucial and pharyngeal tonsils are of a more natural color than is found in the calcarea-carbonica patient. The nasopharyngeal discharge is not as profuse, and is more tenacious, but the larynx and bronchi are much more likely to be effected than in the preceding remedy. The patient has almost invariably either a slight cough or is constantly clearing the throat to rid the larynx of its viscid secretion. Excitement arouses the patient to unwonted activity of mind and body, which condition quickly gives way to languor and depression of spirits.

Both types take cold easily, the calcarea-carbonica patient being more subject to nose and nasopharyngeal inflammations, the catarrh being greatly aggravated, while the second type of patient is mostly affected by a cold, either in the faucial tonsils, the pharynx, the larynx or the bronchi, the nasopharyngeal discharge not being altered to any great extent.

We find in the third remedy mentioned, calcarea iodide, many of the iodine characteristics; namely, the thinness of flesh, the tendency to glandular swellings, the diathesis, scrofulous or syphilitic, the latter condition being a strong indication for the use of the remedy. This patient also takes cold easily, but the colds take the form of a vasomotor rhinitis; that is, swelling of the erectile tissue, with its itching, heat, watery discharge, etc., or asthma or croup may make manifest the onset of the cold. The tonsils, though enlarged, present a ragged appearance, from the numerous crypts and diseased follicles which indent their surface.

Luschka's tonsil may be very greatly hypertrophied. It is firm, unlike the calcarea-carbonica condition, where it is enlarged but soft; unlike also the calcarea-phosphate condition, hard and small. The discharge is mucopurulent in character, like the calcarea-carbonica discharge, rather profuse posteriorly, scanty anteriorly, whether the postnasal obstruction be complete or the contrary. Persistent hoarseness is a common symptom. The calcarea-phosphate patient has a cough, but is not hoarse; at least, not persistently so.

We cannot always trace a specific origin to this type of patient, but if this can be done, an additional indication for iodine is obtained. The first two of these remedies seem to act best in the third and sixth decimal trituration, but the iodine combination should be used in a more material form. The writer uses either a IX trituration of Billings Clapp & Co.'s iodide of lime, or a preparation prepared by the Abbott Alkaloidal Company, called by them "calcidin." Irritation of the digestive organs has never been observed, and the effects are satisfactory. After the proper remedy has been carefully selected, it should be used persistently for months. It should be clearly understood that tonsilar hypertrophies are not expected to be absorbed by the action of these remedies, or by the action of any other remedies internally administered, but to prevent recurrence, after removal by surgical means, and at the same time promote an improved general bodily condition.

The majority of the chronic affections of the tonsils of a benign nature, and many of the acute affections, are prevented by the above surgical and remedial measures. When called upon to treat the acute streptococcus and staphylococcus infective manifestations,—namely, follicular tonsilitis, pseudo-membranous tonsilitis and peritonsillar abscess,—we must look to the following internal remedies, aided by topical applications and surgical procedure, for relief: acon., bell., gels., apis, phytolacca, guaiacum, lachesis, merc. bin., merc. prot., merc. cor., merc. dul., merc. viv., hepar sulph., kali bichrom. and hydrastis. Indications for some of these remedies, including

the first four, may be omitted, the indications are so well known, but the mercurial group needs constant study, that the best form may be selected for the case in hand. In a paper written by H. D. Cochrane, M.D.,¹ is to be found the most comprehensive study of the different forms of the drug the writer has yet seen, and, therefore, free quotations from the article are here given.

“The striking keynote of the mercuries is their adaptability to mucous and parenchymatous inflammations, with tendency to suppuration, all the discharges being offensive and acrid, and there is increased salivation, with a thick flabby tongue, showing the imprints of the teeth. All the symptoms are aggravated at night, and from the warmth of the bed, especially the bone pains.”

Merc. prot. and merc. bin.—The union of mercury with iodine gives us valuable agents; namely, mercurius protoiodide and biniodide. Their field is primarily in the throat, involving the glandular apparatus, especially in troubles due to a syphilitic or scrofulous diathesis. The protoiodide has a special affinity for right-sided affections, with a tongue, yellow coated at the base, and a clean tip. The biniodide, owing to the double equivalent of iodine, is the greater irritant, hence it is characterized by more fever and glandular enlargement. It selects the left field for its field of action.

Merc. cor. and merc. dul.—Next on our list we find mercurius corrosivus and dulcis, combinations of mercury with another of the halogen group, chlorine. It is here we find the extreme limits of the action of the mercurial preparations meet, *merc. cor.* exerting the most profound, and *merc. dul.* the mildest, effect of any of the group upon the organism. The former is a specific irritant to the living tissues, exerting a stronger elective affinity for certain tissues than *merc. viv.*, and producing inflammatory symptoms of the most violent character, with burning, agonizing pains.

Head.—The keynote of the headache of *merc. viv.* is the

¹*North American Journal of Homœopathy*, December, 1898.

feeling of fullness, giving rise to the sensation of a tight bandage around the head, intensified by hot or cold applications.

Merc. cor. cures a somewhat similar but more intense headache, with more vertigo, and is relieved by cold applications.

In merc. prot. we find a right-sided headache, relieved by diverting the patient's mind from himself.

Merc. viv. should be used also under the general indications first named.

Phytolacca and guaiacum are particularly useful in those affections where a rheumatic tendency is suspected. The general condition¹ produced by phytolacca is one of inflammation, which in the fibrous tissues partakes of a rheumatic character, and in mucous and glandular tissue shows a tendency to suppuration. The indications are: fauces and tonsils are swollen, dark and congested, with dryness. Thick whitish yellow mucus about the fauces. Pain at the base of the tongue when swallowing, indicating corresponding congestion of the lingual tonsil. Sharp shooting pains through the ears when swallowing. Rheumatic pain in arms and hands. Symptoms worse at night and in wet weather. Where the drug is indicated, it should be used as a gargle (five drops of the tincture to four fluid ounces of water) as well as internally.

Guaiacum² acts also upon fibrous tissue, and produces rheumatic pains. It is indicated when there is stiffness of a rheumatic character in the back of the neck and small of the back; burning, redness and pricking in the throat, with dryness of the mouth, and thirst; violent stitch-like pains in the throat and cheeks; sweating about the head, usually offensive. This drug should also be given in material doses. A tablet of guaiac in black currant paste dissolved in the throat is also helpful.

Cleansing, local treatment is of importance in these cases. Much relief is experienced by gargles and sprays of a warm

¹Cowperthwaite's "Materia Medica."

²Ivins' "Diseases of the Nose and Throat"; Quay's "Nose and Throat"; Allen's "Materia Medica"; Hughes' "Pharmacodynamics."

alkaline antiseptic solution, and an occasional swabbing of the inflamed surface with argyrol (twenty-five per cent.). If the patient is tolerant of applications made on a cotton swab, the crypts and follicles can be cleansed, and argyrol applied.

A peritonsillar abscess should be opened as soon as it can be determined that pus has formed. The point of opening should in the large majority of cases be as indicated in Fig. IV. In a limited number of cases the incision must be made below and behind the tonsil.

Keratoses and mycoses are usually treated by the persistent use of some destructive agent, or by forcible removal of the tissue with forceps. Dr. Shearer¹, in an extensive study of mycosis tonsillaris, says: "Unfortunately up to the present time no remedies have been shown to exert any direct influence upon this mycosis, but I am sure that a careful study of the subject would, at least, assist us greatly in treating these cases. Where the disagreeable odor is a prominent feature, I have often modified it by prescribing kali phos., sixth decimal trit., two tablets three times daily, possibly because of its wonderful power in controlling putrefactive processes. A remedy which is worth a trial in mycosis is *ecchinacea angust.* It is best to employ the tincture five drops three times daily. This plant seems particularly adapted to those diseases that depend on microorganisms for their existence,—carbuncle, boils, septic conditions, etc.,—and it has a direct action upon the pharyngeal mucous membrane when it is the seat of acute virulent affections. Where a profuse nasal catarrhal secretion exists, *lemna minor*, 6x dilution, five drops at night on retiring, will be found an excellent remedy." Cleanliness of the mouth and teeth is important in connection with surgical or internal remedial treatment.

Keratoses, according to Knight,² is not influenced by local applications. Kyle³ says: "The most satisfactory treatment is the actual cautery and curettement followed by applications of twenty to forty per cent. chromic acid." The author believes the latter teaching to be correct.

(To be concluded in the March number.)

¹ *Transactions of the American Homœopathic O. O. and L. Society*, 1897, p. 174.

² "Diseases of the Nose and Throat," p. 267.

³ "Diseases of the Nose and Throat," p. 506.

EDITORIAL.

Books, exchanges and contributions—the latter to be contributed to the GAZETTE only, and preferably to be typewritten—should be sent to the Gazette Associates, 279 Dartmouth Street, Boston; personal and other news items to Dr. A. T. Lovering, 10A Park Square, Boston; subscriptions and all communications relating to advertising, etc., to the business manager, Mr. Chas. A. Boynton, Hyde Park, Mass.

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AN OPEN LETTER.

The attention of every practitioner of homœopathy in New England is called to the reorganization of the editorial and business management of the GAZETTE, the full announcement of which now appears for the first time. The names of the new staff are well known. They are those of men prominent in the profession, and are a guarantee of a high order of journalism, and also of a policy essentially liberal and progressive. The journal will be published for the many, and not in the interests of a few, and able contributions, reflecting all shades of opinion, will be welcome to its pages, and are here cordially invited.

Homœopathy in New England is surely entitled to representation in current medical literature. No important section of the country like this should be without such representation. The NEW ENGLAND MEDICAL GAZETTE, after forty years of continuous publication, is the natural exponent of our school in New England. But to be a powerful and successful organ, more is required than an able editorial staff or business manager. The good will, the personal service, and the individual support of every New England homœopath is necessary; *your* news item, *your* report of a case, *your* letter of

suggestions, *your* article, *your* subscription, *your* advertisement or patronage of our advertisers. The GAZETTE is to be conducted by the profession, and for the profession, and will depend upon the profession for its success. It is, therefore, fraternally urged that every reader of this letter will consider it a personal appeal, to be responded to promptly and generously. An especially earnest plea is made to every alumnus of Boston University School of Medicine, believing that the advancement of the interests of the school through the pages of the GAZETTE will insure to its graduates a higher professional standing and wider recognition, while their loyalty will be greatly appreciated by those members of the editorial staff now serving on the faculty.

In return for this coöperation, so necessary and so gratifying, the editors and the business manager will strive faithfully on their part to give to this undertaking their best thought and service, making all their confreres equally welcome in a common endeavor to increase the prestige of homœopathic principles and practice in the New England States.

LABORATORY SCIENCE.

In a recent number of the *Therapeutic Gazette*, Dr. H. C. Wood, Jr., takes occasion to express editorially the current views of the profession regarding scientific medicine. He does this in answer to an article appearing in *American Medicine*, in which the claims of the practical physician are upheld as distinguished from those of the medical scientist. As the views here advanced bear so directly on the principles underlying all therapeutics, and, therefore, on the fundamental principles of homœopathy, this slight controversial flurry in the regular camp invites some words of comment from our quarter of the therapeutic field.

Without entering upon a consideration of the arguments advanced on either side of the questions at issue, it will be

enough to cite the closing words of Dr. Woods' article, which make clear the attitude assumed to-day by all who stand for pure science in medicine. Dr. Woods declares: "It is true that the practice of medicine is an art, but to be practiced successfully, the art must be founded on science, and while our knowledge of the human organism or of the conditions which affect it are not as yet complete, nevertheless, *for hope of future advances in human medicine we must turn to the investigator in his laboratory.*" (The italics are ours.)

That this is not the expression of an individual opinion, but said in the name of this great body of the profession is sufficiently shown by the distinct aim and tendency of practically all medical research to-day, and of all medical education as well. Everywhere the foremost medical schools and hospitals, and, in their wake, those of lesser claims to authoritative standing, are directing their chiefest energies to the erection and perfect appointment of laboratories, and to the pursuit and teaching of laboratory methods. It could be readily shown that these latter have so come to dominate all medical thought and action that our literature teems with the reports of laboratory investigations and results, and that clinical diagnosis has come to rest in the largest proportion of cases on the decision of the laboratory report.

That the rapid development of technic and earnest pursuit of laboratory investigation is to be hailed as a marked sign of progress, and is full of promise for the future, we are the last to deny. It constitutes, in fact, the groundwork on which many of the most important advances of the past half century in all practical and theoretical branches rest. And yet we do not hesitate to declare with the same degree of positiveness which characterizes Dr. Woods' sanguine assertion, that the time has come to question sharply the authority of the investigator in his laboratory as the highest court of appeal in clinical medicine, in so far as this branch is concerned with the indications for treatment.

We challenge this authoritative position of the laboratory

worker in the fullest consciousness of the fact that bacteriology has revolutionized clinical surgery, that uranalysis has disclosed means and methods of vital moment for the control of abnormal metabolism; that physical chemistry of the contents and secretions of the digestive tract has given new force and direction to dietetic and hygienic measures; that the blood count has given into our hands the power to differentiate between diseases which but a few years ago were classed and treated on most vague and general principles, if principles they could be called; that the prop and stay of the general practitioner in diphtheria is antitoxin—to mention only some of the best known and widely accepted achievements of the laboratory. Yet it is certain that the leading part now conceded to laboratory work on the strength of these achievements has led, and is still further leading, the profession into precisely the same slough of stagnation and of misdirected energies to which it has been led in turn by every new discovery, and every advancement in the auxiliary sciences. It is not only diverting attention from exact clinical observation, and forcing therapeutic reasoning from the path of strict induction to that of loose deduction from half-fledged theories, but is also substituting hasty generalizations derived from laboratory tests and experiments for individualization at the bedside. Thus by its one-sided specialization it is narrowing a field of labor which is, by its nature, broad and many sided. In point of fact it is little better than to adhere to an exclusive dogma, to declare that, “for hope of future advancement in human medicine we must turn to the investigator in his laboratory.” To seek for the solution of the countless problems presented by disease and cure from one source alone, is to forget not only that biochemistry, indeed all laboratory research, is as yet in its infancy, with the limited and uncertain promise of everything immature, but also to disregard the fact that all therapeutic activity is, and must ever remain, the art of cautiously drawing inferences and establishing rules from many different observations

taken from most varying points of view. Not only must all the sciences contribute to our knowledge of pathology and the effects of therapeutic agents and measures, but above all, clinical observation and experience at the bedside must be the determining factor in establishing the standard by which the results of all other methods of investigation are to be measured. Dr. Woods implies far too much of sound and positive knowledge in using the phrase "while our knowledge of the human organism and the conditions which affect it are not yet complete." They are in reality so far from complete that Dr. Osler in his article on "Medicine" in the *New York Sun's* series on "Nineteenth-century Progress," is wholly warranted in his parenthetical remark, when speaking of drugs, "of the action of which we know little, yet we put them into bodies of which we know less." Such admissions, though when taken from their context they may be open to misleading interpretation, yet as coming from a man whose work is at the bedside and who knows their fullest meaning, they are far more wholesome for the medical body than the overweening faith of the laboratory man in his animal experimentation, his test tube and his microscope far away from sick human beings. It is the patient and all the phenomena of his individual case with which the practical physician has to deal, and the hope of future advance in human medicine rests upon the study of every agency by means of which the normal balance of the disturbed forces within the organism may be restored. The time has passed when drugs were the sole reliance in the sick-room, but, despite the alleged disbelief in their curative effects, they remain among our most indispensable resources. The incompleteness of our knowledge concerning them is surprising, and, in view of the centuries during which so many have been in common use, little short of disgraceful to a profession calling itself scientific, more especially since their effects could have been fully studied by accurate provings and clinical tests before the laboratory era. How little of practical value this has added to our knowledge of drug effects is seen at

once on opening any of the most modern works on pharmacology, despite its contributions to pathology.

As we recognize pathology to be the handmaid of therapeutics, so laboratory science can never be more than an humble helper in the household of medicine. If she ventures to assume the airs of a mistress, she must be relegated at once to her pots and kettles, where alone she can do useful work.

ANGIONEUROTIC EDEMA.—Angioneurotic edema was first described by Quincke some twenty-five years ago, and by many others since that time. It is characterized by circumscribed swellings on the skin and subcutaneous tissues, and occurs also on the mucous membranes. There is rarely any fever though the temperature occasionally rises one or two degrees. According to most authorities it is a disease chiefly of adults, children and the aged being rarely attacked. The etiology is somewhat obscure, gastrointestinal disturbances, malaria and the indigestion of certain articles of food have each been held responsible for an outbreak of this condition. It is considered as a vasomotor neurosis, and is probably a symptom occurring in the course of a disease, similar, for example, to purpura, to which by some authorities it is considered closely allied.

The disease is usually harmless and runs a short course, unless a dangerous or fatal issue should occur through involvement of the upper air passages. Osler reports two cases of fatal edema of the larynx from this disease. These occurred in a family where the disease was hereditary for five generations, twenty-two different members having been affected with it.

St. Louis Courier of Medicine.

SOCIETIES.

BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

The annual meeting of the society was held at the Boston University School of Medicine, East Concord Street, Boston, Thursday evening, Jan. 5, 1905, at eight o'clock, the president, J. Emmons Briggs, M.D., in the chair.

The records of the last meeting were read and approved.

The reports of the secretary, treasurer and auditor were read and accepted.

The committee appointed to draw up resolutions on the death of Conrad Wesselhoeft, M.D., made the following report, which was accepted:

In the death of Dr. Conrad Wesselhoeft on Dec. 17, 1904, the Boston Homœopathic Medical Society meets with the loss of a dearly beloved and valued colleague, esteemed for his many excellent qualities as an associate and teacher, and prized by the entire profession for his eminent and exemplary life.

His death has left a vacant place in our membership, in the faculty of Boston University School of Medicine, in the membership of other medical societies, and in the community at large, that cannot be filled. Those of us who have most intimately known him for over a quarter of a century of inspiring comradeship, mourn his loss almost as a personal affliction, while the younger members of our society remember him as a beloved instructor and adviser.

We desire to record our gratitude that one so loyal to the welfare of homœopathy should have been among the founders of our society in 1873, and filled positions among its officers for many years.

We desire hereby to engross upon the records of this society this tribute of respect to his memory, and request that the secretary tender a copy of these resolutions to his afflicted family.

HORACE PACKARD,

FREDERICK P. BATCHELDER,

Committee.

Dr. W. H. Watters described and demonstrated the work of the reflectoscope, and stated that plates from books, either bound or unbound, also the text, can be thrown upon the screen without the expense of making slides, by the aid of this instrument.

The president, in his interesting address, contrasted the crude, painful and frequently unsuccessful surgical means employed one hundred years ago, with the painless, rapid and skillful operation of to-day, which the surgeon performs with confidence as to a successful outcome. By means of charts, the alarming increase in mortality from cancerous affections was clearly demonstrated. The statement has been made by one surgical authority that unless something is done to check this increase, the mortality will reach that of typhoid fever, pneumonia, consumption and smallpox combined. Early and radical excision, followed by X-ray treatment, was advocated as the best means known at present of treating the distressing conditions resulting from cancerous diseases.

Dr. H. C. Clapp, for the election committee, reported the following officers of the society elected for the ensuing year: President, J. Herbert Moore, M.D.; first vice-president, Frederick A. Davis, M.D.; second vice-president, Jane S. Devereaux, M.D.; secretary, Benjamin T. Loring, M.D.; associate secretary, E. P. Ruggles, M.D.; treasurer, Alonzo G. Howard, M.D.; auditor, G. H. Wilkins, M.D.; censors, F. A. Hodgdon, M.D., C. Y. Wentworth, M.D., and S. H. Blodgett, M.D.

J. Herbert Moore, M.D., the newly elected president, responding to a request by Dr. Briggs, briefly addressed the meeting, and said he was very glad of an opportunity to speak just a word in appreciation of the courtesy of the nominating committee, and to thank the members of the society for the honor conferred by his election as president of this old society. He pledged for the executive committee that their best efforts would be directed during the ensuing year, not only to the management of the society, but also to continuing the methods now in vogue in presenting at the meetings the coming year as

interesting programs as possible. While always mindful of what is truly valuable in medicine, Dr. Moore believed, with no disparagement, that the factor which distinguishes this society from the old school, can be kept clearly in mind, and it will be the endeavor of the executive committee to follow out the good work that has been done the past year in emphasizing homœopathic principles. The executive committee desires the hearty coöperation of the members, for success depends not only upon the management by the executive committee, but upon the interest that is manifested by the members, both in the preparation of papers and in the discussion on the floor, and what is still more important, their presence, which is so helpful to those having matters in charge. "Again," he said, "I thank the society for the honor conferred."

Upon motion of Dr. T. Morris Strong, it was voted that the suspension of By-Law VIII, which refers to the organization and work of sections, the place of meeting, and arrangement of the program, be left with the executive committee, with power.

The exercises were pleasantly varied by selections by the Technology Male Quartet.

At 9.15 o'clock the meeting adjourned to the new building, where a collation was served to the members and their friends.

B. T. LORING, *Secretary*.

BOOKS AND READING.

Medical, literary and scientific publications will be reviewed in this department. Books and journals should be marked NEW ENGLAND MEDICAL GAZETTE, and sent to the Gazette Associates, 279 Dartmouth Street, Boston.

THE CRAFTSMAN. Syracuse, N. Y.: Gustav Stickley, publisher.
Price, \$3.00 a year; 25 cents a copy.

One of the most seductive features of *The Craftsman* is the series of plans for homes in and out of town. Just now, plans for city houses are being presented, with all the fascinating details of finish and furnishings. The January number gave an interesting sketch, with insert portrait, of "William Morris, the Man," by Mr. George Wharton James; a paper on "Pewter Craft"; a description of the Flower Memorial Library, recently completed at Watertown, N. Y., and a sculptured fountain lately erected in Syracuse. These and other articles were freely illustrated; indeed, every number of this art magazine is as rich in engravings as in descriptive matter. A rich variety of subjects is given, with practical and instructive accounts of the methods pursued by the artisan in bringing his work to true artistic perfection. During 1905 the principal topics treated will be the city, the home and the child.

EDUCATION. A monthly magazine devoted to the science, art, philosophy and literature of education. Boston: The Palmer Company, 50 Bromfield Street. Price, \$3.00 a year; 35 cents a number.

We have called attention to *Education* before in this department as a magazine well adapted to familiarize one with the rapid progress in educational methods in this country and abroad. In the January number, the leading article, on "Work and Play," will meet with the approval of our profession, since it points out the danger of overtaxing the growing child at puberty, at the same time indicating how this tendency may be judiciously avoided.

The February number has some fine papers by educators of note, discussing "The Ethical Function of the School"; "Economics in the High Schools"; "Children's Dramatic Games, Ancient and Modern"; "College and University Work in Music," and "Music in the Public Schools." The "Foreign Notes" are always well worth reading, and much may be learned from *Education* as a whole to broaden one's view of the educational field.

ABSTRACTS FROM BOOKS AND JOURNALS.

THE MODERATE DRINKER.—After the age of forty the moderate drinker tends to incur the cumulative action of alcohol and indirect poisons in establishing degenerative changes which, in their generality, constitute senility. He is older than the total abstainer in his liver, kidneys, stomach, heart, blood-vessels, perhaps in his spinal cord, is less capable of the exertions of the younger man, and his expectation of life is diminished.

The Hygienic and Dietetic Gazette.

PROPHYLAXIS OF DIPHTHERIA.—1. Preventive injections are of value in immunizing children exposed to the danger of diphtheria. They are never followed by bad results, and produce, at most, ephemeral skin eruptions; more rarely joint pains. Unfortunately, the period of immunization is short, not exceeding three or four weeks.

2. Injections are indicated in families where one member has contracted diphtheria, and in institutions where many children are congregated, where diphtheria has broken out.

3. Even in the absence of distinct cases of diphtheria in institutions, injections may be of value, for instance, in scarlet-fever pavilions, etc.

4. The giving of injections does not imply the dispensing with other prophylactic measures (disinfection and isolation), but renders these easier and more efficacious.

Revue Mensuelle des Malades de l'Enfant.

DURATION OF QUARANTINE IN DIPHTHERIA.—1. The severity of the disease bears no relation to the duration of infection.

2. An arbitrary and fixed time-limit in the quarantine of diphtheria is incorrect and unfair.

3. Positive cultures after a single negative has been obtained are shown to occur as a rule rather than as an exception.

4. The importance of taking cultures from the nose as well as the throat for the release of pharyngeal cases is demonstrated by the number of cases in which the nose remained longer infected.

5. Two negative cultures taken on alternate days from both nose and throat after two weeks have elapsed from the outset of the disease is suggested as a requirement which is not unfair to any, and which permits the release of only six per cent. of infected persons.—*Dr. Thomas Salmon, United States Public Health and Marine Hospital Service.*

EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.—The first sign of commencing phthisis consists often of fine *râles* in the suprascapular region. As in this situation the breath sounds are fainter than in any other, and adventitious sounds are correspondingly difficult to hear, one may frequently with great success verify the presence of doubtful *râles* by the simple device of making the patient lie on the affected side, with the arm drawn downwards and forwards, so as to leave as large a space as possible above the scapula. In this position the breath sounds, and with them the adventitious sounds, are very much louder over the lung in the inferior position than over the other. In a case lately examined the writer fancied he heard the finest *râles* over the left apex posteriorly while the patient was sitting up; but the respiratory murmur was very faint in this situation, and the supposed *râles* were fainter still. With the patient on her left side the inspiration was quite loud and clear, there were no *râles*, and the writer enjoyed confidence instead of suffering the fear that on the next examination the fact that the patient had phthisis would be manifest.—*British Medical Journal.*

PERSONAL AND GENERAL ITEMS.

FOR SALE.—A good opening in a New England town. Collected \$1,400 the first year. Only little money needed. Address P. Q. R., care of C. A. Boynton, Dana Avenue, Hyde Park.

DR. SETH R. BECKWITH of New York, formerly of Cleveland, Ohio, died at Atlantic City Jan. 20, aged seventy-five. He was one of the organizers of Pulte Homœopathic Medical College at Cincinnati, and opened the first private insane asylum in the state in which homœopathy was practiced.

THE secretary of the treasury to-day sent to the senate a request that there be added to the estimate for preventing the introduction and spread of epidemic diseases a provision permitting the use of the appropriation for special inquiry into the cause of prevalence or spread of tuberculosis and typhoid fever. The secretary asks that \$100,000 be added to the appropriation in order to promote inquiry.

THE Massachusetts state board of charities has on its hands three alien lepers, in different parts of the state; one at Harwich, and two on Gallups Island. With the idea of bringing them together, it has recently purchased a tract of land on Cape Cod, thus incurring the strong disapproval of residents and summer sojourners in that part of Massachusetts. It is said, and with considerable truth, that it will be most disadvantageous to the interests of the Cape to have a leper colony there.

THE first congress of the International Surgical Society will take place at Brussels in September, 1905, under the presidency of Prof. Th. Kocher of Berne. The congress will be devoted exclusively to the discussion of selected questions. These are: (1) the value of the examination of the blood in surgery; (2) treatment of hypertrophy of the prostate; (3) surgical intervention in noncancerous affections of the stomach; (4) treatment of articular tuberculosis; (5) treatment of peritonitis; (6) diagnosis of surgical diseases of the kidney.

DR. SAMUEL WORCESTER of Portland, Me., has given up private practice and joined the medical staff of Dr. Givens' Sanitarium at Stamford, Conn. Dr. Worcester was at one time professor of mental and nervous diseases at the Boston University School of Medicine, and is one of our leading authorities in this specialty. In 1881 Boericke & Tafel published his "Insanity and Mental Diseases," the first work written on the subject by a homœopathic physician, and still in use as a text-book in many colleges. Dr. Worcester is a senior member of the A. I. H., ex-president of the Vermont society, ex-vice-president of the Maine society, and an honorary member of several other state organizations. A man of scientific attainments and of marked literary ability, it is to be expected that his work at Dr. Givens' Sanitarium will

not only benefit the patients in the institution and still further enhance its reputation, but prove of lasting value to the medical profession.

THE annual meeting of the corporation of the Massachusetts Homœopathic Hospital was held Jan. 24. The treasurer reported that the expenditures during the year were \$150,835.90, and that the receipts from all sources were \$132,314.26.

The report of the superintendent, Dr. William O. Mann, showed that 69,631 days' board had been furnished patients. Of this number, 33,000 were furnished free; 26,000 were paid for in part, and 10,000 were paid for in full. The daily average number of patients throughout the year had been 190, and the number of nurses averaged 87. For the past five years from \$5,000 to \$10,000 has been spent each year in renovating the hospital, so that the institution is now fitted up with all modern conveniences for the treatment of the sick. In the hospital at the present time there are thirty-one free beds, which is an addition of four since the annual meeting a year ago. The endowments for the establishment of these four beds, amounting to about \$20,000, and one or two small legacies, represent practically the entire gifts received by the hospital in the past twelve months.

The hospital has taken an important step during the past year in purchasing a sightly location, opposite the Arnold Arboretum, in Jamaica Plain, known as "Green Hill," and consisting of thirty-seven acres. On this site it is desired to build a modern hospital on the cottage plan, and it is intended that a maternity department, of which the hospital is very much in need, shall be one of the group of these cottages. It is estimated that the main cottage on the new site ought to cost somewhere between \$50,000 and \$75,000.

THE NEW ENGLAND MEDICAL GAZETTE

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VOL. XL.

ORIGINAL COMMUNICATIONS.

GAS-BACILLUS INFECTION IN A COMPOUND FRACTURE.

BY J. A. O'LEARY, M.D., WAKEFIELD, MASS.

[Read before the Massachusetts Surgical and Gynecological Society.]

Emphysematous gangrene is not so common that the average practitioner can hope to see many cases, and I can understand how a man could go through a long medical life without seeing one. In my own experience, covering seventeen years of active observation, I have been privileged to see but one, and that fact may serve as an excuse for this paper.

I can hope, of course, to add no information to what has been already contributed by men who have seen several or many cases, but I would like to draw your attention to the subject, so that you can look it up and be prepared for your first case, which may come to you any day.

It is an ugly complication of a bad injury, and the early recognition of it is of the greatest importance to the patient as well as the physician.

A brief sketch of my case is as follows:

Friday, July 13, 1900, was an unlucky day for two of my young patients. Both active, mischievous boys were climbing trees, and both fell to the ground, each breaking his right arm.

The first lad fell upon his right hand, and received a greenstick fracture without any break in the skin. This was reduced under ether, and resulted in a good arm, there being no

complications. A few hours afterward the second lad fell from a tree in the same way upon his right hand, and when I saw him shortly after the accident, showed a bad green-stick fracture about two inches above the wrist, the lower fragment being at a sharp angle with the upper. There was a small opening in the skin, a punctured wound, about half an inch long upon the inner side of the arm over the apex of the angle. The wound was clean, there was no evidence of earth about the opening, and I was unable to decide whether the wound was made by some object that punctured the skin from the outside, or whether it was caused by a fragment of bone at the point of fracture. The opening however was there, and called for surgical cleanliness before reducing the fracture.

The arm was scrubbed, and then washed with a 1-1,000 bichloride solution, and a pad wet with the same placed over the wound. The boy was etherized, the fracture reduced, a long anterior and a short posterior straight splint applied, and the arm put in a sling. He rested quite well that night, and said the arm pained him very little. The next morning, Saturday, when the dressing was removed there was only the usual swelling, and the arm looked all right. The pad was removed, and the splints reapplied. That afternoon the arm began to pain him a good deal, and I was sent for because his parents thought the bandage was too tight. The bandage did seem tight on looking at the dressing, and the fingers at the exposed parts were somewhat rounded and cool to the touch, but were not discolored. On removing the dressing the arm seemed a little plumper than it should be, even after making due allowance for the swelling that follows a fracture. The fingers were cool at the tips, but the hand was warm, and the wound area appeared all right.

The patient was restless and uncomfortable, and duller than usual. I reapplied the dressing very loosely, and conveyed to the family my suspicions that things were not going well. After talking the matter over carefully, we decided to put off calling in a consultant until the next morning.

Now here is where I think I made a mistake that under the same circumstances, with my present knowledge, I surely would not repeat. Never having seen a case like it before, I failed to grasp the full significance of the symptoms, and did not recognize the value of time to the patient. While I suspected that I had gangrene for a complication, I did not know that its course was so rapid, and so in stating the case to the family I failed to urge immediate consultation, and thought we could safely wait until morning.

The boy passed a bad night, and on my visit in the morning there was no question about what we had to deal with.

The arm was very much swollen and soft to the touch, the fingers were very cold and rounded, and the disease had advanced nearly to the elbow. I stated the condition briefly and plainly to the family, and it was agreed that there should be something done at once. I was fortunate enough to get Dr. Winfield Smith, who had the summer service at the Homœopathic Hospital, and he very kindly brought with him Dr. Souther, who was at that time in the pathological department of the Boston City Hospital.

As both these gentlemen had seen other cases of the same infection, they were able to clear up all doubt as to the diagnosis and treatment, and immediate amputation was advised and done that afternoon. By this time the patient was in bad shape, and the family was given very little hope as to the outcome of the operation, which was done as a last resort. He stood the ether badly, and at one time it seemed as if he would die upon the table. He rallied, however, the operation was successfully completed, and he made a slow but good recovery, and to-day is almost as active and mischievous as ever.

Dr. Souther injected some guinea pigs with the culture from the arm, and they promptly swelled up and died, leaving no doubt that the cause of the infection was the *bacillus ærogenous capsulatus*. The arm at the time of removal was in a gelatinous, almost liquid, state, that made it difficult and

disagreeable to handle, and there was no small amount of danger to the operators from infection, should there be any opening in the skin of the hands or arms. I think there are few emergencies that we have to face that present such serious possibilities as this. A boy breaks his arm, has for a complication a skin wound that admits this destructive bacillus which gives no hint of its presence for twenty-four hours, and in forty-eight hours the patient has lost his arm and nearly his life. Surely this accident is as tragic in its possibilities as anything that comes before us in our daily experience.

Emphysematous gangrene was recognized clinically long before the discovery of the gas-bacillus, and it was known by many names, as "septic emphysema," "progressive gangrenous edema," "gaseous phlegmon," etc. Bottini in 1871 was the first to demonstrate the infectious nature and transmissibility of the disease.

But it remained for the development of bacterial research to discover what is now fully admitted to be the cause of this much-dreaded wound complication.

In November, 1891, Welch of Baltimore reported to the Johns Hopkins Hospital Medical Society his observations on the *bacillus aerogenous capsulatus*, and in July, 1892, a full report of the knowledge obtained up to that time was published in the *Bulletin* of the Johns Hopkins Hospital by Welch and Nuttall. In January, 1893, E. Frankel published a monograph on "Gaseous Phlegmon," and, in the summer of that same year, papers were published by P. Ernst, Graham and several others, all observers finding the *bacillus aerogenous capsulatus* to be the cause of their cases of emphysematous gangrene.

From that time on much attention has been given to this subject by pathologists in this and other countries, resulting in confirmation of Welch's original investigations and discovery, so that to W. H. Welch may be fairly awarded the credit due for this very important discovery.

I would recommend to your attention Dr. Welch's address before the Massachusetts Medical Society in June, 1900, on

"Morbid Conditions Caused by the *Bacillus Aerogenous Capsulatus*," being the Shattuck lecture for that year. This was published in full in the *Boston Medical and Surgical Journal* of July, 1900, and several other leading medical journals later. I was fortunate enough to see the article when it was published, and, coming as it did just when I was conducting my case, it was very interesting, and I need not say very welcome.

This bacillus is found in the soil, both out doors and in, in earth cellars, in dust, on clothing; has been demonstrated post-mortem in the intestines, and has been found in the feces. It has a wide distribution. No country can claim it as its own, as it has been reported from many parts of the world. I will not enter into the details of the symptoms, as the literature on the subject published in the last three or four years gives them fully. The first thing that attracted my attention in my case was the increasing symmetry of the fingers, the coldness of the finger tips, and the slight darkening of the skin. This was less than twenty-four hours after the accident, and in twenty-four more the whole arm was involved even to the shoulder, and we very much feared beyond that. I cannot emphasize too much the rapidity of the process once it starts in, and we should also view with alarm the sudden cessation of previous pain and sensitiveness in the injured part. The patient takes on a profoundly septic state, and shows symptoms of shock, the skin darkens and changes color very rapidly to a dark green or bronze black. The limb swells, blisters form, and soon the tissues are reduced to a pulpy mass that oozes a dark liquid pus. There is a characteristic odor that is not apt to be forgotten, and the whole picture is a dreadful one. The prognosis of emphysematous gangrene is of course more favorable to-day than before the antiseptic period.

When the disease is accessible to surgical treatment, and is promptly recognized and treated, the prognosis is not considered very unfavorable. The cases on record have been comparatively so few that the percentages obtained are not a

fair test of the mortality, and even under hospital observation the rate has been high. In the Johns Hopkins Hospital ten cases showed a mortality of fifty-nine per cent., and no doubt in private practice in the past, when even the condition itself has not been recognized, the death-rate must necessarily have been high. Before appendicitis was recognized, and the need for early operation known by the average practitioner, the mortality was far greater than at the present day. So in this condition early recognition and prompt operation will have a large influence upon the prognosis in the future.

The first aim in treatment of course is prophylactic, but there seems to be no mode of cleansing a wound that will insure against the entrance and development of this bacillus.

Cases have been reported from several hospitals of gunshot wounds and compound fractures where every effort was made to prevent the development of gangrene, but notwithstanding the use of the strongest antiseptics, the most careful cleansing of the wound, it has developed, and even resulted fatally while under the eye of the most careful surgeons.

There has yet to be discovered a means to destroy this bacillus or to prevent its destructive work after entering a wound. The only safeguard that we have is to take advantage of our present knowledge of the bacillus by making microscopical examinations in those cases most likely to have this complication, and demonstrate the presence or absence of it in the wound before active symptoms set in. After gangrene has commenced, free incision, antiseptic cleansing and drainage have given the best results, and in many cases have proved sufficient. The reason for the good results may be attributed to the fact that the bacillus is anærobic, and exposure to the air has stopped the multiplication and growth. When the case has got well started, nothing short of amputation can check it, and it is only a question of how much of the limb can be saved. Here is where early diagnosis is of so great importance, for truly hours may be said to be worth inches of limb to the patient.

SHALL WE FRATERNIZE?

BY JOHN J. SHAW, M.D., PLYMOUTH, MASS.

The truths of homœopathy, received at first with apathy or incredulity, have come to be recognized throughout the civilized world as a potent factor in medical progress. In the beginning, few believed that homœopathy had sufficient vitality to survive the hostility of those whom prejudice or self-interest made bitter opponents. Only its self-sacrificing supporters, a handful of broad-minded men who worked with tireless energy and unremitting zeal, had faith in its future. Fortunately for homœopathy, the period of its inception was a period in which men were strong to fight for, as well as against, new principles; strong to uphold their convictions, and to maintain them at any cost. Notwithstanding this courageous and convincing attitude towards the teachings of Hahnemann manifested by an increasing number of practitioners and of the laity, it was many years before the dominant school of medicine ceased to be deluded by the idea that homœopathy was a temporary aberration which would pass away; a delusion which could be dissipated by ridicule; a system whose claims could be discredited. But when, at last, its enemies became conscious of its rapidly increasing growth, as evidenced by the number and character of its hospitals for the sick or for the insane, its dispensaries, its sanitariums, its literature current and permanent, its medical colleges with fine equipment and high standards of education, then its foes realized that homœopathy had become an enduring school of practice, which must be reckoned with from a new viewpoint, and by new tactics.

This viewpoint took cognizance of the fact that much had been apparently lost, and certainly nothing gained by active hostility. Open warfare began to cease, and a radically different attempt at extinction was embodied in the plan of absorption.

So long as open war existed between the two schools, the loyalty of the practitioner of homœopathy and his disapproval

of old-school methods kept him from fraternizing with his opponents. But with the recent change in the latter's tactics, a new danger has arisen, threatening the younger, if not the older, men in our ranks. A claim of superiority, if not a bid for unity, is made on the ground that the old school represents the scientific side of medicine, and that their drugs can be and are used universally.

Profiting by the acceptability of our medicinal preparations, they have striven to put on the livery of homœopathy, and to outward appearance have often succeeded in giving their remedies the semblance of ours. Through such writers as Bartholow and Ringer they have appropriated the fruits of our labors to their own exceeding advantage, an appropriation to which we should not object if due acknowledgment were made.

They have adopted all the hygienic agencies, such as air, rest, diet, electricity and massage, after denouncing—and this only a few years ago—their advocates as quacks. And now they attempt to delude the public into the belief that they were the first to apply these agencies, and that such reforms in methods originated in their own ranks.

Drug failure led them to work in the field of surgery, and the results have been brilliant and satisfactory. But success there has caused many of their brightest men to ignore medical treatment. One of New York's most prominent gynecologists stated before his post-graduate class, that when a woman applied to him for treatment, he never gave medicine a thought, but only examined her to see what operation he should perform.

The old school is misleading the younger men by the multiplication of new and attractive palliatives, whose primary action is pleasing, but whose ultimate effects are deadly. Unfortunately the final results are often so remote as to obscure their cause. Thus we see that the old school follows its wonted system of drugging, however disguised; that when apparently brilliant results have been obtained, it has been

at the expense of safety, or that the really good work accomplished in therapeutics has been brought about by appropriating the discoveries of those whom, for many years, they denounced as quacks:

The younger members of the homœopathic school are in danger of being led astray by all these things; but most, perhaps, by the would-be friendly attitude of the old school, not realizing that, while the latter professes an earnest desire to see the lion and the lamb lie down together, it is only that the lamb may be so surrounded by lion as to become non-existent.

The skeptical and antagonistic attitude of the older homœopaths is somewhat unacceptable to their younger colleagues, who have not watched the evolution of the present methods of attack which are not less, but more fatal to the integrity of pure Hahnemannian principles and practice.

In order that these methods may prove ineffective, we need particularly to impress on those seeking to enter the homœopathic profession, that they should do so not merely because of the prospect of satisfactory financial returns. The man who is not a homœopath because he believes in homœopathy and disbelieves in allopathy, will never strengthen our school of practice. It is good to see a practitioner of homœopathy strong in his convictions, and prepared to give a reason for the faith that is in him. Unless those in our ranks are thus equipped, and, therefore, not to be misled, surely there is grave danger in fraternizing with the old school.

THE FAUCIAL TONSIL.

BY GEORGE B. RICE, M.D., BOSTON, MASS.

(Concluded from the February number of the "New-England Medical Gazette.")

The treatment applicable to primary chancre is the same wherever it may have occurred, and this treatment is universally acknowledged by thinking and experienced practitioners of all schools to be by the proper administration of some form of mercury carried over a considerable period of time (two to three years).

To one interested in the study of the treatment of this disease, past and present, the fact will be disclosed, that there has been a gradual modification of the large doses formerly employed by practitioners of the dominant school, and on the other hand that a large proportion of homœopathic practitioners are employing material doses of the drug in place of the highly potentized preparations.

Although mercury had been used for the treatment of syphilis for many years before Hahnemann's time, yet it is this master who pointed out the homœopathy of the drug to the disease. Hahnemann experimented mainly with the black oxide in material doses on himself and eight associates.

The similarity of the effects of mercury given in material doses and to the condition produced by syphilis are given by Franklin,¹ as follows:

Syphilis.

Syphilis produces on the skin pustules, scales and tubercles.

Excites inflammation of the periosteum and caries of the bones.

Produces inflammation of the iris.

Produces inflammation and ulceration of the mouth and throat.

Mercury.

Mercury produces severe forms of skin diseases.

Produces inflammation of the bones and periosteum.

Produces a disease called mercurial iritis.

Produces ulceration of the mouth and throat.

Produces enlargement of the inguinal and other glands.

¹ "Venereal Diseases," E. C. Franklin, M.D.

Syphilis.

Produces enlargement and hardening of the glands.

Produces chloro-anemia, a diminution of blood corpuscles, and an increase in the proportion of serum.

Produces ulcers on the genital organs.

Mercury.

Diminishes the coagulation of the blood, and increases the proportion of serum.

Produces ulcers and induration of the genital organs.

In addition to these symptoms, we find from the later experiments that mercury is capable of decomposing the blood and diminishing the number of red corpuscles, thus producing marked interference with cell nutrition.¹ These effects are also produced by syphilis when the poison has asserted its constitutional influence. Microscopical study has also demonstrated the fact that mercury administered in doses sufficient to pervert nutrition in the healthy individual, produces in the syphilitic patient just the contrary result. These facts are explained by some old-school authorities as an effect of the law of substitution, but by the followers of Hahnemann as a practical demonstration of the law of similars.

Hahnemann in his work on "Venereal Diseases" taught that the cure of syphilis depended upon the supervention of mercurial fever.² Constantine Herring in his preface to the British edition of the *Organon* says: "Of all the medicines used in the treatment of syphilis, mercury is the only one that has stood the test of time and experience." Berjeau, one of the homœopathic extremists, gives indications for ten remedies in the treatment of syphilis, recommends consulting sixty-seven more, and also advises a selection from twenty-eight in addition, for their antidotal effects on those syphilitics who have been treated by mercury in material doses.

Authorities from the dominant school are almost without exception united in the belief that in mercury we have the

¹ "Sajou's Annual," Vol. IV, p. 602.

² "Hughes' Pharmacodynamics," p. 626.

only drug capable of eradicating the disease, although there is a considerable variance of opinion as to the advisability in giving mercury on the first appearance of the chancre or the so-called primary stage.

The majority of syphilographers, however, believe that the drug should be administered as soon as the diagnosis is made. To the writer this seems reasonable from the fact that it has never been determined that the virus is not immediately absorbed, so we must infer that the disease becomes constitutional almost from the period of infection, without an appreciable time of incubation.

It is a somewhat difficult matter to determine the best form in which the mercurial salt shall be administered and quite as difficult to determine the proper dose. It does not seem possible to lay down a hard and fast rule to be followed in all cases, for many modifying conditions must be taken into consideration. The object to be attained is, to give enough mercury, in a form which the system can assimilate, to antagonize the specific virus, but not enough to produce mercurial poisoning. This amount can only be determined by making repeated and accurate examinations of the blood, the excretions, and of the patient's general condition. A short quotation from an article, to which reference has already been made, is to the point.

Regarding the amount of hemoglobin present in syphilis in relation to the benefit derived from mercurial treatment,¹ three incontestable facts are demonstrated: (1) that if a syphilitic patient has no treatment, the hemoglobin in the blood will diminish from time to time; (2) that if mercury be given to persons not suffering from syphilis, the amount of hemoglobin will be diminished in a few days; (3) that if a syphilitic person, who shows that the amount of hemoglobin is diminished, be put on a mercurial treatment, an increase in the amount of hemoglobin can be determined at once, and very markedly

¹ "Sajou's Annual," Vol. IV, p. 602.

in the course of seven or eight days. From these facts we have a very valuable indication as to just when mercury ceases to do good and therefore should be temporarily discontinued.

Most authorities agree that the mercurial inunction is the safest and most effective way of bringing the patient under the influence of the drug. The rule applicable to the average case in an infant is an inunction of dilute gray mercurial ointment, grains XV, mixed with an equal quantity of simple ointment or vasogen, and for an adult, from four to eight times this amount, used often enough to control the symptoms.

Merc. prot. can be given in doses from 1-100 to 1-4 grain, three or four times daily, according to the age of the patient, susceptibility, and severity of the disease; merc. bin., in doses from 1-100 to 1-20 grain,—and this form is particularly applicable to those cases when the glandular involvement is marked.

Hyperdermic injections are on the whole unsatisfactory. The above treatment should be continued after all symptoms have disappeared for additional periods equal to one-half or one-third the time occupied by the original treatment.

The effects of iodine in this disease are not generally well understood. Iodine is not strictly homœopathic to the tertiary form, as is mercury to the primary and secondary stages. Iodine does not cure; it inhibits the toxic effects of the syphilitic poison, and has the property of dissipating and causing absorption of gummatous deposits. It is of the greatest value, therefore, in the treatment of the conditions occurring during the latter part of the secondary stage and in the tertiary stage. Its use prevents tissue destruction, and gives the physician time to combat the poison with mercury and hygienic measures.

The usual form of administration is by the use of the iodide of potassium salt, given in doses of from five drops of the saturated solution or five grains of the salt, four times a day, increasing to sixty grains a day if necessary. As this preparation is frequently very irritating to the stomach, it should be

well diluted with water or combined with some digestant, like an essence of pepsin. When it is not tolerated at all, as is frequently the case, the iodide of strontium, the iodide of lime, Wyeth's iodine and petrogen, or a preparation called "nigridine" prepared from the thyroid and thymus glands of the sheep, may be substituted. Iodine should be used until the desired effect is produced, and then continued, preferably combined with the mercurial treatment, for some months, when the mercury can be given alone for a limited time.

Care of the mouth is of great importance. The skin should be kept active and healthy, and great attention should be given to diet, bathing and outdoor exercise, etc. The consensus of opinion is that the disease can be eradicated from the system in the majority of cases, and that the general health of the patient need not be impaired by the process of cure.

In considering the treatment of malignant disease of the faucial tonsil we are confronted with such an array of suggestions that we are bewildered by their variety. Experience teaches that where in a given disease there is no uniformity of opinion regarding the best methods of cure, that no methods are satisfactory, and this is particularly the case with malignant disease located in the faucial region. Inflammatory tissues here are so well supplied with blood, are so exposed to the air, and are so irritated by the movements of mastication and deglutition that the probabilities of successful interference by medication or surgery are rendered very small indeed. A few cases are recorded of cure of some of the sarcomatous forms of tonsilar involvement, but not enough up to the present time to render the prognosis at all favorable.

In an analysis of forty-five cases collected by Bosworth,¹ five appear to have been successfully operated upon; but there is no definite knowledge of ultimate results. This author concludes his study of these cases by writing that sarcoma of the tonsil must not always be regarded as absolutely hopeless,

¹ "Diseases of the Nose and Throat," Bosworth.

and that the first and prominent indication seems to be through extirpation of the growth by such means as will accomplish the end with the least degree of injury to the surrounding parts.

Hayes Agnew¹ states that, to his knowledge, only one case is on record when recurrence has not taken place, and in this the growth was removed by the thermocautery.

Knight,² after a review of the literature on the subject, thinks that there is a fair hope of prolonging life where the disease is confined to the tonsil, and that those cases where the surrounding parts are involved, we may mitigate suffering.

Kyle says the prognosis is bad, and dismisses the treatment by calling attention to the necessity of early recognition of the disease and of radical surgical measures as soon as recognized.

The cure of carcinoma of the tonsil is still more unfavorable. In fact, after considerable research of the literature and books on the subject of the past fifteen years, the author is unable to find a single case of authentic cure.

Both sarcoma and carcinoma occurring in other regions have been undoubtedly cured by operations, injections and by the X-ray treatment, but when the tonsil is the seat of the malignant growth, the results of any sort of interference are extremely unsatisfactory. Browne³ concurs in this opinion.

It would seem that these facts teach the necessity of early and thorough removal of chronic hypertrophied and inflamed tonsils, and particularly when occurring in adults.

Treatment of secondary tuberculosis of the tonsil must be directed both to the secondary local lesion as well as to the patient's general condition. In reviewing the subject of local treatment in these conditions in the text-books and periodicals, we find that cases of laryngeal tuberculosis have been cured by one of several methods, curettement followed by

¹ *Philadelphia Medical Record*, May 25, 1889.

² "Diseases of the Nose and Throat," Knight, p. 288.

³ "Diseases of the Nose and Throat," Price Browne, p. 4.

application of lactic acid, lactic acid used alone, iodoform and ether, cupric electrolysis, and the application of formol. A number of cures of the local ulceration have come under the writer's¹ immediate observation from the use of formol, and so in advocating a method of cure of the more severe forms of tuberculosis involving the fauces and tonsils, he believes that there is a greater probability of controlling the lesion by the use of this medicament than by any other.

In the case mentioned in the preceding pages of the control of a secondary tubercular ulceration of the soft palate and fauces by local application, formol was the drug used, and it undoubtedly saved the patient from much suffering. It is, of course, extremely irritating at first, even in a one per cent. solution, to the inflamed tissues, but the patient in the majority of instances becomes tolerant to even a five per cent. solution. The drug is much more easily borne if prepared in a glycerin vehicle. It should be used every day or every other day according to toleration, and the patient should be taught how to cleanse the parts and apply the drug. For the relief of pain, orthoform is perhaps the best remedy we have for that purpose. Its use is not followed by the reaction of cocaine, and the anesthetizing effect is more prolonged.

The plain orthoform tablets may be given in from two to five grain doses in the form of lozenges dissolved in the throat slowly, or Dr. McConachie's formula may be used.

Orthoform, 1 grain.

Campho-menthol, 1-10 grain.

Knight recommends the following:

Menthol, 1-15.

Ol. amygdal. dulc., 30.

Vitelli ovorum, 25.

Orthoform, 12.5.

Aqua. distil. q. s. ad., 100.

Ft. emulsio.

¹ "Tuberculosis of the Upper-air Tract," Feb. 15, 1901, by George B. Rice, M.D.

A little of this can be held in the mouth or the parts sprayed with an oil atomizer before eating.

In primary tuberculosis, Dr. Winslow¹ recommends the entire removal of the tonsil to prevent infection of the other tissues, and this method would seem the only reasonable one to pursue. The same treatment should be advocated when the crypts contain cheesy masses showing the presence of tubercular bacilli.

The medical profession as a whole are so unitedly in favor of the so-called fresh-air treatment for general tuberculosis, and the results of this method are so superior to any other, that no argument is needed on the part of the author of this paper.

It is not possible to recommend unqualifiedly a group of homœopathic remedies as efficacious in localized tuberculosis because we have no demonstrable evidence that a single carefully selected remedy is capable of bringing about a cure of the disease so localized. However, there is one remedy which should be mentioned in this connection, *viz.*, arsenicum iodide. This drug, although proved by Dr. Eugene Beebe in 1866 and by Blakely in 1866, and briefly mentioned in "Hale's New Remedies," 1875 edition, yet was not given a prominent place as a remedy for tuberculosis until Sir Thomas Nichol of Montreal, now deceased, wrote a series of articles on the drug, which appeared in the NEW ENGLAND MEDICAL GAZETTE in 1887 and 1888. Dr. Nichol shows by a considerable number of cases that arsenicum iodide is efficacious in the treatment of a variety of types of tuberculosis. Dr. Crisand of Worcester, in an article which appeared in the NEW ENGLAND MEDICAL GAZETTE in May, 1899, says: "There are many remedies and adjuvants which are very helpful in combating the disease, but of those which I have tried *ars. iod.* is the one which has given me the best results. Under its administration some of my tuberculous patients have been cured, and therefore I have great confidence in the remedy. And when I

¹ *Maryland Medical Journal*, May 3, 1899.

make the honest confession that my faith in medicine is very limited, and that I believe the *vis medicatrix naturæ*, in company with proper feeding and hygienic surroundings, will accomplish more and greater cures than our long list of vaunted remedies, as for example, at our Rutland hospital, my listeners will, perhaps, give more credence to my words, and will not consider me a crank on ars. iod. or any other remedy, and will, I trust, be all the more interested in my experience with the remedy."

There is abundant additional testimony throughout our homœopathic literature of the great value of arsenicum iodide in this disease. Distinctive symptoms can be obtained from a perusal of Dr. Nichol's articles. The remedy does not keep well in the lower triturations as ordinarily prepared. The writer has for some time been using it in the form of a powder enclosed in a small gelatin capsule.

Thanks are due Dr. Chappelle of Brooklyn, N. Y., and Messrs. W. B. Saunders & Co., for their courtesy in allowing the use of some of the cuts shown in this article. To Dr. Watters and Dr. Griffith should praise be given for the excellent microscopical work, and to Dr. Taylor for her drawing from the microscope, of sarcomatous tissue.

ANTHRAX.

BY WILLIAM T. HOPKINS, M.D., LYNN, MASS.

[Read before the Massachusetts Surgical and Gynecological Society.]

Anthrax, known variously as malignant pustule, splenic fever and wool-sorter's disease, is an infectious disease due to inoculation with the *bacillus anthracis*. This is a rod-shaped bacillus which multiplies by fissure. In culture, these rods grow into long filaments, are very numerous and curve upon themselves, giving somewhat the appearance of locks of hair. The beginning segmentation may be clearly seen. It is a large bacillus, measuring some six or eight micromillimeters, and will take any of the aniline stains. These bodies were

first discovered in the blood of infected animals by Pollender in 1855, since which time the disease has been pretty thoroughly studied by various pathologists and bacteriologists. In man the bacillus is not so readily discovered in the blood, but in all patients suffering from this disease it may be found at the point of infection and throughout the adjacent tissues. It is found most often in hides, wool and hair.

It gains entrance to the system by inhalation, by ingestion with food, and lastly, and by far most frequently, by inoculation of an abrasion of the skin. It has a period of incubation of a few hours to three or four days when, if the skin is the seat of the infection, burning and itching are felt at this point, followed in a few hours by the appearance of a reddish papular elevation, which is speedily surmounted by a vesicle, the contents of which soon become hemorrhagic. This vesicle ruptures, and generally dries showing a dark depressed crust surrounded usually by a chain of smaller vesicles, the whole being the center of a violent inflammation characterized by heat, redness, tumefaction and extensive infiltration of the surrounding tissues. The infiltration and swelling rapidly extend, the neighboring lymphatics being swollen, hard and tender. The swelling is sometimes enormous, suffocation sometimes occurring when the initial lesion is on the face or neck. Evidence of systemic infection is usually manifest within twenty-four hours of the appearance of the characteristic pustule, ushered in by chill, increase of pulse-rate, and rise in temperature, the latter often reaching 105° F. The spleen is sometimes enlarged, but not uniformly so. The pulse becomes more rapid and weaker, the patient suffers from dyspnea, becomes either comatose or delirious, and dies.

Some cases do not seem as severe from the very start, and recover even without treatment, the pustule sloughing and leaving a comparatively clean ulcer to granulate. In these cases the fever is not as high, no coma or delirium is seen, the pulse remains good, the patient can take some nourishment, and dyspnea is not a prominent symptom.

The diagnosis is usually not difficult if one is familiar with the appearance of the initial lesion. The diagnosis should always be verified by the microscope, the work of a few moments only. By rupturing the vesicle or, if seen later, by removing the crust, serum containing the bacilli may be obtained for a smear which is easily stained, and should be readily recognized. The gastrointestinal and pulmonary varieties can seldom be diagnosticated ante-mortem.

The prognosis is grave in all cases, but if the cutaneous form, those having the initial lesion on the extremities seem to have been least severe, while those occurring on the face and neck have been most fatal.

Prophylaxis is a matter which should receive the attention of boards of health, as well as of all physicians who come in contact with the disease. The burning of the bodies of all infected animals; the incineration of the remains of persons dying of the disease, and the destruction by fire of their garments and other belongings capable of conveying the infection; the sterilization of hair, wool and hides from infected districts, as well as from all sources not positively known to be free from the disease, should be insisted upon.

The treatment is practically confined to the cutaneous form, and should be prompt and energetic.

Some advise injecting various substances into the tissue around the periphery of the inflamed area, with the object of causing tissue coagulation, and thus preventing, in a measure, the further absorption of the poison; others remove the infected tissue with a cautery; still others first excise with the knife and then cauterize, but it seems to me that the best plan is to excise widely with the knife and leave the wound open, not close it with the cautery, but utilize the opened lymph spaces for drainage, seeking to promote a flow of the lymph current toward the open wound, and to withdraw as much of the poison from the system as possible, just as we drain the peritoneum with a wick. To accomplish this, abundant warm moist dressings of gauze, covered with some dry absor-

bent material, will serve better than any other measure with which I am familiar. I prefer to use normal salt solution to moisten the dressing, which should be changed frequently. Stimulants are usually necessary in the form of salt solution, strychnia and alcohol. The antitoxic serum for anthrax has not yet reached a sufficient degree of perfection to make it entirely trustworthy, I fear, nor has immunization proven uniformly successful.

The practical points seem to me to be the early recognition of the disease, its prompt treatment and scrupulous attention to prophylaxis.

SHOULD THE PHYSICIAN PATENT HIS RIGHTS?—G. Frank Lydston, writing in the *New York and Philadelphia Medical Journal*, Sept. 3, 1904, believes that by the patenting of surgical instruments the following benefits would accrue to the profession: (1) The physician inventor would get the benefit of his ingenuity just as laymen inventors do. (2) He would protect himself against dishonest men in his own profession, who steal his ideas and publish them as original, and who possibly, not content with stealing the products of his inventive genius, claim as their own the operation which the invention has made possible. (3) The question of priority in surgical invention and operation would in many instances be settled once and for all. (4) Competition and invention would be stimulated, and the best brains of the profession would be devoted to new inventions. (5) The profits now monopolized by the surgical instrument maker would be participated in by the men who furnish the ideas. I am aware that the instrument maker will have a counter plea upon this point, and state that a large proportion of the alleged inventions of medical men are really designed by the instrument maker, the doctor's name being used in connection with them to boom their sales. Very good. The patenting of surgical appliances would put a stop to this arrant fraud, and give the instrument maker what was legitimately his due. The rule would work both ways. The instrument maker who invented a valuable instrument would get not only the profit but the reputation incidental to its invention. This would be only just. (6) A better class of instruments would be invented, and there would not be in our offices so much metal and glass to be consigned to the dead lumber room of blasted hopes in medical and surgical inventions.—*Exchange*.

EDITORIAL.

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H. C. CLAPP, M.D., *Diseases of the Chest.*E. P. COLBY, M.D., *Neurology.*N. W. EMERSON, M.D., *Gynecology.*F. B. PERCY, M.D., *Materia Medica.*G. B. RICE, M.D., *Laryngology.*W. S. SMITH, M.D., *Surgery.*S. S. WINSOR, M.D., *Obstetrics.*

HOMŒOPATHY AND THE ADDRESS IN MEDICINE AT THE CONGRESS OF ARTS AND SCIENCES.

The congress of arts and sciences at St. Louis in September last, convened with the object of showing the advances in the sciences, and especially their unity and synthetic purpose, was an event of which the originators may well feel proud. It was indeed an occasion of such signal importance, and the gathering of representative men in all departments of knowledge so noteworthy, that its influence cannot fail to make itself felt long after the immediate impressions left on the minds of those present, or on those of the more numerous readers of the reports, shall have passed away. It is not without interest, therefore, to review, after the lapse of several months, that part of the proceedings which deal with medicine, and to comment on such points as may be seen to have both a direct and indirect bearing on the principles which it is our function to uphold. The address in medicine¹ was delivered by one of Boston's foremost teachers and investigators, and if thoughtfully read will be seen to have been worthy of the occasion. But unfortunately for its general acceptance it mentioned

¹ *Boston Medical and Surgical Journal*, Oct. 10, 1904.

homœopathy, and the manner and matter of this cursory mention demand that we should again define our position in relation to "The Modern Conceptions and Methods of Medical Science" (the title of the address), and to certain misconceptions regarding our principles and practice current among those who claim the right to speak for the whole profession. This right can be assumed only by one who is master of every department of his subject concerning which he feels impelled to speak, but as such the author of the address, despite his learning and his evident intention to be just, had failed to qualify before approaching his task. Thus an analysis of the following passages will, we believe, sufficiently show. He says, in speaking of Christian Science and other speculative systems: "Homœopathy is the most prominent survivor of these speculative systems." And again further on: "The system presented by Hahnemann was complete; it offered names and seeming explanations for all conditions. The practice of the medical art under the system was easy, and involved no toilsome investigations. It was put forth at an early period of the Natur-Philosophie, and was carried upward on the tidal wave which swept through Germany. It at once found great favor with the people, and was adopted by many physicians. In the course of time the adherents of the system became divided into three camps. In one its principles have been extended beyond the conception of Hahnemann, in that the products of disease have been used as remedial agents; a second have remained true to the principle of the founder, and a third, comprising many intelligent physicians, hold to it only in name."

Here are statements containing much that is partially true, but much more that is wholly incorrect. To analyze them all in detail would call for volumes. We can consider only those which do not too evidently bear on their face their own reputation, meanwhile accepting patiently the old experience that error may travel around the earth before truth can put on its boots to follow.

In order to place in their true perspective the scientific character and the rise of homœopathy, it is essential to point out first of all, certain errors of history into which the address has been permitted to fall. The gravest of these are contained in the statements that homœopathy, as originally conceived and as now held, was and is a survival of the speculative systems of the eighteenth century, and that it was put forward at an early period of the Natur-Philosophie, concerning which the address has much to say. While it was unquestionably carried upward on the tidal wave of speculation, which swept through Germany, as Christian Science and osteopathy are carried upward to-day by certain waves of mistaken reasoning incident to the rapid spread of the partial culture so manifest about us, it is to be remembered that Hahnemann was born in 1775, that he had already conceived his idea of a law governing the curative effects of drugs as early as 1790, and published his first essay on the subject in 1796. Schelling, on the other hand, was not born until 1775, and his Natur-Philosophie had produced no effect upon the public mind until after the first decade of the last century, and after the publication of the *Organon* in 1810. Although it is readily admitted that, in certain circles, both professional and lay, Schelling's philosophy was distinctly instrumental in favoring the spread of homœopathy, nothing can be further from the mark than the assumption that it was inspired by the speculative philosophy then in the air. That Hahnemann's later views were strongly tinged by it is not questioned. But his departure from the prevailing practice of his time, and his conception of the law of cure followed directly and inductively from clinical data. It was Hahnemann¹ who first and most effectively raised his voice against the aberrations of Brunonianism, and no one of his contemporaries or followers saw more clearly than he the futility of Schelling's

¹ See his essay, "On the Value of Speculative Medical Systems," "Lesser Writings," and Section 13 of the *Organon*, with footnote. First edition, 1810.

philosophy as a guide in medical practice, or as a source of inspiration in medical research.

These points disposed of, the answers to those remaining are to be found well stated in the address itself. They follow more particularly from the references to the influence of Virchow on the advancement of medical knowledge. What is said of this great reformer applies *mutato nomine* with equal force to Hahnemann. It is true that the circumstances surrounding them were widely different, and the problems before them and the materials with which they worked were of a wholly different nature. Yet both tended in the same direction. As it is possible according to the address to see the influence of the Natur-Philosophie on its greatest opponent, so it is possible to see the influence of the speculative philosophy upon the scientific mind of Hahnemann. As no one laid down more clearly the methods of scientific investigation than did Virchow in his *Archiv*, so no one more clearly than Hahnemann laid down the methods of first investigating the effects of drugs, and then of determining their curative relation to pathological states. The parallelism might be pursued much further by the light of the address, but it is important to distinguish between the outward circumstances of the two cases. Virchow was a pure scientist, an investigator dealing with matters directly observable, and under control; the results and products of disease, to be dissected, analyzed, described, classified, and had at his command the most abundant hospital material with the most generous means of utilizing it. Hahnemann, on the other hand, was a general practitioner deeply conscious as have been few, of being confronted by all the gravest problems of practice, and facing single handed the deep-rooted traditions and destructive practices handed down from many generations, and finding their support in the misconceptions of precisely those philosophical systems which the address deplures. The objects of his inquiries were the unstable, obscure, intangible phenomena

of disease, their clinical aspect, and the little understood pathological processes causing structural and functional changes, incomparably more difficult to grasp than the macroscopic and microscopic material of the cadaver. His observations could not be pursued calmly in well-appointed laboratories or hospitals, but had to be carried on at the bedsides of the ignorant poor, or at those of the unreasonable well-to-do. The rich he never saw. If these things are duly considered, the wonder is not that Hahnemann should fail to command general recognition as a man of science and a reformer, but rather that despite his disadvantages and the obstacles in his way, he was in many respects so many generations in advance of his time.

Another misconception of the address, though not aimed directly against homœopathy, yet calls for adjustment to modern views, since it conflicts with practical knowledge and experience, and would, if generally taught to the young, continue seriously to retard progress in therapeutics. It reads: "Modern therapeutics is guided by two principles, in both of which *efficiency is dependent on the knowledge of disease.* (The italics are ours.) In the most important the remedial agent has a specific action on the cause of disease, either destroying it or opposing its action. In the second the remedial agents are used not with the views of exerting any specific action against the cause of disease, nor even in assisting in the restoration of tissue which has been injured, but with the view of restoring function." Here again we have one of those half truths which constitute the stock in trade of the therapeutic scientist. To say that all therapeutic efficiency is dependent on the knowledge of the causes and nature of disease, or to imply that such knowledge is in a sufficient measure in our possession or within reach, is—all bacteriology and laboratory science notwithstanding—to state a position about which there has been endless controversy for over two thousand years, and one to which no candid practitioner of

average intelligence will or can subscribe. It is a conception of therapeutic aims and possibilities, which thrusts wholly out of sight that very large and indispensable body of empirical knowledge, without which the power of the practitioner would be restricted in a manner not to be contemplated for a moment.

This matter of empirical knowledge concerning the effects of drugs, has always been and still remains a very sore spot in the minds of many representatives of scientific medicine, since they can neither find a place for it in their artificial schema, nor a general principle governing its application in practice. In opposition to the attitude taken in the address, every thinking man must be ready to accept that more rational one, plainly enunciated by another distinguished teacher and investigator.¹

In discussing the principles by which the practitioner must be guided, Professor Moritz emphasizes the fact that, from the clinical point of view, it is the living human being, not the laboratory material, which is the object of the physician's most studious endeavor. He says (in literal translation): "This wonderful organism is here no longer a passive object of scientific consideration; it makes the most imperative demands of a practical nature, the demand, that is, for the cure and relief of its sufferings and infirmities. To this end of medicine (*Heilkunde*) every means of value must be sought, the purified gold of exact scientific research, as well as the unclarified empirical knowledge. With both of these the clinic is called upon to reckon."

In thus criticising the conceptions of the address we are not unmindful of its chief aim, which was that, as well, of the whole congress; *viz.*, to set forth the unity and harmonious

¹ Inaugural address on assuming the directorship of the Internal Clinic at Greifswald, by Professor Moritz.

development of science. Discords, therefore, were to be studiously avoided, and this the address accomplished most successfully. But in doing so, and aiming to elucidate the conceptions and scope of medicine at large, there was a distinct hiatus in the failure to reach and give due prominence to, by no means, the least important branch of practice, that of pharmaco-therapeutics, which remains the vulnerable point in medicine. In order to remove the numerous stumbling blocks in this wide field there is but one course, that of accepting without reserve the position so clearly indicated by Dr. Moritz among other thinking men, and having accepted it without fear of discords, to raise what is acknowledged as yet to be crude empiricism to the level of an empirical science. For this, again, there is no other way than that of exact drug proving, controlled by the clinical test and wholly free from preconceived theories or pathological, biological and philosophical speculations. This, for example, is the method adopted by the Agricultural Department at Washington to test the injurious or other effects of food preservatives, and, what is more to our present purpose, it is the conception and method of Hahnemann on which homœopathy rests. How much has been accomplished by it, and whether it has been disturbed and retarded by speculative or other interferences, is a separate question. The main point is that it has for its basic principle an inductive law; not one deduced from any system of speculative philosophy, but derived from observation and experiment, and supported by a method capable of a development of which the limitations cannot yet be foreseen. In what measure its adherents shall accept this principle, and how far they shall apply it in practice, must depend in part upon these limitations, and in part upon the degree by which each individual is influenced by other methods. The scientific value and ethical justification of the principle and method remain unaffected, whether we take our stand squarely upon them with both feet, balance ourselves there with the one toe of isopathy, or cling to them with our eyelids, as do

the "large number of intelligent physicians who hold to them only in name." The extreme difficulty, so unwarrantably overlooked by the narrow and superficial, of determining to-day in what cases and under what circumstances one therapeutic method or the other is applicable, calls for greater discrimination and wider knowledge than the address would lead us to suppose, and makes the practice of the medical art according to the homœopathic law far from the easy matter it is there described as being. Moreover, the study of our pathogeneses, and the adaptation of their details to varying pathological conditions, both involves the most toilsome investigations, and explains many wide differences of opinion and varying degrees of adherence to our method.

LETTER TO THE EDITOR.

WAKEFIELD, MASS., Feb. 10, 1905.

Editor-in-Chief New England Medical Gazette:

The recent advances in medicine and surgery have been so numerous and of such importance that one is almost appalled at the ignorance of the profession only a few short years ago. To even think of caring for diphtheria without antitoxin is sufficient to cause the bravest heart to shudder. The profession glories in the progress made, and confidently looks forward to greater achievements in the future. But no advance is, perhaps, of greater potential good or evil, than the recent movement toward education of the public in the causation, prevention and treatment of disease.

Within the past two years several of the "popular" magazines have devoted considerable space to the sanatorium treatment of tuberculosis, and the curative properties of fresh air, with the apparent intention of awakening the public to the menace of the terrible scourge, and of securing united, consistent and determined action on the part of city, state and nation to stay its ravages. These articles have been

written for the most part by thoroughly competent physicians, are scientifically accurate, yet "popular" in that the style is interesting, and the language easily understood by the reader of ordinary education and intelligence. The public has shown a distinct interest in the subject, and is clamoring for more information. If future articles, on this or kindred subjects, prove as reliable as the majority of those already published, the profession will have reason to congratulate itself that an ally indeed has arisen.

Recently, however, an article on this subject, written by a layman, made its appearance in a magazine of wide circulation, which contains a suggestion of what these articles are likely to become and the injury they may do the cause they seem to serve. This article states in substance that in the fight against tuberculosis, the greatest obstacle that the boards of health have to overcome is failure on the part of physicians, in many cities, to report cases of tuberculosis. The implication is that physicians as a body are not doing what they can, and all they can, to prevent the spread of tuberculosis. If this were true, it were indeed a grave arraignment of the profession. The author fails to grasp the fact that there is difference of opinion as to the most effective administrative methods, and assumes that all who do not entirely agree with the health officials consulted, are trying to block the wheels of progress. (The writer, however, is of the opinion that tuberculosis should be reported to the board of health.)

The second erroneous impression such articles may give, and are giving, is that tuberculosis may be easily cured. From these articles, some legitimately draw the conclusions that almost any consumptive can and will get well—a belief every consumptive already possesses—if he sleeps out of doors, and is reasonably careful as to his habits. No greater mistake could possibly be made than to have the public confirmed in such a fallacious opinion, particularly if it is associated with that other erroneous impression, that many

physicians are resisting modern requirements and methods, and are not using all their resources to combat the spread of the disease as well as to cure the patient. These two ideas, if they become in the least degree prevalent, will result in many a tubercular subject's attempting to cure himself, even more frequently than is the case at present, to his own and the public's detriment.

This epoch of education, however, has come to stay, in one form or another. The day is past when the majority of physicians could wish it to be otherwise. The only danger is in partial knowledge. This popular crusade against tuberculosis has accomplished something already. It is educating the public toward the sanatorium idea, which is the first step in any effort to get public appropriations, and is teaching a few to be more careful in the destruction and disposition of their sputum. But further than that it probably cannot go, for the principle upon which this popular crusade is based is an essentially vicious one from the true viewpoint of those who have the welfare and health of humanity at heart, in that it is undertaken as a commercial venture, because the public show an interest for the moment, and will buy the periodicals on account of such articles. Then, too, the tendency is to write and print such subject-matter as will attract public notice. If the facts are too prosaic, a little flight into the realms of the imagination adds zest and flavor, while on the slightest indication that the public has had enough of a subject it will vanish from popular literature like frost before the sun. To make the effort at education stable and permanent is the problem that confronts the medical profession. Safety lies in dissemination of knowledge. It must reach the high and the low, the rich and the poor alike—particularly the poor. It must be thorough, and not superficial. A thorough knowledge can never be obtained from popular literature, though that may do something to arouse interest, and serve as a preliminary and introductory chapter. It cannot be obtained from literature supplied by the board

of health, which is only casually noticed, and half appreciated and understood. It can be gained only from personal contact and association with those in whom the individual has full confidence; with those who are scientifically qualified and in every way competent to speak with authority, and who are filled so full of the subject that they perforce present it in all its phases in an interesting and impressive manner. This can be done only by the united, consistent and sustained efforts of the entire profession.

CHAS. E. MONTAGUE, M.D.

**THE ONE HUNDRED AND FIFTIETH ANNIVERSARY
OF HAHNEMANN'S BIRTHDAY.**

It is to be remembered that on the 13th of April, 1755, Hahnemann was born. Since that time great changes have taken place in the minds of men on many subjects, not less in medicine than in all other departments of knowledge. Since we hold that the reforms in our art have followed largely from his initiative, it is fitting that this anniversary should be celebrated in a manner commensurate with his merit, and the respect we owe to his memory. We hope that early steps may be taken for the appointment of active committees from our various organizations to take this matter in hand.

SOCIETIES.

BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

The regular meeting of the society was held in the hall of the Boston Society of Natural History, Thursday evening, Feb. 2, 1905, at 7.55 o'clock, the president, J. Herbert Moore, M.D., in the chair.

The records of the last meeting were read and approved.

SCIENTIFIC SESSION.

Pathological Specimen.

Dr. Horace Packard exhibited broad ligaments removed three weeks before from a puerperal case, which came under his observation the eighth day after confinement. The patient was thirty-six years of age, and had already borne five healthy children, and gone through each confinement without incident. At this time, after the sixth or seventh day, there was a rise of temperature, with pain in lowertabdomen, right side. Temperature, 102°; pulse, 120. Upon examination the uterus was found large and edematous. Bimanual examination disclosed boggy masses in each broad ligament. "I assumed at once that the infection, contracted incident to confinement, had made its way into the tubes, and that a double pyosalpinx existed, with probably already extension of the infection to the pelvic peritoneum. The problem, whether surgical measures are advisable in such a case, is always present. The virulence of puerperal infection is such, and the fatality so great there always is a feeling that something must be done. It seemed to me a case for surgical interference and I made an abdominal incision, and my surprise at what I found is my reason for presenting the case to-night.

"The tubes were normal; at least, they were not the seat of abscess. They were pervious, free, and showed no more change than should be expected at a period so slightly removed from parturition. In both broad ligaments was an abscess,

showing that the puerperal infection had spread from the uterine cavity to the intraligamentous cellular spaces by way of the lymphatics. I have heretofore accepted the doctrine that such infection reaches the abdominal cavity by way of the tubes, but this condition seemed to refute that theory. I now recall that I have observed a few cases where after recovery from puerperal fever the patient has again become pregnant and borne children, thus proving beyond question the functional integrity of the tubes.

“The best course to pursue in this case was difficult of decision. The uterus was infected, the tubes and ovaries normal, or apparently so, but each broad ligament infected by multiple abscess, and on close inspection adjacent loops of intestine showed culture patches. It was finally decided to excise the broad ligaments close to their uterine and pelvic attachments, with recognition that the outlook was at best very poor. Subsequent culture showed staphylococcus infection. The patient ran a high temperature (103° F.) for a few days, but there was no further spread locally of the infection. The uterus gradually decreased in size, there was surprisingly little vaginal discharge, and three weeks from the time of the operation the patient is convalescent.”

PROGRAM.

1. “Differential Diagnosis of the So-called Rheumatoid Diseases.” Illustrated by stereopticon. Joel E. Goldthwait, M.D. Discussion opened by Alonzo G. Howard, M.D.
2. “Osteopathy.” Douglas Graham, M.D. Discussion opened by George E. May, M.D.
3. “Some Homœopathic Remedies in Joint and Muscular Affections.” Frederick B. Percy, M.D. Discussion opened by Frederick P. Batchelder, M.D.

DISCUSSION (DR. GOLDTHWAIT'S PAPER).

Dr. May: There are very many questions that naturally arise in connection with this broad subject, but the limited time at my disposal will not permit me to ask all of them.

However, I would like to know how closely tuberculous-joint disease may simulate some of these rheumatoid affections, and a few of the points in differential diagnosis.

Dr. Packard: I would like to ask Dr. Goldthwait the extent that these diseases affect the articulation of the feet. The illustrations have referred to the hands alone. The inquiry comes to my mind because I have under observation a case where both hands and feet are involved, the X-rays of the hands showing complete absorption of some of the phalanges.

Dr. Goldthwait (in closing): To answer Dr. Packard's inquiry first, of course any of the joints may be infected with this disease, and the feet are very commonly involved. The illustrations were not used because the hands are usually more affected than the feet, but because they are very commonly involved, owing to their exposed condition. The same treatment is required for the feet as for the hands and artificial support should be given while treatment is going on.

All these cases belong properly to general medicine, and my plea to all physicians is for better work. I make that plea as one of the profession, knowing how easy it is to try preventatives and let the case go. Strip the patient and try to find out what type of arthritis you are dealing with, and know that some need one treatment and others another. Do not give them all one treatment. Find out what type of disease you have to deal with, and you will then apply the treatment more intelligently.

As to the tuberculous cases, to which Dr. May has referred, it is, of course, difficult at times to differentiate between them and infectious processes, but rarely is there much confusion between other types, the infectious type being more acute.

You may be interested in what is going on at present in the laboratory. The natural line of treatment is to isolate the organism, and develop an antitoxin from it. The work we have under way at this time is to try to isolate the various infectious types. There are three at least which repre-

sent distinct organisms, but there are very many others from which antitoxins have been successfully made, of which we are ignorant.

Adjourned at 10.10 o'clock.

B. T. LORING, *Secretary.*

AMERICAN INSTITUTE OF HOMŒOPATHY.

To the Members and Friends of the American Institute of Homœopathy:

At a recent meeting of the executive committee, held in Chicago, the date for the annual meeting of the Institute was fixed for June 26 to July 1, 1905. The committee of local arrangements reported sufficiently to assure the executive committee that everything necessary to the comfort and convenience of the members and their friends who attend, has already been outlined and will be completed.

The headquarters will be at the Auditorium Hotel. The management of this hotel, which also controls others in the same neighborhood, have made very liberal reductions from their usual rates.

As is well known, the Auditorium Hotel is situated on the lake front, assuring fresh, cool breezes, and freedom from noise.

The meetings of the Institute will be held in Music Hall, adjoining the Auditorium. The affiliated societies have been provided rooms on the "assembly" floor of the Music Hall building and in the banqueting-rooms of the Auditorium. Thus are provided four large, well-lighted and well-ventilated rooms, and several smaller ones, under the same roof, and conveniently connected with elevators and halls.

The subcommittee on entertainment has planned so as to interfere as little as possible with the work of the Institute. Besides the opening reception and ball on Monday evening, there will be a banquet on Friday evening. At this banquet

the Illinois State Homœopathic Medical Association and the Hahnemann Medical College of Chicago, each celebrating their fiftieth anniversary, will act as host to the members of the Institute and their friends, and will celebrate the one hundred and fiftieth anniversary of the birth of Samuel Hahnemann.

The presidents of the affiliated societies and the chairman of the bureau, with two exceptions, were present with the executive committee.

They all reported excellent progress well under way. The keynote sounded by these officers clearly indicated that the coming meeting is to be one for effecting a more vital and aggressive organization.

The officers earnestly ask for the inspiration of your presence at this meeting.

GEORGE ROYAL, *President.*

CHARLES GATCHELL, *Secretary.*

THE NEIGHBORHOOD MEDICAL CLUB.

The Neighborhood Medical Club held its regular meeting at Hotel Bellevue, Boston, Jan. 19, 1905. Dr. N. W. Emerson gave a talk on "Fibroids," illustrated by stereopticon, which was exceedingly interesting and instructive. The February meeting was held Feb. 16, at Hotel Nottingham. Dr. O. R. Chadwell's paper, "Some Laboratory Suggestions for the General Practitioner," contained many helpful suggestions.

WILSON F. PHILLIPS, *Secretary.*

COLLABORATORS' DEPARTMENT.

Tuberculous school-teachers are now forbidden to continue their work in the Jersey City schools. If the disease is suspected, the teacher must undergo an examination by a school board physician. H. C.

The Agnes Memorial Hospital for Tuberculosis in Montclair, Col., now contains one hundred patients and has one hundred on its waiting list. A new wing, to cost \$100,000, and to accommodate one hundred more patients, is projected. H. C.

In addition to the special dispensaries for tuberculosis already established in New York City, another has just been opened by the New York Throat, Nose and Lung Hospital. Patients will visit the dispensary three or more times a week for treatment and advice. H. C.

The Rhode Island idea of utilizing old trolley-cars for cheap sanatorium buildings on a small scale, is again to be copied, this time near Hoboken, N. J. In this case, as in others, a railroad corporation has been found willing to donate old out-of-date cars for the purpose. H. C.

A new book has just been issued jointly by this society and the New York Charity Organization Society, compiled by Lilian Brandt, which every physician ought to own. It is a directory of institutions and societies dealing with tuberculosis in the United States and Canada. It is beautifully and tastefully printed on nice paper, fully illustrated, and gives just what information is needed. H. C.

The Massachusetts legislature has been petitioned to appropriate \$2,000 for making public exhibition of the various means and methods used or recommended for treating or preventing tuberculosis, under the auspices of the State

Board of Health. Such an exhibit is capable of doing an immense amount of good, as did the one in Baltimore a year ago, and the smaller one in Mechanics Hall, Boston, last fall, directed by the Boston Society for the Relief and Control of Tuberculosis.

H. C.

The National Association for the Study and Prevention of Tuberculosis, organized last year, will hold its first annual meeting in Washington, D. C., at the New Willard Hotel, on Thursday and Friday, May 18 and 19. There have already been several attempts to hold tuberculosis "congresses" in this country, but unfortunately they were so organized as not to include, to any extent, the really able and most representative men in the medical profession of the United States.

This new association, however, either now contains, or is expected to contain, most of the "shining lights," such as Drs. Trudeau, Osler, Biggs, Sternberg, Jacobs, Anders, Bridge, Bowditch, Flick, Klebs, Knopf, Otis, Probst, Solly, Councilman, Welch, Janeway, Musser and many others. There will be general sessions and division of the work into three sections: sociological, pathological and bacteriological, and clinical and climatological.

Many papers will be presented, and an exceedingly interesting meeting is expected.

H. C.

Dr. John N. Mackenzie (*New York Medical Journal* and *Philadelphia Medical Journal*, Jan. 28, 1905), in an article on "The Abuses of Intranasal Surgery," deprecates most strenuously the practice which persists among so many laryngologists of reckless and indiscriminate performance of surgical procedures in the nasal and accessory cavities. Many operations on the nasal septum, turbinated bodies and bones, and accessory cavities are performed from a purely theoretical standpoint without regard to a careful diagnosis of the individual case, and consequently the result cannot fail to be anything but deleterious. He does not decry in the least

degree the many excellent measures for the surgical treatment of intranasal affections in properly selected cases by skillful operators, but his appeal is to teachers of laryngology to teach their pupils conservatism and moderation in the surgical treatment of simpler affections, and thoroughness and completeness when brought face to face with graver emergencies. The cure for the evil existing he believes to be educational; the adoption of special studies only after a broad and liberal medical education, the course to be pursued, given at length in his "Chairman's Address" at a meeting of the American Medical Association in 1901, and published in the *Journal of American Medical Association*, July, 1901.

G. B. R.

Dr. Francis J. Quinlan (*Laryngoscope*, January, 1905), in a lengthy article, enumerates the various throat complications in typhoid and emphasizes the importance of symptoms during convalescence of typhoid, placing those relating to the larynx and trachea as likely to be the most serious and frequently requiring operative interference. Statistics show a high rate of mortality where such complications occur, and hoarseness developing during the third or fourth week should be looked upon with suspicion, as it may be the result of an edematous condition, pressure of an abscess growth, or the destruction of cartilages, all of which may terminate in a deadly stenosis. At the conclusion of his paper he states: "Tracheotomy offers many advantages over intubation in that the air current can be tapped by the former operation below the obstruction and the danger of forcing fragments of cartilage into the trachea is overcome. Again, the tube may rupture an abscess and flood the respiratory tract with pus, which, if not causing imminent danger, may provoke a septic pneumonia at a later day.

2. A laryngitis occurring during the course of typhoid fever must always modify our prognosis.

3. Continued hoarseness with slight dyspnea should at once demand an inspection of the larynx and trachea.

4. A faulty movement of the laryngeal muscles should require internal local medication.
 5. Marked dyspnea should at once call for operative surgical interference.
- G. B. R.

In a paper on "The Ultimate Results of Cauterization of the Lower Turbinal, with Therapeutic Suggestions Based upon Histological Findings" (*Boston Medical and Surgical Journal*, Dec. 29, 1904), J. L. Goodale, M.D., of Boston summarizes the histological phenomena of these examinations as follows:

1. Caustic applications to the nasal mucous membrane may cause a loss of the columnar epithelium, with a replacement of this by cells of a squamous type.
2. Such applications may cause an obliteration of the canaliculi in the basement membrane.
3. Immediately below the cauterized mucous membrane, new connective tissue may be formed, which extends downward to the depth dependent upon the intensity of the trauma.
4. The contraction of the tissues which is observed clinically to follow caustic applications is due to the contraction of this new-formed connective tissue, and the subsequent compression of the lymph sinuses, and of such cavities as the lumina of blood-vessels and glands.
5. Repeated superficial applications of caustics tend to the formation of connective tissue immediately beneath the epithelium, which by its contraction may constrict the lumen of the ducts of the glands, and lead to cystic dilatation of the latter with subsequent return of nasal obstruction.

By taking the preceding phenomena as a guide for clinical practice he determines that certain of these changes are beneficial, while others are harmful to the physiological functions of the nose.

The proper application of the cautery may be recommended, first, where alternating nasal stenosis is due to relaxation of the mucous membrane of the lower turbinate anteriorly, and of the septum posteriorly.

Secondly, where there is excessive secretion of mucus from the posterior nares, the result of relaxation of the mucous membrane with healthy sinuses.

Thirdly, in vasomotor rhinitis, where there is anterior obstruction of the nose with consequent inspiratory rarefaction which allows an increased flow of lymph and blood adding to the severity of the vasomotor symptoms.

The injurious effects he sums up as follows: In the first place by destroying the ciliated epithelium there is impairment of one of the important functions of the nose, the expelling of foreign particles from the mucous membrane.

Secondly, by destruction of the canaliculi of the basement membrane the normal secretion is diminished, hence the inspired air is insufficiently moistened, and dryness of the mucous membrane of the nose and throat results.

Third, by obliterating the orifices of the ducts of the glands, cystic dilatation of the ducts result, causing secondary enlargement of the tissues.

Fourth, by obliterating the blood-vessels, lymph channels and gland beneath the mucous membrane with their replacement by connective tissue the amount of heat imparted to inspired air and the amount and character of the secretions are influenced.

To bring about the best results in the application of the cautery he advises the deep linear application with a minimum amount of destruction to the mucous membrane where contraction of a relaxed mucous membrane is sought.

To diminish the amount of secretion a broad superficial application to a definite area is more applicable, and finally in the event of recurrence of the hypertrophy to dispense entirely with the cautery and resort to excision of a definite amount of obstructive tissue.

G. B. R.

These two abstracts are placed side by side because in the article by Dr. Goodale, Dec. 29, 1904, the author does not give Dr. Beaman Douglas credit for his article published May

12, 1900, although the method and results are not dissimilar. Both are valuable contributions and should be read by those who have been in the habit of using the cautery in the nose indiscriminately.

Beaman Douglas, M.D., in a "Study of the Application of the Galvano-cautery in the Nose" (*New York Medical Journal*, May 12, 1900), to determine the reason for the failure of the cautery to do satisfactory work, gives the result of his microscopical examinations made from tissue taken from the nose at different times after cauterization, and compares them with another series of specimens where the knife incision had been made.

In specimens removed immediately after cauterization it was observed that the epithelial layer of the mucous membrane was destroyed for a considerable area beyond the point of application, the area was cone shaped, with the most marked effect at its outermost edges, the subepithelial hyaline membrane was destroyed, the center formed a brown slough, and the epithelium stained irregularly. The specimen, examined after a cut with the scissors had been made, presented none of these changes, the only tissue affected being that immediately destroyed by the cutting edge.

The next specimen removed one hundred hours after cauterization showed the process of repair beginning in the surrounding tissues, while in the cauterized area all the normal elements had disappeared. Three hundred and sixty hours after, the specimen showed a further stage of repair with the sloughed area filled in with granulated tissue, while in the fully healed specimen new connective tissue had entirely replaced the ordinary nasal structure.

His deductions are that the cautery should never be used superficially or over a wide area, but should be introduced rapidly into the deeper structures, using a cautery point that will burn evenly and readily and exert equal pressure along the whole extent. The linear cauterization should be discarded except where superficial effects are desired, and instead,

a series of cautery punctures should be made along the hypertrophy, using a stiff, short, wire cautery, and diminishing the amount of heat as the cautery is introduced and withdrawn.

He attributes many failures in the use of the cautery to mistaken diagnosis, and considers a careful differentiation of the conditions present necessary. The conditions where it may be selected are: on soft tissue structures, where round cells predominate in the tissues, and in tissue where blood vessels are to be destroyed, and in chronic congestions, etc. The parts where the cautery should not be used are: the septum, except that portion covered by erectile tissue, hypertrophic masses going on to polypoid degeneration, the upper surface of the inferior turbinated body, and the main portion of the middle turbinated body, the region of the outer nasal wall, and the ethmoidal region.

The dangers accompanying its use are those incident to any surgical interference, with the single exception of hemorrhage; besides having special dangers of its own, such as furnishing nutrient pabulum for bacterial growths, producing atrophic conditions, etc., while in selected cases and in the hands of a skilled operator, it may perform its work better than can be done by cutting methods.

G. B. R.

ABSTRACTS FROM BOOKS AND JOURNALS.

BACILLINUM IN COUGHS.—In troublesome coughs which do not yield to your seemingly well-selected remedy, whether they are due to tuberculosis or not, do not forget bacillinum. The keynote is weakness and exhaustion. This remedy works better in the 1c to 2c potency. Anything lower aggravates.

North American Journal of Homœopathy.

STENOSIS OF THE PYLORUS.—Bear in mind, if you please, that in stenosis from a tumor due to an ulcer, HCl is present in abundance, and lactic acid is absent; and when carcinoma develops in the base of an old ulcer large quantities of free HCl are also found.—*Dr. J. M. Anders, in Medical Bulletin.*

CHEAP PHARMACY EXPENSIVE.—The difference between first-class and second-class remedies in cost is infinitesimal when the cost of each individual dose is considered, but the variation in the result to the patient and physician may be very great. A reliable, physiologically tested remedy may make a reputation, and an inert drug may destroy it.—*Therapeutic Gazette.*

CONTRAINDICATION FOR PROSTATECTOMY.—MacGowan summarizes the contraindications thus: "A tendency to bleed freely from very slight injuries; the existence of serious heart lesions accompanied by a great general muscular feebleness, and (most important) the inability of the kidneys to secrete a reasonable quantity of urea,—namely, from fifteen to twenty-five grams per diem." Murphy's only contraindication is "severe arteriosclerosis, with cardiac changes." Age taken alone is not a contraindication.—*The Post-graduate.*

SILENCE DURING OPERATIONS.—Laughing and loud talking should be forbidden in every surgical operating-room. It has been shown by experiments with the Petri dish and otherwise that in speaking in a low conversational voice saliva containing bacteria is not projected from the mouth, but that in every explosive vocalization, as laughing and loud talking, bacteria are thrown out, perhaps upon the field of operation. "*Noli loqui, noli tangere,*" should be the unwritten if not the written, motto of every operating-room.—*Central States Magazine.*

EPIDEMIC CEREBRO-SPINAL MENINGITIS. — Cerebro-spinal meningitis in epidemic form has appeared in several parts of the United States during the past year. A specially interesting feature has been the suggested relationship between epidemic cerebro-spinal meningitis and croupous pneumonia. Monti (*American Medicine*, July 30, 1904) has reported a case in which he was able to demonstrate the micrococcus of Weichselbaum. The consensus of opinion favors the view that this micrococcus is the etiologic factor of the disease. Treatment has been practically unsatisfactory. About fifty per cent. succumb.

St. Louis Courier of Medicine.

ASTHMA AND HALLUCINATION OF SMELL.—F. S., male, aged forty-four, has been subject to attacks of bronchial asthma since boyhood. For four years his attacks have been infrequent, and for the past year he has had none at all. He has never suffered any pain. For years he noticed that for twenty-four hours before an attack came on he could not drink coffee on account of its smell, which was like sulphureted hydrogen to him. This sign was so invariable that he came to look upon it as a warning that an attack was approaching. An examination of his nose showed nothing pathological.—*Johns Hopkins Bulletin.*

WINTER COUGH AND ECZEMA: PSORINUM.—Mrs. M. came for relief from a winter cough which had returned and persisted for seven winters. It had returned every fall and continued until the appearance of warm weather. A physical examination revealed a slight bronchial catarrh. There was a foul odor from the body, and an eczematous eruption upon the hands. The general conditions led us to prescribe psorinum. Within two weeks the cough had subsided (during the middle of the winter); the offensive odor from the body was removed. She has returned from time to time, but there is no return of the bronchial or other troubles.—*The Medical Visitor.*

PERSONAL AND GENERAL ITEMS.

DR. HUBERT T. DEAN is very pleasantly located at 499 Northampton Street, Elmwood, Holyoke, with office hours until 8.30 A.M., and from 1 to 3 P.M. Telephone, 601-1.

BOSTON'S death-rate for 1904 was 17.50, or against 17.69 in 1903. The total number of deaths from all causes was 10,757 last year, being an increase of 125 over the total number for the previous year.

WHAT is said to be the first statue erected to a woman physician in the United States, has been unveiled in Fullerton Memorial Hall at the Art Institute in Chicago, in honor of Dr. Mary Thompson. Dr. Thompson was the founder, in 1865, of the Mary Thompson Hospital for women and children, and was the pioneer woman physician of the Northwest.

OF 6,000 samples of food products of 61 different kinds examined during the last year at the Connecticut Agricultural Experiment Station, more than one-third were found to be adulterated, according to the report just issued. Of 81 samples of tomato catsup and chili sauce examined, 71 were colored with red dyes, and 77 were preserved with salicylic or benzoic acid.

THE total number of deaths among physicians in the United States and Canada for 1904 was 2,142, making the death-rate 17.14 per 1,000. This rate is higher than for the two previous years. Among the causes of death appear the following, in order of frequency: heart disease, pneumonia, nephritis, tuberculosis, cancer, typhoid fever, septicemia. Thirty-six physicians committed suicide. The greatest number of deaths occurred at the age of sixty.

THE Newton Hospital has recently had a new nurses' home given to it. Now it is promised a modernly-equipped maternity ward, fitted with twenty-five beds, to cost not less than \$25,000, by an unnamed donor, the announcement being made at the annual meeting of the Hospital Aid Association. These officers were chosen: Mrs. Emmons Paine, president; Mrs. Howard Bellows, vice-president; Mrs. Lewis Speare, secretary; Mrs. William Gould, treasurer, and Mrs. Frank Day, auditor.

AT the annual meeting of the trustees of the Homœopathic Medical Dispensary, held Jan. 18, 1905, it was reported that the new patients for the year numbered 17,217, and that the total of the prescriptions made was 47,751. The net income for the year was \$5,739.76, and the outgo \$6,359.60 (\$970.35 of the latter sum having been spent for improvements, including the addition of three rooms.) We regret that the secretary's report, through no fault of his, was received so late that it cannot be given in full.

DR. DOYEN of Paris has won the first of a number of civil actions in which he is concerned. He claimed damages from the manufacturers of cinematograph films, who sold, for public exhibition, records of certain operations performed by Dr. Doyen. The court decided that Dr. Doyen was the sole proprietor of the films and can prevent them being exhibited against his will, and also that he suffered moral detriment through their exhibition at nonscientific gatherings. He was awarded 8,700 francs (\$1,740) damages.

THE first report of the New York State Hospital for the Treatment of Incipient Tuberculosis, which was established, by an act of the legislature, at Raybrook, in the Adirondacks, states that, although the institution has been open only since July 1, 1904, indications point to complete success. Of the 82 patients admitted, 11 have been discharged as cured. Of the remainder, 5 have not been in the hospital long enough to justify any conclusions; 19 have apparently recovered; the disease of 34 has been arrested, and all the rest show improvement.

THE Metropolitan Hospital of the City of New York has twenty-two resident physicians. Its competitive examination, open to all graduates in medicine, for the fifteen services, of eighteen months each, commencing in June and December, 1905, will be held on April 28, 1905. Applications should be addressed to Edward P. Swift, chairman committee of examination, 170 West 88th Street, New York City. This hospital has over one thousand beds, and gives unusual opportunities for experience in surgery, gynecology, genitourinary diseases, neurology, dermatology, physical diagnosis and general medicine, and homœopathic therapeutics.

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ORIGINAL COMMUNICATIONS.

ECTOPIC GESTATION.

BY J. EMMONS BRIGGS, M.D., BOSTON, MASS.

[Read before the Massachusetts Surgical and Gynecological Society, Dec. 14, 1904.]

It is my purpose in this article to consider the subject of ectopic gestation in a thoroughly practical manner, to avoid as much as possible technicalities, and to eliminate from my paper points still under dispute. There is enough evidence accumulated to warrant us in the assumption that extra-uterine pregnancy is of comparatively frequent occurrence, that early and accurate diagnosis is of vital importance, and neglect or expectant treatment tragic in its consequences.

By the term ectopic gestation we mean a fertilization and implantation of the ovum at any point outside of the uterine cavity.

In order to comprehend the *modus operandi* of tubal pregnancy, let us consider briefly the physiology of normal pregnancy. The uterus is the seat of normal conception. The ovum, having made its escape from the Graffian follicle, is engaged between the fimbriated extremities of the Fallopian tube, and conveyed to the uterine cavity by the agency of the ciliated epithelium. There the ovum meets with the spermatozoa, and lodgment of the fertilized ovum within the crypts of the uterine mucous membrane occurs. The subsequent history of the impregnated ovum does not concern us in the consideration of this subject.

Let us now turn to the consideration of the pathological conditions to be found within the Fallopian tube which act as the causative facts in tubal pregnancy. The ciliated epithelium of the Fallopian tubes while in its normal condition serves two functions; its wave-like motion from the ampulla of the tube toward the uterus propels the ovum onward, and at the same time prevents the entrance of the spermatozoa. Suppose that the tube is the site of a desquamative salpingitis, the cilia destroyed, the mucous membrane of the tube is immediately converted into a condition similar to that of the endometrium. The cilia destroyed, or nonoperative, permits stagnation, and allows the entrance of the spermatozoa into the tube where fertilization and implantation occurs.

The degree of salpingitis requisite to occasion tubal implantation is unknown, but our experience has taught that a severe inflammation of the tube causes a permanent closure, and renders the patient ever afterwards sterile. It must be, therefore, a salpingitis of rather a mild type which would permit of tubal impregnation. Not infrequently in cases of extra-uterine pregnancy have adhesions been demonstrated which evidence a pre-existing pelvic peritonitis.

A notable feature in these cases is the history of a long period of sterility preceding the extra-uterine pregnancy. The typical conditions are found in the patient who has gone years after marriage without becoming pregnant, or has borne children followed by a number of years of sterility with menstrual suffering. Common indeed is it to find a history of delayed convalescence from a previous confinement followed by pelvic suffering. Thus, after the lapse of years an ectopic pregnancy occurs, ending in rupture and collapse.

In attributing to salpingitis the chief causative facts in tubal pregnancy, I am aware that many able authorities discredit this theory altogether, and ascribe it to the premature arrest of development of the tube, a truly infantile tube, or a twisting of the tube with narrowing of its lumen at the uterine end. Nevertheless, the weight of opinion still strongly

supports Tait's theory of inflammatory alteration in the mucosa of the tube due to septic processes.

The whole subject of extra-uterine gestation is simplified if we classify all cases according to the site of the implantation of the fertilized ovum, and from thence describe the steps in its evolution. Clinically, two forms of tubal pregnancy exist, the one where the fertilized ovum becomes implanted in the mucous membrane of the tube outside of the uterine tissue, the other where the implantation occurs in that portion of the tube which is imbedded within the uterine tissue. To these varieties we use the classification indicating the portion of the tube involved as (*a*) interstitial, (*b*) isthmie, (*c*) ampullary, (*d*) infundibular.

The clear and comprehensive tabulation of ectopic gestation by Tait has never been improved upon and is therefore reproduced:

I. Ovarian, possible but not yet proved.

II. Tubal, in free part of tube, is (*a*) contained in tube up to fourteenth week, at or before which time primary rupture occurs, and then progress of the gestation is directed into (*b*) abdominal or intra-peritoneal gestation, uniformly fatal (unless removed by abdominal section), primarily by hemorrhage, secondarily by suppuration of sac and peritonitis; (*c*) broad-ligament or extra-peritoneal gestation; (*d*) may develop as broad ligament to full term, and be removed at viable period as living child; (*e*) may die and be absorbed as extra-peritoneal hemocele; (*f*) may die and suppurating ovum may be discharged at or near the umbilicus, or through bladder, vagina or intestinal tract; (*g*) may remain quiescent as lithopedion; (*h*) may become abdominal or intra-peritoneal gestation by secondary rupture.

III. Tubo-uterine or interstitial is contained in part of tube embraced by uterine tissue, and, so far as known, is uniformly fatal by primary intra-peritoneal rupture before the fifth month.

When the fertilized ovum is contained in the free part of

the tube, there is invariably rupture from the fourth to the fourteenth week, usually between the fifth and eighth. This may occur into the general peritoneal cavity, and may be classified as primary intra-peritoneal rupture, or into the folds of the broad ligaments, termed extra-peritoneal rupture. The essential cause is the destruction and thinning of the tubal wall, this being usually thinnest at the site of the placental attachment. On two occasions, at least, I have observed this to be the case, as I have been able to demonstrate the placental attachment close to the margin of this rent in the tubal wall, and through this tear a portion of the placenta has been found to protrude. Through it, also, the products of conception escape either as a whole or in part, and from this lacerated tube hemorrhage occurs. This is severe, as the blood supply to the tube has been greatly augmented by the existing pregnancy. Again, if the tear involves the tube at the placental site, this hemorrhage is profuse.

I have already stated that a rupture of the tube occurs, with escape of the fetus and hemorrhage. We have now to consider the intra and extra peritoneal rupture and their subsequent course.

The primary intra-peritoneal rupture is the most disastrous accident known among women. It may be immediately fatal from hemorrhage or, what has happened in my experience, the patient may bleed until the heart pressure is low and all symptoms of internal hemorrhage are pronounced, when Nature asserts herself and there is an improvement in pulse, and symptoms of shock abate. Extreme pallor is present. Now follows a few hours of reaction from shock, and again further hemorrhage with collapse. Many factors may operate to postpone the fatal issue. The rupture of the tube may be some distance from the placental attachment, and the bleeding consequently slow. The membranes may engage at the rent in the tube and temporarily tampon the opening. An unstable hemocele may form about the tube which will offer some resistance to the outpouring of blood.

Any of these may serve to postpone, but none of them is liable to avert, the dreaded calamity. The fetus usually dies immediately after rupture, due to the total or partial separation of its maternal attachments. The mother may succumb to immediately fatal internal hemorrhage, or the fatality may be averted by prompt surgical interference. The fetus, however, may survive this. In order for this to happen it must retain its attachment to the tube and the hemorrhage spontaneously cease. This occurring, postpones the immediate danger of intra-abdominal rupture, but substitutes other complications equally disastrous.

Extra-peritoneal rupture in tubal pregnancy is of somewhat frequent occurrence, and is the result of a perforation of the tube from its under-surface so that the exudation fills the space between the peritoneal fold of the broad ligament. The primary rupture in this case is extra-peritoneal. The fetus and membranes, frequently the placenta, escape into the folds of the broad ligament. There is now considerable bleeding, which occasions the formation of a hemocele. The shock and loss of blood in these cases is far less severe than in intra-peritoneal ruptures. Since peritoneal walls of the broad ligament offer considerable resistance, the bleeding may be spontaneously arrested. The hematoma and the fetus may undergo absorption. This termination of an extra-uterine pregnancy is the most favorable possible, and, without doubt, occurs far more frequently than is supposed. In case the rent in the tube is of considerable size and involves the rupture of an important vessel, the hemorrhage may be very violent, and the thin peritoneal covering of the broad ligament prove inadequate to the strain suddenly placed upon it, in which case an immediate secondary intra-peritoneal rupture will occur. More often this comes about at a later period, due to a gradual distention of the tube occasioned by a living fetus which, having descended from the tube with its placenta intact, continues to develop as a broad-ligament pregnancy. At any time during the progress of pregnancy the distended hemocele may give way resulting in fatal hemorrhage,

It is possible for the fetus to develop to full term within the folds of the broad ligament; in order for this to occur the placenta must have at least a partial attachment at its original site. As it was originally within the tube, and as the gestation sac is now within the broad ligament, it will be seen that the placenta will occupy a position anterior to the fetus, and, as the pregnancy advances, the parietal and visceral peritoneum is raised to meet the demands of advancing gestation until finally the fetus appears high in the abdomen, and the placenta no longer overlies it. The fetus, in cases of this kind, has been removed at a viable period and survived.

Another course which the broad-ligament pregnancy may take is to rupture into the peritoneal cavity, its placental attachment to the tube remaining intact and developing as an abdominal pregnancy.

The only other possible termination for extra-peritoneal pregnancy lies in the death of the fetus at any period of its development, suppuration of the sac, its subsequent discharge through the rectum, vagina, bladder or at a point at or near the umbilicus, or occasionally the fetus remains quiescent as a lithopedion.

Thus far we have considered the pathology of extra-uterine gestation; it remains for us to discuss the symptoms which are quite typical yet often disregarded, so that it is rare for the case to come to the surgeon with a diagnosis made, and I am sure that the appearance of blood in the peritoneal cavity is now and then a complete surprise to the operating surgeon.

SYMPTOMS OF ECTOPIC GESTATION.

If a woman has previously borne children it is possible that she may fancy herself again pregnant, not from definite symptoms, but rather from general sensations or a kind of premonition. Occasionally nausea or changes in the breasts are observed. Often colicky pains are noticed by the patient which may be occasioned by dilatation of the tube.

Great variations occur in the menstrual symptoms of ectopic

gestation. I cannot do better, perhaps, than to cite the menstrual history of the cases which have come under my observation, and on whom I have operated.

Case I. Menstrual periods always irregular and has flowed irregularly for fifty-six days, discharge dark blood.

Case II. Menstruation regular until Oct. 1. After this period patient flowed more or less steadily until Nov. 14, blood dark and clotted, occasionally bright red.

Case III. Has flowed quite steadily for two weeks prior to operation.

Case IV. Middle of June had normal menstrual period. Regular July period skipped, but on July 21 began to flow very scantily, and has continued to date of operation.

Case V. Menstrual symptoms not influenced at all by ectopic pregnancy.

Case VI. Menstrual symptoms not influenced at all by ectopic gestation.

Case VII. Has been flowing scantily for one month, and does not know the date of last period.

Case VIII. Last menstruation Dec. 19. For past two months has been passing shreddy material, sometimes bloody. Operation March 4.

Case IX. Menstrual period ended eight days ago, but is now menstruating again.

Case X. Patient considered herself pregnant, and three weeks ago had attempt made to produce abortion, and has flowed quite constantly since.

Case XI. May period five days late, at which time she flowed more than usual. Has flowed irregularly since until date of operation, July 19.

Case XII. Always irregular, last menstruation Oct. 4, normal in character. No show whatever from that time until after rupture of tube, Nov. 15.

It will be seen that in the twelve cases operated upon, ten presented abnormalities in menstrual symptoms, while in two no irregularities existed. It will be seen that in only one

case (Case VIII) has a history of a discharge of decidua membrane been given.

VAGINAL EXAMINATION.

Vaginal examination is rarely made prior to rupture, for it will be understood that the patients are usually in average health, and have no occasion to consult the gynecologist. Certain changes do occur, however, in the uterus, notably an enlargement of that organ, and, if there is flowing and decidua discharge, an open cervix and patulous os can be demonstrated. If primary rupture into the broad ligament has occurred very definite pathological changes cannot escape observation. The accumulation of blood in the broad ligament will push the uterus to the healthy side of the pelvis, and a hemocele will be found to occupy the greater part of the pelvic space. Upon abdominal palpation nothing abnormal can be detected before rupture, but immediately after, the whole abdomen may be exquisitely sensitive. If a hemocele of the broad ligament is present the tumor may be detected upon abdominal palpation, and is usually very sensitive. All preliminary symptoms, however, pale into insignificance when compared with the clinical picture presented at the time of rupture. Some of the symptoms before mentioned, chiefly menstrual, may have existed for a few weeks, but these are usually so trivial as not to occasion the least anxiety on the part of the patient, when suddenly without warning the woman is stricken with sharp, usually very severe, lancinating pains in the lower part of the abdomen, sometimes referable to the side affected, but often in the part of the abdomen remotely located from the affected tube. There may be severe, epigastric pain, with or without nausea or vomiting. This may be accompanied by considerable shock or there may be none, but whether this is present or not, one symptom predominates over all others, and that is anemia. This is evidenced by pallor of the face, blanched lips, cold extremities often bathed in cold perspiration, low temperature and rapid pulse. This

change is, perhaps, the most characteristic of all conditions, and in recent rupture is of greatest diagnostic importance. The pulse is weak and thready in character, easily compressible, and although accelerated only a few beats immediately after rupture it will be found to be increasing at each subsequent examination, and, if taken at frequent intervals, if the hemorrhage is copious, the rate has increased to 120 or 140 within a few hours.

The pain which was so distressing at the time of rupture has now subsided, and the rapid pulse and blanched features, restlessness, dizziness and thirst are the chief points upon which the diagnosis is made. Distention of the abdomen by the accumulated blood never takes place as the woman has become completely exsanguinated before this is apparent. If surgical aid is not promptly rendered, death may occur in a few hours.

Such a case has just occurred in the practice of a colleague which illustrates the gravity of this accident. A woman perfectly well at eight in the forenoon, and in eighteen hours dead from internal hemorrhage. This rapidly fatal termination is rather the exception, the rule being, judging from my own experience, to have sharp pains and primary rupture with shock and symptoms of collapse, followed in a few hours by an improvement in the patient's condition, which may continue a longer or shorter period when more intra-peritoneal hemorrhage occurs, and a repetition of symptoms of collapse. How many times this will occur before the fatal termination is uncertain, but without operation a disastrous outcome is to be expected.

In case primary rupture occurs into the folds of the broad ligament the initial pain will not be so severe or the shock so pronounced.

The chances are that the walls of the newly formed hematocoele will offer considerable resistance and diminish the amount of hemorrhage. The pain, however, will be more continuous, and cause more persistent discomfort than in

intra-peritoneal rupture. Should the hematocele increase greatly in size, due to repeated hemorrhages, or the fetus remain viable, its increase in size may rupture the overdistended broad ligament causing secondary or intra-peritoneal hemorrhage.

I am aware that this subject is altogether too extensive to allow me to even touch upon many phases of it. I must therefore proceed to the prognosis and treatment, leaving out very much which I should like to say. The prognosis of primary intra-peritoneal rupture is very unfavorable, from free and persistent hemorrhage. We must conclude that extra-peritoneal rupture is relatively rare, though undoubtedly cases of this variety frequently occur and escape observation, the fetus perishing and absorption taking place.

Secondary rupture of the broad-ligament pregnancy is very fatal from rapid exsanguination. Interstitial pregnancy, a subject concerning which I have said next to nothing, because of the rarity of the condition and lack of time, is an especially fatal form of ectopic pregnancy. In a word, the only form of extra-uterine pregnancy which offers any reasonable hope of spontaneous cure is the extra-peritoneal hematocele, and then only in case the fetus dies and is absorbed.

This naturally leads us to the consideration of ways and means of cure which are to be found only in the early recognition of the condition and appropriate surgical interference. These cases demand the judgment and skill which only the experienced surgeon possesses, as patients are usually *in extremis* when operation is undertaken.

Martin and Kelly are the chief exponents of colpotomy in the treatment of ectopic pregnancy. Among all other surgeons there is a wonderful unanimity of opinion as to the advisability of proceeding by the abdominal route.

As regards the time for operating, there are still some who advocate delay when in shock until the patient commences to rally, claiming that there are few cases indeed where Nature is not able to assert herself, and the patient show symptom

of improvement after the shock of the primary rupture. They therefore advocate delay until the period of reaction from shock. To this argument one has only to question what about those where, from the violence of the bleeding, there never comes a reaction. It is in these very cases that a life may be sacrificed by delay.

How many years it has taken to sweep away the counter-indication for operating in acute appendicitis. The writer is firmly convinced that the smallest mortality will be found in cases operated upon as soon, or even before, diagnosis is made.

All the cases operated upon by me have been of the ampullary or isthmic type, never having seen interstitial or a so-called ovarian pregnancy. Ruptures have all occurred fairly early, all the patients have been in varying degrees of shock either at the time operation was undertaken or previously. I have never personally treated an extra-peritoneal ectopic gestation, although have seen a few such cases.

In cases of intra-peritoneal rupture operate as early as possible. The patient's life depends upon the prompt arrest of hemorrhage. In these cases I have always removed the tube, either as a whole or in part, including the gestation sac. A still more conservative operation would be the removal of the gestation sac by a lateral incision into the tube, and then closing the wound. This I have never done.

Patients do somewhat better if the free blood and clots are washed out, and the abdomen flushed with saline solution and considerable amount left in the peritoneal cavity. No time should be lost in these operations. It is unnecessary to say that drainage should never be used unless absolutely needful in order to control hemorrhage in long-standing cases. In case the pregnancy is within the folds of the broad ligament (extra-peritoneal), open and drain *per vaginam*; or, if operating through an abdominal incision, find a fluctuating point in the hemocele, open and evacuate the contents.

I append the report of twelve cases of ruptured tubal pregnancy operated upon during the past five years, all of whom recovered.

At the Massachusetts Homœopathic Hospital during that period, a total of forty-six cases has been operated upon, or an average of nine annually.

REPORT OF TWELVE CASES.

Case I. Mrs. G., aged thirty-one, patient of Dr. Noble H. Hill, was operated upon on April 29, 1899. One child and several miscarriages.

History: Her menstrual periods have always been irregular varying from one to six weeks; the last regular period occurred Feb. 3, and this continued until the 29th of March, when it ceased for a few days, to begin again,—a very dark discharge. On the 22d of April, at 1 A.M., she was taken with very violent pain in the abdomen with nausea and vomiting. The severe pain lasted one hour, and was followed by extreme tenderness over the whole abdomen, which has persisted since.

Operation: Median abdominal incision 4 inches in length. The abdominal cavity was found partially filled with blood, dark and clotted. The right tube was found much enlarged, length $3\frac{3}{8}$ inches, diameter $1\frac{1}{2}$ inches. Rupture had occurred at the distal extremity where there was an opening $\frac{1}{4}$ inch in diameter, with irregular edges from which blood was constantly but slowly oozing. Right tube and ovary removed. The left tube was the seat of a hydrosalpinx, and the left ovary cystic. Both were removed. The wound healed by first intention. Highest temperature was 100° . Excellent convalescence.

Case II. Mrs. B., aged twenty-eight, patient of Dr. Nelson M. Wood, was operated upon Nov. 21, 1900. Three children, youngest seventeen months, and one miscarriage.

History: Menstruation regular until Oct. 1, since which time she has been flowing steadily. Blood dark and clotted, occasionally bright. Recently she has had two attacks of severe pain, cramp-like in character. Has been very pale of late. Examination revealed a boggy tumor back of the uterus.

Operation: Median abdominal incision revealed a ruptured tubal pregnancy on the right side, with abdomen filled with blood. Ovary and tube on left side normal. Excellent recovery.

Case III. Mrs. W., aged thirty, patient of Dr. W. H. Sawyer, was operated upon June 11, 1902.

History: May 28 she began to flow and has persisted since. Has severe pain in abdomen and bladder, with tenderness over the whole abdomen. Temperature and pulse normal. For the past week has been vomiting a great deal.

Operation: Median abdominal incision. Abdomen filled with blood, rupture of right tube at distal end, with free bleeding. Excellent convalescence.

Case IV. Mrs. D., aged twenty-three, patient of Dr. J. Tucker Cutler, was operated upon Aug. 8, 1902. Miscarriage two years ago.

History: Middle of June patient had a normal period. Middle of July no period occurred, but on the 21st of July she began to flow scantily and has persisted since. One week ago, Aug. 1, she had severe pain across the abdomen which lasted one and one-half hours. Aug. 2 had very severe pain for two and one-half hours; for the next three days she was better, and able to be about the house, but vomited occasionally. Aug. 6 had subnormal temperature, and pulse of 120. Aug. 7 temperature was normal, but pulse 148, very feeble. Extreme pallor, and general soreness over the whole abdomen.

Operation: Median abdominal incision. Abdomen filled with blood. Left tube greatly distended and ruptured, with constant moderate oozing from the rent. Excellent recovery.

Case V. Mrs. T., aged thirty-six, was operated upon Oct. 11, 1902. Four children, oldest eighteen, youngest five years.

History: Menstrual periods normal. Four weeks ago was seized with intense pain in the right side of the abdomen, accompanied by nausea and vomiting. Following the pain there has been extreme soreness over the entire abdomen.

Operation: Incision was made in the right linea-semilu-

nares over the appendix. That organ was not diseased, but the abdomen was filled with blood and a right ruptured tubal pregnancy was found. Tube and ovary were removed. Excellent convalescence.

Case VI. Mrs. S., aged thirty-four, patient of Dr. J. P. Sutherland, was operated upon Nov. 28, 1902. One child, twelve or thirteen years old.

Operation: Median abdominal incision. Abdomen contained free blood from ruptured tubal pregnancy of the right side. Excellent recovery.

Case VII. Mrs. B., aged twenty-six, patient of Dr. John D. Tupper, was operated upon Dec. 24, 1902. Two children.

History: Has been flowing scantily for one month, and does not know the date of her last period. Had severe pain in the abdomen for past week, with sensitiveness.

Operation: Median abdominal incision. Abdomen filled with free blood and clots. The right tube was distended and ruptured, active bleeding. Excellent convalescence.

Case VIII. Mrs. M., aged twenty-five, patient of Dr. J. E. Blaisdell, was operated upon March 4, 1903. Never pregnant before.

History: Last menstrual period Dec. 19, 1902. For the past two months has been flowing, and has discharged decidua per vagina. Two weeks ago was taken with intense pain in the abdomen and pit of stomach, with tenderness over the whole abdomen. Yesterday at 3 P.M. she was seized with very violent pain, followed by profound collapse. Pulse imperceptible, temperature 96° , body bathed in cold, clammy perspiration. Patient rallied somewhat this morning, but is still in desperate condition.

Operation: Median abdominal incision. Abdomen filled with free blood and clots. The fetus (estimated at two months) had escaped from the tube. Rupture at distal end of tube, and bleeding still active. Patient developed a very severe pleurisy with effusion, and struggled between life and death for two weeks, but finally made a fine recovery.

Case IX. Mrs. S., aged twenty-nine, patient of Dr. E. E. Allen, was operated upon Oct. 17, 1903. One child eighteen months ago.

History: Menstrual period ended eight days ago, but has commenced to flow again. Eight days ago had a very sharp attack of pain in the right side of the abdomen. On the day following soreness in the abdomen, but no rise in temperature. This morning patient had another attack of severe pain, right sided, accompanied by nausea and vomiting.

Operation: Median abdominal incision revealed the cavity filled with blood. The right tube was distended and had ruptured. Excellent convalescence.

Case X. Mrs. W., aged thirty-five, patient of Dr. Nelson M. Wood, was operated upon Dec. 24, 1903.

History: Patient considered herself pregnant, and three weeks ago had attempt made to produce abortion, and has flowed quite constantly since. Recovering from the effects of the instrumentation she got about again, and went in town shopping, where she was taken with extreme violent pain in the abdomen. Getting home with difficulty, she became exceedingly pale, and vomited several times. When seen by me that evening she was very pale, practically pulseless, and sensitive over whole abdomen. I advised immediate removal to the hospital.

Operation: On making abdominal incision the abdomen was found filled with blood and clots. The right tube was distended and ruptured, and active bleeding was present. Recovery.

Case XI. Mrs. D., aged thirty-two, patient of Dr. F. P. Batchelder, was operated upon July 18, 1904.

History: May period five days late, at which time she flowed more than usual, and has flowed irregularly since. July 1 had very severe pain in the right side, with nausea and vomiting. Considerable sensitiveness over the right side. Temperature since July 13 has been slightly above normal. About July 1 a bunch appeared especially noticeable in the right side, sore and sensitive on pressure,

Operation: Median abdominal incision. An unstable hematocele occupied the right side of the lower abdomen. There was free blood and clots in the peritoneal cavity. The right tube was distended and ruptured. Excellent convalescence.

Case XII. Mrs. P., aged twenty-two, patient of Dr. Clarence Crane, was operated upon Nov. 15, 1904.

History: Last menstrual period 4th of October, which was normal. Has always been irregular. Yesterday had sharp, cramp-like pains in the abdomen, followed by soreness. At 8.30 this morning, had another seizure of pain, much worse than before; somewhat faint and dizzy.

Operation: Abdominal incision showed cavity to be filled with blood and clots. Right tube had ruptured, and there was free oozing from distal end. Excellent recovery.

DISCUSSION (DR. BRIGGS' PAPER).

Dr. Packard: This is certainly a subject pregnant with interest. My experience in the matter of diagnosis and treatment of ectopic pregnancy began some years ago, but the total number of cases I have seen of this unfortunate condition I cannot at present say. I have operated by abdominal incision upon twenty-eight or thirty, and I have, first and last, had a large number of cases of hematocele which we now know are ruptures into the broad ligament.

The varying conditions, which have been met, are of the greatest interest, and if I refer to a few of the unusual ones and those which have created some confusion in diagnosis and treatment, such will be more profitable than the plainer, straighter cases.

I recall many years ago a case of pelvic hematocele, almost the first I had seen. The patient was seized with abdominal pain and prostration. The physician, on being summoned, was very much disturbed over the obscurity of the case, and asked me to see the patient. I made an examination, and found a large fluctuating mass in the pelvis. I called further counsel, and after a lapse of a day made an examination under

ether, introduced the aspirator needle and out came blood. In this case no further operation was performed. The tumor gradually underwent absorption and the patient got well, as they do sometimes, without operation.

In a few cases of tubal pregnancy, the diagnosis of appendicitis has been made before I attended the case. How this can be, I do not understand, as the two troubles present different phases—in one there is inflammatory infection and in the other none at all, but instead a subnormal temperature and a weakening of the pulse. Where mistakes of this kind have been made, they are due to a lack of study. If an accurate history is made at the time of the examination, and then carefully read over afterward, it will greatly assist in making a correct diagnosis. I know of no disease which is so terrifying and so shocking in its effects, as a rapid hemorrhage from a ruptured tubal pregnancy. I remember the case of a young married woman, to whom I was called "to curette after a miscarriage." The patient was lying upon a couch with the countenance of death itself, pallid, and except for labored breathing seemed as if dead. I ordered her removed to the hospital at once, operated, and found the abdomen full of blood. She had had no miscarriage. She recovered.

Several years ago I was called early one morning, and found a patient who had suffered all night with pain in the lower abdomen, countenance pallid, lips pale and pulse scarcely perceptible. In the transference to the hospital she lost strength rapidly and was in such an alarming state that an intravenous saline infusion was given the first thing before operative measures could safely be undertaken. She rallied sufficiently to go through the operation, although she collapsed on the table and I thought she was gone. Another intravenous saline infusion revived her and she recovered. This has been of great importance in these critical cases in keeping the heart going until the hemorrhage is stopped and the operation completed.

Another point which I wish to suggest is how to handle a

patient who is in this condition. The physician in attendance upon such a case is often very much embarrassed to know what to do. He may not be called until the hemorrhage has been going on for some hours, and the patient is *in extremis*. What shall he do when he finds this condition, the patient almost dying and perhaps in the last gasp from internal hemorrhage? A hospital is the best place for such a critical operation, and if one is available the case should be hurried to it. I will tell you what occurred one time. I was called in the small hours of the morning, over the telephone, by a physician, who said: "I have a mysterious case; I fear life is in danger." From his description I recognized tubal pregnancy. I replied: "Put the patient in a carriage and start for the hospital immediately, and I will do the same. If I get there first, I will have things in readiness for immediate operation." I got to the hospital first, and shortly after he telephoned that the patient died in the carriage on the way.

In a recent case which has come under my observation, the first pain was felt about eight o'clock in the morning, but those immediately interested did not take alarm until about 5 P.M. The patient lived three or four miles from a hospital, and there was some delay about getting an ambulance sent out, so that it was 7.30 before the case came to operation, thus an hour and a half were lost, which may have made the difference between the life and death of the patient who collapsed on the table, was resuscitated, but lived only five hours. Time was lost sending for the ambulance, and the hemorrhage had two more hours to go on. It is not necessary to wait for an ambulance, a carriage will do just as well, the important thing is to get your patient to the hospital without delay.

I have an extremely interesting specimen, which I brought over to-day, from my last case, ten days ago. You will see the little fetus peeping out of the sac. The large mass is the distended tube containing clots and placental tissues. It is a most perfect specimen of ruptured tubal pregnancy, because all the parts are shown. In many cases the fetus is not

demonstrable. As a rule, the success of the surgical management of these cases is very gratifying. Only two of my cases have died. One was at the fifth month and the fetus still living. The other case occurred within the last few weeks and is the one above referred to. Here the hemorrhage was so great prior to operation that no blood, practically, was left in her veins. She lived on salt and water for five hours. The heart kept pumping until the nerve centers failed.

Dr. Chandler: Dr. Briggs' paper is so complete that very little room is left for discussion, especially by one so inexperienced as I, I never having operated on a case of extra-uterine pregnancy.

In dealing with the etiology it seems to me that enough prominence is not given to obstruction as a factor. It would seem as though a body, as light as an ovum must be in order to be propelled by cilia, could be stopped in its journey by a very slight obstruction, such as a very small polypus, or a scar, such as might result from the stretching of the tube in a previous pregnancy.

There is very little said in the literature regarding the liability of the patient to the condition developing again in the other tube. I have seen one such case, and know of two others.

It has been my fortune to see twenty or more extra-uterine pregnancies. Among this number have been three in which the fetus has developed, and has been delivered per abdomen at full term. Two of the mothers and two of the children have been saved. Another case which I saw was that of a fourteen months' extra-uterine pregnancy in which the mother was saved.

I think the diagnosis very difficult, the difficulty arising from the absence of the perfect picture. One or more important symptom is lacking. We do nearly always get an irregular menstrual history which is very important.

In regard to treatment, I am entirely in accord with Dr.

Briggs, and should operate at once and by the abdominal route. It is well to remember that we are treating a case of internal hemorrhage rather than a case of extra-uterine pregnancy.

MULTIPLE OR DIFFUSE OSTEOSARCOMATA.

BY J. EVERETT LUSCOMBE, M.D., FITCHBURG, MASS.

[Read before the Massachusetts Surgical and Gynecological Society.]

The subject of this paper relates to a case which came under my care and observation for six months, until the death of the patient. The primary symptoms would not ordinarily seem to indicate a serious prognosis, but the gradual development of new lesions at different locations over the body, clearly pointed to a fatal issue. I am led to believe that the case was an unusual one, not occurring frequently in the experiences of any practitioner, and in most of them never; as numerous inquiries made to members of the profession, and the searching of medical and surgical records, have failed to bring to my notice one of like character, especially in its varied manifestations. Therefore, it has seemed appropriate, having been invited to read a paper at this June meeting, that I report here the particulars of this very interesting case.

Mrs. A., aged fifty-eight, was never pregnant. Had enjoyed a fair degree of health through life. Family history negative as to cancer, tumor or any abnormality of like nature. There was a bare possibility of syphilitic taint.

On July 14, 1900, I was called to treat her for rheumatism located in the shoulder, hip-joint and thigh, of the right side. Found the patient up, and able to do light housework. She had recognized rheumatic symptoms during the early spring months, which in that year had been unusually damp. She complained of a dull pain in the localities mentioned, which was nearly constant. Temperature 99.6°, pulse 88.

I visited her daily for ten days until July 24. In this time

the pulse and temperature had been reduced to normal, and the pain to a great degree had been overcome.

Subsequent visits were made weekly, until the evening of Sept. 28, a month and a half after my first visit, when I was suddenly called to my patient, as a very unexpected accident had occurred. While her husband was assisting her into bed, she felt a sudden sharp pain in the right thigh, followed by a snap that could be heard in the room, and the leg became helpless.

Under ether anesthesia a complete fracture of the right femur was diagnosed at the upper third of the bone. The fracture was reduced, splints adjusted, extension applied, and the patient made as comfortable as possible for the night, with the intention of transferring her to a Crosby surgical bed in the morning, which was satisfactorily accomplished.

My conclusions at this time were still in harmony with the idea that rheumatism was the primary cause, and that the fragilitas ossium exhibited in this case, was a sequela of rheumatic osteitis spoken of by some authors. In "Holmes' Revised Surgery," it says that "in all rheumatic affections of joints, and in many of those of the limbs, although it may be true that the complaint originates in the fibrinous tissue, yet the bones will become involved if the disease lasts long enough. The patient was now in a position which admitted of frequent inspection and close observation. Among the first revelations were a hard ovoid tumor on the right clavicle near its distal end, of about an inch and a quarter, in its longitudinal diameter, and a hard ridge around the right shoulder joint.

The dull pain about this locality continued and was at times aggravating. Topical applications of hot water and alcohol or arnica had a temporary, soothing effect. The pain from the fractured limb was not severe, and after ten days attracted little attention. The temperature, which rose to 100° after the fracture, was normal again at this date, Oct. 8. The diet was mostly malted milk, which was very acceptable to the patient, with an occasional change to beef extract. Such

remedies were prescribed from time to time as the totality of the symptoms seemed to call for, and were selected mostly from the rheumatic group. Nothing had yet appeared in the case of sufficient import to me, to cause a change in the original diagnosis.

On Oct. 12 a dull pain was for the first time felt in the lower third of the left arm. In a week's time just that portion of the arm only became extremely sensitive, so that the slightest touch would cause the patient to cry out. Yet there was no external evidence of inflammation either in contour or change of color. Loss of voluntary movement was at this time observed in that arm. The same topical applications were employed as were being used about the right shoulder.

As the case further developed, new manifestations, with varied characteristics, came to notice. Oct. 22 a small cystoma was discovered, projecting from the anterior superior spine of the ileum. This was the first symptom observed that was sufficiently definite to cause a modification in the diagnosis. Others soon followed. Nov. 3 the integument covering the lower third of the affected left arm began to change to a copper hue, and upon gentle palpation the tissues beneath were found to be indurated. Another cystoma appeared on the eighth rib of the left side, near its union with the costal cartilage. There was no pain complained of at any time that was referable to the cysts. At about this stage of the disease, there was a remission of all pain throughout the body. Nov. 8, six weeks after the fracture of the right femur, the splints were removed. The length of the limb upon comparison with the left was nearly the same. Upon gentle manipulation, the fracture seemed to have permanently united. Nov. 11 found the limb shortened two inches and the foot everted. A metallic posterior femoral splint was placed beneath the point of fracture as a support, and further effort for inducing union was abandoned, as it was now very evident that the osseous system was being invaded by a serious disease, which precluded any possibility of union. From this

time through the latter half of the month of November, the patient, although with a helpless arm and leg, together with the numerous abnormal processes that were going on in the organism, experienced so little discomfort, that my visits were made at intervals of three days. On Dec. 3 preternatural mobility was noticed at the middle of the lower third of the affected left arm, with no apparent shortening or deformity. Daily visits were now resumed.

On Dec. 12 a flat, nodular growth was discovered immediately beneath the abdominal parietes, extending from the bone in the right iliac fossa out over the intestines toward the median line. Another irregular mass of similar characteristics was outlined, imbedded in the muscles of the thigh, attached to the upper fragment of the fractured femur. The tumor on the clavical and the ridge around the right shoulder joint began to soften. To make a conclusive diagnosis was still very difficult. The varying phases of the different points of lesion were confusing. No exploratory incision would be allowed. The integument had not been broken through. Syphilis, osteitis, mollities ossium, chondroma and carcinoma, one after the other, were eliminated, as the correlation of symptoms came more nearly under the head of osteosarcoma.

After Dec. 15 no new lesions were discovered. On Dec. 17 Dr. J. K. Warren was called in consultation, who confirmed the diagnosis and gave a grave prognosis. The effect of the diseased condition upon the vitality of the patient was now becoming more and more apparent, not in the general depletion of the tissues of the body, but in increasing anemia and marked physical exhaustion. There was no emaciation. The lungs, heart and kidneys performed their normal functions to nearly the end, which came on Jan. 17, 1901, six months and three days after my first visit.

In reviewing the case, I do not think of any time that I believe that the surgeon's knife could have relieved the condition, or aborted the disease.

It was very much to be regretted, that even after death no

histological facts were obtainable, to give scientific confirmation to the diagnosis, "multiple or diffuse osteosarcomata," as any mutilation of the body was emphatically denied.

DISCUSSION (DR. LUSCOMBE'S PAPER).

Dr. Packard: There is nothing for me to say, except to compliment Dr. Luscombe upon the careful description of a very interesting case.

There are two forms of sarcoma which affect the bones: one that takes place in the periosteum, splintering the shaft; the other having its origin within the shaft of the bone, and it is either round or giant-cell sarcoma. It is very evident in this case the sarcoma had its origin in the shaft of the bone, and the gradual growth and pressure upon the walls of the shaft weakened it and caused it to break, as described. Spontaneous fracture takes place also in the flat and round bones. Osteosarcomatas are frequently found in the inferior maxillary bones as well. I have seen them in both localities.

One thing that Dr. Luscombe left out—the cause. The biggest punctuation mark is the interrogation point. I am sanguine that we are on the threshold of the discovery of the cause of malignant diseases. By some it is thought to be an infection of protozoön, the lowest form of animal life in distinction to that of vegetable life, the bacillus. The fact of the almost simultaneous appearance of sarcoma in different parts of the body suggests a causation of this kind.

Dr. Luscombe: I realize the lack of original facts and I endeavored to obtain them. This is the second case of osteosarcoma that I have had under observation. The second case was that of a young lady, eighteen years of age, and the sarcoma was in the inferior maxillary, and attributed to the extraction of a tooth by the popular painless method. A few months after more or less pain developed in the jaw, and a year after there was an enlargement of the jaw of a cauliflower growth up from the cavity where the tooth was extracted. The inferior maxillary was removed by Dr. Packard. She is now married and the mother of children, and gets along very well in masticating food.

**THE TREATMENT OF THE PERINEUM AND VAGINA
IMMEDIATELY AFTER PARTURITION.**

BY J. C. SHAW, M.D., NEW BEDFORD, MASS.

[Read before the Massachusetts Surgical and Gynecological Society.]

I have chosen this very common occurrence as my subject, not expecting it to interest the specialist, as much as the general practitioner.

I would like to ask the question, Is it important that a laceration of the vagina or perineum be repaired? If so, should it not be very carefully done?

The first point needs no discussion. But does the general practitioner exercise at all times, proper care in performing the operation, upon which many times, depends the future health and nerve strength of the patient? The eminent surgeon who by a capital operation relieves great suffering, and perhaps saves life, is of no more real value to the world, than the man who, by his quiet skill, and up-to-date knowledge, unknown, it may be to his patient, saves her a life of wretchedness, to say nothing of the rest of the family.

I need not go into the anatomy of the parts.

The vagina, as well as the perineum, unavoidably suffers many times after parturition, and it is the repair of the vagina upon which I would lay great stress, as being the part most frequently neglected. Repair is many times made, of the perineum, while the deep tears in the vagina, are left unnoticed.

The condition of the patient being good, the time for the proper repair of the perineum and vagina is immediately after the expulsion of the fetus,—the cause of the accident. At this time, we are taught that repair can be made without the aid of an anesthetic, there being less sensitiveness of the parts. If this is not done, it is the cause of many later troubles.

Surely the vagina and perineum can at this time be thoroughly examined with little discomfort to the patient, but to operate upon the patient—unless the repair is exceedingly slight—without etherizing, seems to me to be entirely wrong. Too many times, even small lacerations, and especially slits in

the vagina, are not properly repaired. The nervous condition of the patient, after a long and tedious labor, causes her to be unwilling to suffer any more, and the idea of putting in a few stitches is unbearable to her, even if no pain is caused by doing it—and she begs you to let it go, no matter what the result may be.

This pleading weighs more heavily upon the young physician, than upon those of greater experience,—and all have doubtless seen the result of letting even a small repair go undone. Then the physician, especially the young man, does not like to own that much damage has been done, and is inclined to allow the entreaties of the patient to influence his best judgment, and to trust that all will come right in nature's way, but this will not do.

The necessity of etherizing should be quietly, but positively explained to the family, for in no other way can a thorough repair be made; otherwise the natural tendency is to hasten, and to slight the operation, which one would not do if the patient were unconscious, in which case one can take all necessary time to prepare the parts for the stitches, to begin at the top of the vagina and examine carefully for lacerations in the vaginal mucous membrane, which is of as much importance as the perineal body, especially when delivery has been with forceps.

Long slits in the vaginal mucous membrane are many times found, after artificial delivery, and in our office examinations we have all found long stretches of cicatricial tissue on both sides of the vagina, which cause much suffering, and compel the patient to seek a specialist to have them removed and the mucous membrane brought together, as it should have been done by the obstetrician at the time of the accident.

A pertinent question in the consideration of this subject is: Does the average student who graduates from our colleges, have a proper, practical knowledge of the importance of vaginal, as well as perineal repair, after parturition, if such repair is needed?

EDITORIAL.

Books, exchanges and contributions—the latter to be contributed to the GAZETTE only, and preferably to be typewritten—should be sent to the Gazette Associates, 279 Dartmouth Street, Boston; personal and other news items to Dr. A. T. Lovering, 10A Park Square, Boston; subscriptions and all communications relating to advertising, etc., to the business manager, Mr. Chas. A. Boynton, Hyde Park, Mass.

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RADIO-ACTIVITY, MATTER AND FORCE.

It is a noteworthy fact, and one by no means to the credit of the profession, that much as the subject of radio-activity has been discussed in our current literature, this has been done mainly from the practical side. In these utilitarian and materialistic days in which every discovery is at once turned to account even before it is sufficiently matured to yield results of a trustworthy character, no other course could be expected. Nevertheless, there is another side to this most interesting and much-exploited subject which, though not promising immediate returns, is yet of great practical importance, we mean the scientific side. This aspect the chemists and physicists are pursuing with all the ardor aroused by a young science, and with all the resources which modern technic and modern knowledge place at their command. And here it is made clear once more that no scientific investigation, however it may concern itself with facts, can proceed without speculation and without theories; the only demand of science being that speculations shall be deduced from ascertainable data, and that theories shall neither exclude nor be at variance with established facts.

An article by the late Prof. Clemens Winkler in the January

number of the *Popular Science Monthly* suggests these reflections, and presents certain considerations directly bearing on matters repeatedly discussed in these pages, and which have formed the subjects of the most animated debates at the recent meetings of the American Institute. The title of the article is "Radio-activity and Matter," and coming from the pen of the discoverer of *germanium*, a congener of radium, may be accepted as the offer of one who knows whereof he speaks. The searching analysis of all the knowledge and all the theories concerning radio-activity, and the various substances manifesting this phenomenon, brings the author to the conclusion that the chemical individuality of radium is almost entirely unknown, despite the fact that it is everywhere sought, and its isolation effected by chemical means. And, moreover, that so far as known the occurrence of radio-active substances is tied to uranium which, in its turn, is obtained mainly from pitchblende. The question therefore arises, in what form of combination is radium contained in pitchblende, a question the more perplexing since uranium-bearing rocks, especially granites, are found in many places where pitchblende does not occur, and may be observed to act on the sensitive plate or seen in the form of uranium calcite even in the crushed rocks used in the streets.

The extremely technical character of the inquiry is too far beyond the ready comprehension of any but the most scientific chemist to warrant its quotation here, but the results to which it leads are so intimately bound up with matters brought forward first of all by Hahnemann, and now occupying the attention of the scientific world, that it is well worth while to present those points on which the most vital discussions of the Niagara meeting of the Institute hinged. The article says, after reviewing the arguments hitherto deemed sufficient to prove the elementary character of radium, polonium, etc.: "But we must be permitted to ask whether it is really justifiable to assume the presence of a new element in a substance for the sole reason that this substance is radio-active, . . .

and what are we to say of the supposed material emanation of radio-active 'elements,' of their instability, of their decomposition by splitting off helium, and the decomposition of the elements themselves.* *Until now there has not been furnished any demonstration whatever that elements of high atomic weight, to which gold and platinum certainly must be counted, are polymers (composite forms) of elements of lower atomic weights and that they decompose into such. The idea of a chemical element in the old sense still remains unshaken and it will require much more thorough chemical experimental researches than those produced so far to disturb it.* On the contrary it appears from day to day more plainly that radio-activity seems extremely widely distributed, and this observation leads us to the question whether radio-activity may not be simply a purely physical phenomenon, which may be exhibited by matter without in any way modifying its chemical nature, comparable to the magnetism of magnetic iron ore, which, like radio-activity, may be intensified, transferred, apparently destroyed and again called forth, and which at the same time also represents a mysterious manifestation of energy." . . . In this connection it is of great interest to note the observation of F. Richarz and Rudolph Schenk, that this same mysterious energy is shown in the fact that oxygen when ozonized becomes radio-active so as to act upon the photographic plate, and to make Tidot's blende glow intensely, and like radium to develop heat.

Here are points which in all future discussions on the divisibility of matter, the validity of the atomic theory, and the possibility of developing a special curative force in any and all substances by attenuation cannot be ignored. We commend them to the earnest consideration of all interested in the questions of dynamization and extreme dilution.

* The italics are ours.

A REMARKABLE CASE OF SELF-HELP.

From a late number of the *Deutsche Medic. Wochenschrift*, one of the most trustworthy medical journals, we extract the following report of an extraordinary case which deserves in some respects to rank with those of Laura Bridgeman and Helen Keller. The subject of the report is a young girl, Selma Kunz, born Aug. 8, 1880, in the small town of Wertheim on the Main, the daughter of a small trader. Her early mental development permitted of her entering school before the customary age, but in her sixth year she was stricken with cerebro-spinal meningitis, which resulted in a complete paralysis of both the upper and lower extremities. The hope of the attending physician for gradual return of the power of motion was not realized. The aid of two other physicians, and the final removal to the university clinic at Würzburg, proved equally unavailing. The extremities remained absolutely paralyzed, although the brain functions suffered no impairment.

Returned to her home she sought, in her utter helplessness, to turn to account the only movable organ remaining to her, her tongue, as a substitute for the powerless limbs. Under the vigilant and devoted care of her stepmother, she acquired the ability so to use her tongue and lips as to feed herself without assistance. Then, too, she learned to write with her mouth, and the regularity and clearness of her characters were most surprising. When reading she turned the leaves promptly with her tongue. Finally she succeeded in learning to sew with her mouth, first fastening the needle into the table before which she sat, then, with the wonderful mobility of her tongue, winding about its tip one end of the thread, and drawing it to a knot before threading the other end through the needle's eye.

Endowed with unusual inventiveness, and still greater perseverance, she constantly sought new fields of activity. At the age of ten she begged her mother for knitting-needles

and yarn. Her wish was granted, though not without expression of doubt concerning the success of the experiment. Great, however, was the mother's astonishment when, after a prolonged absence, she returned to find Selma knitting. Even the "setting up" of the work, which has to be prepared for beginners, she accomplished without assistance. As soon as she had finished one row of stitches she thrust the needle with her mouth into the left axilla, and again with the mouth turned the knitting for the next row. After this she advanced from plain sewing to the finest and most elaborate embroidery. And as her writing was distinguished by its regularity and clearness, her textile work possessed the same qualities in a very high degree. But not content with these accomplishments, her active mind impelled her constantly to new attempts. Thus she learned to draw, and with such perfection that she soon was able to make her own designs for her needlework.

Her extremities grew and developed most imperfectly. The arms and legs were wasted to an extreme degree. Her face, however, was pleasingly fresh and animated, and very attractive. The organ which she had converted into an instrument of such varied and remarkable usefulness, the tongue, gradually assumed a most peculiar shape. It grew narrow and pointed, and of such uncommon length that she was able to touch with it the bridge of her nose nearly to its junction with the forehead, yet it in no way interfered with her speech. Still more wonderful than the length of the tongue were its flexibility and the complexity of its motions. All these peculiarities were developed by use, according to the report of the mother. In the first years the shape and mobility of the tongue differed in nowise from the ordinary.

On the 20th of October, 1903, Selma Kunz died after an illness of two days.

SOCIETIES.

BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

BUSINESS SESSION.

The regular meeting of the society was held in the hall of the Boston Society of Natural History Thursday evening, March 2, 1905, at eight o'clock, the president, J. Herbert Moore, M.D., in the chair.

The records of the last meeting were read and approved. William A. Ham, M.D., of Dorchester, was proposed for membership.

The following resignations were accepted: Bertha L. Hoskins, M.D., removed to Atlanta, Ga., Hubert T. Dean, M.D., removed to Holyoke, Mass., and Harry J. Little, M.D., Norwell.

PROGRAM.

1. "The Social Aspects of Tuberculosis and the Work of the Associations Formed for the Control of the Disease. (Illustrated by stereopticon.)

2. "The Movement for a Municipal Hospital for Tuberculosis in Boston." (Illustrated by stereopticon.) Mr. Alexander M. Wilson, general secretary of the Boston Association for the Relief and Control of Tuberculosis. Discussion opened by Herbert C. Clapp, M.D.

Miss Higgins not being able to be present on account of illness, Mr. Wilson spoke of the "Social Aspects of Tuberculosis" as well as the "Movement for Municipal Hospital for Tuberculosis in Boston," and his remarks were illustrated by charts showing the mortality from consumption in the large cities of the United States and hospitals which have been erected in Europe for these patients.

3. "Epidemic Cerebro-spinal Meningitis and Its Homœopathic Treatment." Frank C. Richardson, M.D. Discussion opened by Edward P. Colby, M.D.

DISCUSSION (MR. WILSON'S PAPER).

Dr. Clapp: I am strongly in favor of a hospital where consumptives in an advanced stage of the disease can be cared for until they die. No objections should be allowed to interfere with such a philanthropy, because the welfare of the whole community is involved. At the present time the city of Boston supports only forty beds for such cases, and these are principally at Long Island. I believe that such a hospital should be within the city limit, West Roxbury being the healthiest section. There is no danger of infection from such a hospital, as it has been shown that consumption actually decreases in places where sanatoria are located, owing to the fact that the people in such localities become educated as regards the prevention of the disease. I would urge the members of this society to become members of the Association for the Relief and Control of Tuberculosis, as I consider its work to be of the utmost benefit to Boston. A general discussion followed.

DISCUSSION (DR. RICHARDSON'S PAPER).

Dr. Colby: The essayist has gone so thoroughly over the etiology, symptomatology and pathology of this subject there remains very little for me to say, save to hark back many years to my experience when I had more to do directly with cerebro-spinal meningitis than since I have devoted myself entirely to neurology.

I think he has more than intimated that there is a cloud over the field of the etiology as to the particular form of the bacterium, which is the excitant in these cases, and certainly the more one studies this subject, the more doubt there is between different authors whether there may be more than one bacterium which may be the cause of this condition. Investigators, under different circumstances, have produced different forms of the same bacterium. I think it differs in the pathology and the etiology from the streptococcus, the

staphylococcus and the pneumococcus manifestation of meningitis. I have seen cases where the staphylococcus was present to a much greater extent than the streptococcus, and also cases where the pneumococcus existed, but in those cases it was different by far from the true diplococcus intracellularis meningitis, from the fact, that in these cases it has almost invariably commenced and existed for a fairly prolonged period as spinal meningitis, and the temperature varies also. In the streptococcus you have a high temperature, the same as in the diplococcus, or whatever may cause it. In the pneumococcus you may never have the temperature rising above 100° or 102° until near the end. In these cases the infection of the cerebral meninges followed quite a little time after the spinal symptoms in the epidemic form. I think my memory is sufficiently good so that I may make the statement concerning cases of cerebro-spinal meningitis I had a number of years ago, that the spinal symptoms were manifested hours, and perhaps a day, before the cerebral symptoms set in. The extremities showed involution of the lower cord before the cranial nerves showed any disturbance at all, or before the intellect was disturbed or obscured. There remains little more to say save the clinical experience of one person. I became firmly convinced, if an attack of cerebro-spinal meningitis of an epidemic nature could be treated early in the disease, that it was a disease fairly amenable to treatment, and that it might be arrested possibly at that stage, and never go on until life was seriously endangered, but oftentimes it is too late because there has been delay in calling a physician.

Of all the remedies that have given satisfaction in my experience there is none that has done so well as veratrum viride, and in every epidemic I learned to rely upon it given early, and almost to the point of sedation and affecting the circulation, sometimes in conjunction with or alternating with gelsemium, as being as surely productive of beneficial results as any other remedy that I could find, even the feverish

condition seemed to be suspended. Cicuta has the convulsive symptoms of any form of spinal meningitis, or cerebro-spinal meningitis. I tried it in a few cases of epidemic meningitis, and was quite disappointed with the results. Why? It was not applicable to the cause, because if you will study the symptoms of cicuta it is still more applicable to the convulsive form, which is like the epileptic, which is almost never the incident in epidemic meningitis. It is not like the mono spasms, because it involves both sides, comes on suddenly and goes off suddenly, and leaves the patient almost entirely like the epileptic patient. For many years, used early in the case, I was perfectly satisfied with the results (revulsive results) of a long mustard paste, two inches wide, extending from the neck to the lumbar region, not for the purpose of blistering or drawing out serum but for the reflex effect upon the circulation of the cord. I am aware this does not agree with any modern theory of bacterial infection, but for many years I found I was not mistaken. In this I seem to take issue with the essayist, who stated that no irritant should be applied over the spine and the patient kept quiet. I have never seen this paste, if applied early in the disease, cause injurious results. One other thing, the beneficial effect of hot packs, and I have been told by some of my talented colleagues that this is being brought up again. The revulsive and other influences of a hot pack, repeated, have most certainly caused relief in many cases that were so far advanced a cure was impossible. Living in the country, within a few miles of hemlock trees, it was possible to obtain the twigs in large quantities, upon which hot water was poured, then a blanket was wrung out of this hot water and the patient rolled up in it for twenty minutes. If necessary, the pack is repeated. I have made use of it in the hospital, and, when hemlock twigs could not be obtained, I have used the oil of hemlock or some other form of spruce. I have seen fatal cases made comfortable for one to six hours by the use of this pack.

□ Dr. Rutter: I would like to say that very early in my

practice I contracted cerebro-spinal meningitis. Prof. J. Heber Smith was called in, and very early in the disease used the hot pack. As the thirsty traveler in the desert longs for water, so I watched for the hot pack. I cannot tell you the ease that crept through my body and mind, and I have never forgotten it. In speaking to young physicians, I always call their attention to the importance of the use of the hot pack in cases of cerebro-spinal meningitis.

Dr. Colby: Concerning lumbar puncture in epidemic meningitis I cannot tell whether this is going to do any good. Possibly it might be of remedial value and help your patients to live longer and be more comfortable, if you draw enough serum by lumbar puncture to relieve the brain pressure, and thus possibly ward off an impending fatal convulsion.

Dr. Richardson: I have nothing additional to say, except to attempt to impress upon the members that we should differentiate ordinary cerebro-spinal meningitis from the form which you have heard spoken of to-night, the epidemic form. Of course, I do not know about epidemics of years ago, except what I have read, but the mortality was certainly very much greater in all the statistics I have found than Dr. Colby had the good fortune to have in his cases, and I should be inclined to think that a mortality of twenty per cent., a small percentage compared with the range we get in recent years in a true epidemic of cerebro-spinal meningitis. From what I have read and investigated, I do believe that we should differentiate the diplococcus intracellularis as the characteristic cause producing epidemic cerebro-spinal meningitis. I believe it does produce a disease, the virulence of which is far greater than the infection produced by the common pneumococcus. I do think in making our reports we should exercise the greatest care and should check by the exudate secured by lumbar puncture, otherwise, I should not consider them of value.

Adjourned at ten o'clock.

B. T. LORING, *Secretary.*

COLLABORATORS' DEPARTMENT.

Brisk walking, 110 to 120 steps a minute, and the patient sitting down as soon as tired, is the latest treatment for varicosis of the legs. J. L. C.

Dr. D. W. Montgomery of California in his interesting description of the mould of dermatitis coccidioides shows that it should not be confounded with the blastomyces, as it has a different method of proliferation. In the latter, like all of the yeast moulds it develops by budding, while the former entirely by sporulation. The clinical manifestations of the two diseases are quite similar. J. L. C.

In the February number of the *Journal of Cutaneous Diseases*, Dr. Granville MacGowan gives an interesting article on the use of adrenalin in hemorrhages and angioneurotic diseases of the skin, and sights several cases of the various forms of purpura and erythema multiforma, in which most excellent results were obtained. The dose was generally ten drops every two hours at first and the time gradually lengthened as the disease improved. J. L. C.

In the January and February numbers of the *Journal of Cutaneous Diseases*, Dr. James C. Johnson has a most exhaustive article upon the melanoma, well illustrated with microphotographs. His conclusions are as follows:

1. Aside from the natural division into choroid and skin tumors, melanotic neoplasms, which from their diversity of origin, are best called melanomata show several varieties.

2. The commonest, and therefore most important, is that derived from soft nevi, which are endotheliomata of lymph-vessel origin. Nevomelanoma whose histogenesis it is not possible to determine, must be referred to the same origin.

3. A second variety exists with the same histological pictures which does not spring from nevi and whose origin is directly traceable to endothelium, probably also lymphatic.

This group includes melanotic whitlow and the malignant lentigo of the French.

4. The third division is truly epithelial in origin, although its existence has been denied. These tumors are of various types and show only a very slight local tendency to malignancy, a fact sufficient in itself to determine a cardinal difference from the melano-endotheliomata whose capacity in this connection can hardly be exaggerated.

5. A histological diagnosis is the only proper method of differentiation between the two.

J. L. C.

Dr. Chas. J. White, in the March number of the journal, reports sixty-five cases of Fordyce diseases, and gives the following excellent description of the diseases:

“When we come to analyze the results of these personal clinical observations we find that the disease consists of the presence of small, irregular, cafe-au-lait maculo-papules. The lesions vary in size from a pin-point to a pin-head. They are irregularly round or polygonal like a mosaic. They are sometimes an orange yellow but more usually a pale buff in color. They are almost always imperceptible to the touch, except on the lower lip, where they sometimes assume a distinct, dome-shaped, papular condition. Their abundance varies all the way from a few isolated lesions to solid, almost homogeneous bands extending the entire length of the lip.

Their presence was in all cases but the first unknown to the persons who bore them, and it is probable that this man's attention was drawn to them only by an accidental superimposed condition of inflammation. They exist in practically all cases upon the upper lip, but may and often do occur on the lower lip and on the mucous membrane of the mouth. Their age and duration cannot be determined because their presence is practically unknown to their bearers.”

As regards the pathology, he does not agree with previous investigators, that it is a sebaceous tumor, but “that the essential change lies in the epidermis, and consists of acan-

thosis edema and parakeratosis," that is he agrees with Fordyce, the original observer. J. L. C.

Professor Politzer (International Congress of Otology, Bordeaux, August, 1904) believes it the duty of the state to found in each medical school a chair in otology, including otiatry in the required examinations, in order that those who devote themselves to general practice may be able to diagnose the simple forms of aural affections which they meet in practice.

A large number of cases of defects of hearing, caused by catarrhal processes in the middle ear, might have been avoided by treatment instituted at the proper time. Suppurative conditions of the middle ear, with the frequent grave complications which jeopardize the life of the patient, are often the result of neglect and improper care. Mastoid abscesses, if not operated upon in time, end fatally by cerebral complications. In view of these facts, Professor Politzer would assign otiatry a privileged place, compared with certain obligatory branches which, in most cases, deal only with the functional manifestations, while many ear diseases endanger the life of the patient. G. B. R.

Dr. Chas. E. Teets, in an article advocating the removal of the inferior turbinals when hypertrophied (*Homœopathic Eye, Ear and Throat Journal*, February, 1905), says there are two things to be decided. First, how much of the turbinal should be removed, and second, the best methods for this removal. If too much tissue is removed, the warming, moistening and filtering function of the nose is interfered with. In both anterior and posterior hypertrophies only those portions which interfere with the normal function of the nose should be removed. The author, from his experience, has seen ailments remote from the seat of lesion improved, and in some cases cured, by turbinectomy. This is particularly the case in affections of the respiratory tract, where restoration of the nose to its normal condition improves the nutrition of the parts affected.

Regarding the methods employed, the use of the galvano-cautery should be limited. For posterior hypertrophies, the cold-wire snare is probably the best instrument, and where the entire length of the turbinated body is hypertrophied, the guarded trephine, drill or saw, or still better, a pair of strong bone clipping scissors.

The anesthetic used is an eight per cent. solution of cocaine, followed by an application of adrenalin chloride to control hemorrhage.

G. B. R.

Partial inferior turbinectomy, that is, exsection of the lower edge of the bone with the corresponding redundant mucous membrane in chronic hypertrophic rhinitis, while designed to improve the drainage of the floor of the nasal fossa and diminish the amount of secreting mucous membrane at the same time increases the nasal inspiration by enlarging the middle meatus while the loss of the turbinal arch destroys physiological inspiration as in atrophic rhinitis. Free inspiration is sometimes interfered with by the presence of degenerated adenoid tissue in the nasopharynx which seems to exert an influence on the vasomotor conditions of the nasal mucosa. Relief from the sensation of dryness and too much air space after operation is obtained by the subsequent changes in the turbinal stump and the readjustment of the secretory function of the nose. The beneficial effect of the operation is seen in phthisical patients, in those suffering from aural affections produced by faulty habits of nasal hygiene—the hawking the screatus which upsets the auditory air-pressure balance provoking a hyperemia and circulatory tinnitus, and in hay-fever conditions, while relief from stuffiness and immunity from colds are prominent results of partial turbinectomies. The operation should be performed fifteen minutes after cocainization before the systemic nervous effect of the drug has begun, using scissors or bevel saw and following by an application of ice for twelve hours and a spray of adrenalin every hour or two for a day to reduce the sequelæ

of hemorrhage and sepsis to a minimum ("The Results of Partial Inferior Turbinectomy," by G. B. McAulliffe, M.D., *Laryngoscope*, February, 1905). G. B. R.

Dr. H. M. Gay of Philadelphia, Pa., in the March number of the *North American Journal of Homœopathy*, reports an interesting case of diphtheria with nasal intubation. An infant four months old was suddenly taken ill with acute indigestion which subsided in two days, but was followed by an extremely violent attack of eczema beginning on the head, and quickly spreading over the face and neck. Lesions hemorrhagic. Temperature 103°. Duration about four days, at which time the child developed an annoying nasal discharge with some rise of temperature. The discharge was found to be diphtheretic in character, both nostrils were closed, and the membrane extended halfway down the pharynx. Three thousand units of antitoxin were given, and Dr. C. F. Raue was called in consultation. The membrane had extended with total occlusion of the nostrils, cyanosis and extreme toxemia. After much difficulty intubation of the nose was accomplished, cyanosis was relieved, and the child slowly improved until on the fifteenth day a suppurative otitis media with perforation of both drums supervened, and on the sixteenth day a laryngeal relapse of the diphtheria occurred when 1,500 units more of antitoxin were given. On the twentieth day, a cough developed with pulmonary congestion, followed by consolidation of the upper lobe of the left lung. Resolution began in about eight days. The child made a slow, but uneventful recovery from all conditions except the eczema. The two chief points of interest are the nasal intubation for the relief of nasal obstruction which can cause fatal cyanosis in infants, and the large initial dose of antitoxin determined by the amount of toxemia, instead of by the age of the patient, as is customary.

Two things are of interest in this case, first, the relief from nasal intubation, and second, the reinfection of the larynx on

the sixteenth day. It would seem to the reviewer of this article that the single dose of 3,000 units of antitoxin was not sufficient for the existing condition, and that reinfection would not have occurred if the initial dose had been followed in six, twelve and eighteen hours by injections of from 1,500 to 2,000 units. The statement that fatal cyanosis can be produced by nasal obstruction is open to discussion. The reviewer has repeatedly seen infants absolutely unable to breathe through the nose, but who never had had any condition approaching cyanosis. A more reasonable explanation in this particular case would be that there was paralysis of the soft palate, and enough membrane in the mouth to interfere with oral breathing.

G. B. R.

TEACHING IN HOMŒOPATHIC COLLEGES.—In short, it is our duty as homœopathic physicians to define, prove and teach, not only similia, but every other law that is in any way connected with carrying on the best possible work by the medical profession. It is our duty to see that our colleges are manned with men who in their various branches shall be good teachers and not narrow critics, and I would even go farther—if the homœopath who is teaching *materia medica* cannot be broad enough to allow proper investigation of other laws, he is not fit to teach in any school, and if the teachers of any other laws of healing are not broad enough and wise enough not to interfere with or criticise the *materia-medica* department, they are not wise enough to teach in any college, and if they criticise, especially the homœopathic law, they certainly have no business in a homœopathic college.—*Dr. B. F. Bailey in Progress.*

ABSTRACTS FROM BOOKS AND JOURNALS.

FOREIGN BODY IN THE LEFT VENTRICLE.—M. Koch reports an interesting instance in which, at the autopsy examination in a man of seventy-two who died from inanition, a needle-like body about 3 cm. long was found imbedded in the wall of the left ventricle. There was no clue as to the origin of the condition to be gained from the patient's history. The author is inclined to believe that the object was introduced suddenly from without at some remote period in the patient's life, judging from the direction of the needle, its position in the cavity and wall of the ventricle with the end fixed in the septum, and the absence of any changes in the pericardium.

Berliner Klinische Wochenschrift.

FACIAL NEURALGIA.—Arsenicum is the right-sided remedy as regards the face. The pains must be hot; the patient must be pale and restless; he is generally thirsty, and always prostrated. Without these characteristic symptoms the remedy will disappoint you, but in some of its combinations it will bring about the results which you had expected from the metal alone. The combination which has served me more than any other is natrum arsenicum. Most of the patients present a dejected picture, because of the wasting of the face in the orbital region. They complain of headache, infraorbital for the most part, and have discharge from the nostrils. The pain is referred to the malar bone, and comes in paroxysms; in fact, it is one of the remedies for the right-sided tic douloureux.—*Dr. J. B. G. Custis.*

DIET IN TYPHOID FEVER.—Certain it is that the old rule of feeding typhoid-fever patients indiscriminately upon a milk diet does not produce the most satisfactory results. Time and again in these cases I have seen the tensely distended abdomen become soft and flat, the high temperature fall, delirium disappear, and the tongue become moist upon substituting broth, thin cereal gruel or egg albumin for milk. On the other hand, where tympanites is not great, and constipation not marked, milk in some form or other gives the best results. It is also well to remember in fevers that the carbohydrates are the most

efficient "proteid sparers," and that their end-products, unlike the end-products of proteids, do not increase the waste matter in the already overcharged blood.

Dr. W. H. Vandenburg, in Hahnemannian Monthly.

OTITIS MEDIA.—Never use oil in cases of earache; use glycerin. When you have occasion to treat earache, after inspection of the ear, irrigate with hot water containing five grains each biborate and bicarbonate of soda and one drop of formalin to the ounce. Carefully dry canal and fill with a warm sol. boroglyceride, one dram to the ounce. Let this remain fifteen minutes; drain and plug meatus with cotton. Then apply dry heat. Repeat every one or two hours for twelve or eighteen hours. Irrigate with a mild alkaline sol. every six hours. If there is no improvement, incise the drum. Never use the ordinary needle or spear sold for this purpose, but use a knife, either Graefe's or a furuncle knife, and make a liberal incision that will be of some use. While making use of these palliative measures, do not neglect your internal medication.

Dr. Carl Rust, in Cleveland Medical and Surgical Reporter.

CEREBRO-SPINAL MENINGITIS.—Treatment: To sustain life we must feed the child. The gastric irritability and tendency to vomit can be overcome by rectal feeding of peptonized milk or peptonized yolk of egg. Gavage should be resorted to and light nutritious food, such as whey, white of egg, soups and broths, should be given at regular three or four hour intervals.

Place the child in a room having a temperature of 68° to 70° if possible. If high fever is present, shave the scalp and apply an ice-bag on the top of the head and at the nape of the neck. A mustard foot bath will, in some cases, relieve the cerebral symptoms. Tub baths (tepid) may be tried. The cold pack or ice-water coil has a very soothing antithermic effect. When delirium is present, a few leeches applied over the mastoid will sometimes afford relief.

The bowels and kidneys must be carefully watched. Retention of urine requires supervision. If the urine is scanty we can stimulate the same by giving high colon flushings of normal saline solution at a temperature of 110°.—*Medical Record.*

OUR PROFESSIONAL RELATIONS.—Many a physician whose daily work is a daily round of beneficence will say hard things and will think hard thoughts of a colleague. No sin will so easily beset you as uncharitableness toward your brother practitioner. So strong is the personal element in the practice of medicine, and so many are wagging tongues in every parish, that evil-speaking, lying and slandering find a shining mark in the lapses and mistakes which are inevitable in our work. There is no reason for discord and disagreement, and the only way to avoid trouble is to have two plain rules: From the day you begin practice, never, under any circumstances, listen to a tale told to the detriment of a brother practitioner. And when any dispute or trouble does arise, go frankly, ere sunset, and talk the matter over, in which way you may gain a brother and a friend. Very easy to carry out, you may think! Far from it; there is no harder battle to fight. Theoretically, there seems to be no difficulty, but when the concrete wound is rankling, and after Mrs. Jones has rubbed in the cayenne pepper by declaring that Dr. J. told her in confidence of your shocking bungling, your attitude of mind is that you would rather see him in purgatory than make advances toward reconciliation. Wait until the day of your trial comes, and then remember my words.—*William Osler.*

FIBRINOUS LARYNGITIS.—Aconite I use as a prophylactic. There are families in which fibrinous laryngitis is a legacy. Every child born into the family is sure to have one or more attacks of the disease between the second and seventh year. Should a child in such a family "catch cold," there will follow a high fever, dry skin, great restlessness, intense thirst, a dry, hacking cough, a rapid, wiry pulse and rapid respiration. For this group of symptoms I have given aconite thirtieth, two drops in water every half hour. In seven cases out of ten the aconite will prevent any exudate.

As auxiliary treatment I have wrapped around the throat a cloth wrung out of cold water, and outside of this I put a dry flannel. In most cases this cold compress will need changing about once an hour, *i.e.*, as soon as it becomes hot and dry.

If, however, the child's skin is hot and dry; if the cough is croupy; if there be some hoarseness; if the respiration, especially

inspiration, be difficult, but the thirst, restlessness and rapidity of the pulse be less than under aconite, I give iodine 2x, one drop to a spoonful of water, and a spoonful every fifteen to fifty minutes.

For auxiliary treatment, I put a drachm of the tincture of iodine into a pint of water, heat, and have the child inhale the steam.—*Dr. George Royal.*

MASTOIDITIS.—The symptoms of greatest significance in leading one to undertake immediate operation are: (1) Pain continuous and severe, making sleep impossible, and radiating upward along the side of the head to the vertex, backward to the occiput, or more rarely, forward to the frontal region. (2) The temperature even in children does not often keep at a high point after the first days of acute illness, but is often markedly irregular. (3) A falling of the posterior superior wall of the external auditory canal. This is caused by edema of the periosteum and tissues over the mastoid cells or may be due to the actual burrowing of pus. It is possible to mistake this condition for furuncle of the canal and *vice versa*. (4) Tenderness over the mastoid is the rule in cases calling for operation, but there are exceptions. Other severe symptoms may be present pointing to perforation of the tegmen tympani.

Medical News.

IRIS VERSICOLOR IN MEGRIM.—Case: E. K., eight years old. May 21, 1902, the father came with his boy to my office and stated that the boy every six to eight weeks had attacks of bilio-mucous vomiting, the egesta having a very strong sour smell. Such attacks generally last two days. He has suffered from these attacks from his early years. Before these attacks the boy complains of headache. The appetite is slight, stools now and then inert, the sleep is frequently disturbed.

An examination showed no organic changes except severe reflexes of the abdomen. The urine was free from sugar. Iris versicolor 4, three drops morning and evening.

The patient has remained free from these attacks until the time of writing, March, 1904.—*The Homœopathic Recorder.*

PERSONAL AND GENERAL ITEMS.

DR. C. W. STILES of Allston has succeeded to the practice of the late Dr. C. C. Ellis of 351 Broadway, Somerville.

DR. J. P. RAND is located at 820 Main Street, Worcester, having disposed of his practice in Monson to Dr. Elwyn W. Capen.

DOCTOR'S OFFICE TO RENT in a private homœopathic hospital on Newbury Street. Rates reasonable. Address A. B. C., 98 Dana Avenue, Hyde Park.

FOR SALE.—A good opening in a New England town. Collected \$1,400 the first year. Only little money needed. Address P. Q. R., care of C. A. Boynton, Dana Avenue, Hyde Park.

MESSRS. BLAKISTON'S SON & Co. announce the sale of 15,090 copies of Gould's Medical Dictionaries during 1904, making the total sales to January, 1905, 181,173.

DR. N. EMMONS PAINE has recently sent to his friends in the profession a very attractive picture post card, showing a portion of the grounds about his sanatorium at West Newton.

FOR SALE.—The best location in Massachusetts, either school, homœopath preferred. Population about 6,000. Cultured and wealthy patrons. Excellent roads. Good fees. Every advantage to right party. Address "Practice," 98 Dana Avenue, Hyde Park, Mass.

DR. ELIZABETH JOHNSON, Brockton's first woman physician, and a graduate of the New England Female Medical College, died at Brockton March 2, at the age of seventy-six. She was at one time connected with the Boston Homœopathic Dispensary.

DR. E. R. JOHNSON, who for several years has been with Dr. George B. Rice, has opened an office in the same building, 220 Clarendon Street, Boston, where he will give special attention to diseases of the ear, nose and throât. Office hour, 1 to 2. Telephone, 1768 Back Bay.

RENEWED attention is called to the sixty-first annual session of the American Institute of Homœopathy to be held in Chicago, June 19-24, 1905. The chairmen of the various bureaus are: Dr. Wm. A. Geohegan, Cincinnati, Materia Medica and Therapeutics; Dr. R. S. Copeland, Ann Arbor, Homœopathy; Dr. E. B. Hooker, Hartford, Conn., Clinical Medicine and Pathology; Dr. F. F. Teal, Norfolk, Neb., Pedology; Dr. G. B. Haggart, Alliance, Ohio, Sanitary Science and Public Health.

DR. FRANK KRAFT of Cleveland, Ohio, will personally conduct a private party to Europe the last of June. Italy, Switzerland, Holland, Germany, Belgium, France, England, Ireland and Scotland will be visited before returning to New York the middle of September. The expense per person is but \$510. Dr. Kraft's parties have been very popular in the past, and doubtless the one he is now forming will prove equally so. If one is going abroad, it is well to make arrangements as early as possible.

THE third annual practitioners' course offered by the New York Homœopathic Medical College and Hospital, will commence May 1, and continue three weeks. The lectures and clinics will be given in the buildings of the college and the affiliated hospitals and are open to all physicians and medical students. It is designed to give the busy practitioner an opportunity to acquaint himself with the newest facts and methods in medicine and surgery, and every opportunity is improved to develop the possibilities of the homœopathic materia medica.

The staff of instructors is made up exclusively of physicians who are in attendance on the institutions represented in the course, and their connection with these institutions insures an abundance of clinical material and experience in its demonstration.

The fee for the course or any part thereof is \$20, but does not include instruction in the operative course upon the cadaver, which is \$20 additional. This general fee will include a certificate of attendance. Prospective students should make their checks payable to Edward G. Tuttle, M.D., registrar, 61 West 51st Street, New York City.

If an intended student finds that he will be unable to carry out his plan of attendance his check will be returned to him if application is made to the registrar prior to April 19, 1905.

THE NEW ENGLAND MEDICAL GAZETTE

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VOL. XL.

ORIGINAL COMMUNICATIONS.

PRESIDENTIAL ADDRESS.

BY J. EMMONS BRIGGS, M.D., BOSTON, MASS.

[Delivered before the Boston Homœopathic Medical Society, Jan. 5, 1905.]

Members of the Boston Homœopathic Medical Society and Friends:

The present meeting marks the departure of the old year and the ushering in of the new as it relates to the affairs of this society. We who have presided over its destinies during the past year gladly relinquish our duties, with the knowledge that its welfare will be intrusted to others who are eminently worthy and well qualified.

In reviewing the work of the society during the past year we are pleased to note an increase in attendance at our meetings, and a very enthusiastic coöperation on the part of the members with the executive committee of the society, so that we have had no difficulty whatever in securing papers of true merit and interest.

Your executive committee take this opportunity to express their appreciation of the very valuable suggestions made in the president's address of a year ago, which we have followed to our mutual advantage.

It will probably be expected of the retiring president this year to unburden his mind, and to unfold to you his ambitions for this society's progress and welfare. He has such ambitions, and can see no reason why they will not be fulfilled. We have the material in men of ability, and the means with

which to execute our undertaking. If we lack anything it is enthusiasm.

In 1893 sections were formed. Each section was presided over by its executive committee comprising a chairman, secretary and treasurer. The principal duty of this committee was to arrange a program for a general meeting of the society. This scheme worked exceedingly well for a number of years, when it became evident it had lost its charm. At the February meeting your committee proposed the suspension for a year of the by-law relating to the sections. This was approved by the society, and during the past year the program has been arranged by your executive committee.

The recommendation which I have to make is that the by-law relating to the sections be suspended for the ensuing year. I do not at this time advocate its repeal, for this course is not necessary in order to render it inoperative, and should the society wish to resume the sectional work I know of no better scheme than is provided by the existing By-Law VIII.

The reason why this is recommended is in order that the incoming president and executive committee may be free to arrange programs as they see fit. They are responsible for the success of the society, and should have a free hand in its management.

Again, the work of the sections tended too much to specialization. Those members who were interested in the bureau to report attended, while those engaged in other lines of work saw an opportunity to stay away. The secret of a truly good program is to have something at each meeting which no one can afford to miss.

The meetings have been held in the Natural History Building, corner Boylston and Berkeley streets, a location which is accessible to all, and may have had much to do with the increase in attendance. It would seem wise that this or an equally centrally located room be secured for the ensuing year.

I shall first call your attention this evening to the enormous progress which has been made in surgery during the past

century, and then point out the rapid increase in cancer, which is so alarming that it must occupy the attention of the medical world until its etiology is discovered and a remedy produced.

I will ask you to step backward with me over a century that we may realize the condition which then existed. In 1790 our great country was only partially explored; our thirteen colonies sparsely populated. Not more than five per cent. of our inhabitants were west of the Alleghany Mountains. Boston had a population of 15,400; New York, 23,380; Salem, Mass., was then the sixth largest city in the Union, with a population of 5,210. The means of communication were by coach, saddle-horse and sailing-ship.

In the medical world the status of surgery can best be shown by quotations from leading authors of the period, illustrated by a few pictures which will be projected upon the screen.

John Bell, in his four-volume work on the "Principles of Surgery," published in London in 1826 (only seventy-eight years ago), is interesting reading, and serves to illustrate the status of surgery at that period. Vol. I, page 477, in a chapter on "Wounds of the Belly," he says: "We find the chief cause of danger to be the tendency of the peritoneum to inflame. We find every wound apt to excite this inflammation, and every inflammation, however slight, apt to spread and terminate in gangrene and death. Upon these grounds we cannot but pronounce a wound of the belly to be a mortal wound. . . . Thus we perceive that a lecture on wounds of the abdomen must be a lecture of inflammation of that cavity. . . . It is also but too plain that here we are spectators merely. . . . Hence it comes to pass that in one short sentence we announce the general principles of such wounds. In one short and general prognostic we declare them to be fatal. We thus bestow but a few moments on their general character. . . . Now I lay down a few short rules which relate to the practice. . . . Nature cannot do much. . . . We are as spectators merely, and every recovery is truly an escape.

"First: Bleeding of the arm is the great preservative against

internal bleeding, and is the only means of preventing inflammation. In every wound of the abdomen we must bleed with a very liberal hand.

“Second: Quietness, rest and opiates, with fomentations to the inflamed belly are next in importance to bleeding.

“Third: The patient must very resolutely refrain from all food for ten or twelve days, for diet would support the strength and encourage the inflammation.

“Fourth: If the wound be in the belly merely and a sound intestine be forced out you must put it back gently with the finger and stitch the outward wound.

“Fifth: When there is a wound of the intestines which you are warned of only by the passing out of the feces you must not pretend to search for it, nor put in your fingers nor expect to sew it to the wound, but you must trust that the universal pressure will make the two wounds, the outward and the inner wound of the intestine to oppose each other point to point. And if all be kept thus quiet, though but for one day, so lively is the tendency to inflame that adhesions will be begun which is to save the patient’s life.

“Sixth: If indeed you have a wound of the intestine fairly in your hands, protruding and plainly wounded, it were madness to let it go back into the abdomen. . . . But do not sew the bowel with a long suture in hope of closing the breach, nor follow the strange and whimsical inventions of cylinders of paper or isinglass, which it is safer to use in experiments upon dogs than to practice in real wounds. You must make but one single stitch and sew the wounded intestine to the outward wound. There the gut will adhere, throw out its feces for some time and then heal, the outward and the inward wound uniting in one knot of scar.”

Compare if you will the feeling of hopelessness and despair which existed in the minds of the chief surgeons of seventy-five years ago, with the assurance of the modern operator who boldly enters the peritoneal cavity with confidence of success.

In the sixth rule laid down by Bell, in which he refers to

cylinders of paper or isinglass, which he so heartily condemns, we perceive the foreshadowing of the decalcified bone plate, the Murphy button, Harrington ring, and like devices, which are now used with such astonishingly perfect results.

On the continent the hospital of a century ago was a hotbed of infection. Erysipelas, pyemia and hospital gangrene were so common and fatal, that to be compelled to go to such an institution for treatment was equivalent to a death-sentence. In America not a single hospital existed. The first in this country was the Pennsylvanian Hospital in Philadelphia, which was completed in 1805. Next in order was the Massachusetts General Hospital in Boston.

An able surgeon, writing in 1826, speaking of hospital gangrene, says: "There is no hospital, however small, airy or well regulated, where this epidemic is not to be found at times, and then no operation dare be performed, every cure stands still, every wound becomes a sore, and every sore is apt to run to gangrene; but in great hospitals, especially, it prevails at all times, and is a real gangrene. It has been named the hospital gangrene, and such were its ravages in the Hotel Dieu of Paris,—that great storehouse of corruption and disease,—that the surgeons did not dare to call it by its true name. They called it rottenness, foulness, sloughing of the sores, the word 'hospital gangrene' they durst not pronounce for it sounded like a death-knell. At the hearing of that ominous word the patients gave themselves up for lost. In the Hotel Dieu this gangrene raged without intermission for two hundred years. A young surgeon, says a French author, who is bred in the Hotel Dieu, may learn the various forms of incision, operations, too, and the manner of dressing wounds, but the way of curing wounds he cannot learn. We find superficial ulcers, splinter wounds, the flat surfaces of stumps, or an open surface the most apt to be seized with hospital gangrene, but when the disease rages nothing can resist it."

How about hospital gangrene to-day? Has it not entirely disappeared from the earth? Lister's great discovery has

eradicated it completely, and the hospital has become a refuge to all who require surgical relief, changed completely from the charnel house to the most beneficent factor in our present civilization. Through her portals the multitude enter when afflicted by disease, and there receive the skillful attention which their case demands.

The nineteenth century began and there was no light. Dark and ominous hung the clouds which enveloped the surgical world. In 1847 the sun broke forth and illuminated the world as never before, for Morton discovered an agent in ether which produced a sleep so profound that operations could be performed while the patient slumbered, and awaking had no knowledge of what had transpired. Since that day we have been enabled to induce this sleep whenever we chose, and operative procedures have been robbed of most of their terrors.

During the century great advancement in every science has occurred, but in none greater than in surgery. Anesthesia has made possible operations which could not have previously been tolerated. The germ theory was developed, and anti-septics have made possible wound closure without true inflammation. This has permitted the surgeon to enter the peritoneal cavity, and added dexterity and skill have developed operative technic to the high standard it has now attained.

Bacteriological study has demonstrated that sepsis is due to the pyogenic microorganisms, and every effort is made to exclude or destroy these germs from the surgical field. So thoroughly has this been accomplished that it is rare for a wound to suppurate.

The typhoid bacillus, as a causative factor in typhoid fever, has been demonstrated, and sanitary science has made every effort to prevent infection by it. All the contagious diseases in fact, have been found to be dependent upon their own pathogenic microorganism, and isolation and fumigation have controlled their ravages. Tuberculosis has been found to belong to this class of diseases, its germ isolated and its death-rate is now diminishing.

In all these diseases it will be observed that the means of mitigation have followed in the wake of the accurately determined etiological factor of disease. Without this knowledge we are groping in the dark, and rarely in the history of medicine have we blundered on to a means of cure. We must know the cause before we can intelligently apply the prophylactic.

Medicine has only recently arrived to the dignity of a science. It now embraces a knowledge of principles and causes which, in reference to certain diseases, has become comprehensive and demonstrable. It is as capable of proof as a problem in mathematics. The tubercle bacillus causes tuberculosis. Injected in the healthy animal, it produces the tubercular lesion. Thus it will be seen that the accurate knowledge of the cause of disease is the essential step when we would formulate a campaign for its subjugation or annihilation.

And now to come to the subject of cancer. It will be shown that this disease is very alarmingly on the increase, and bids fair in the immediate future to surpass all others in mortality rate.

In order that we may intelligently comprehend this increase I have made charts as approximate representations of tabulated figures. As the medical man is used to temperature charts and has become familiar with its "curve," as indicating improvement or aggravation, I have used a similar chart in tabulating figures furnished by health boards of our various cities, and information obtained in published articles and official reports. A glance at these charts will suffice to enforce upon our minds that in cancer we find our greatest danger, and should this ratio of increase continue it will very far surpass all other diseases.

Roswell Parks made the prediction in 1899 that "if the rate of increase in cancer in New York State continues during the next ten years, its mortality will become greater than that of consumption, typhoid fever and smallpox combined."*

* *Medical News*, April 1, 1899, p. 385.

I shall show you that the rate of increase to which he alludes has in the city of New York at least been maintained, for nearly one-half of the period has elapsed. Nor is this increase confined to New York, but is to be found in all of the cities of the United States where I have made inquiries, and an equally alarming condition exists in Europe.

The accompanying chart shows an increase in the mortality rate of cancer per 100,000 living persons in the city of New York from about 32 in 1866 to 70 in 1903, or a little more than double the number of cases.

In Philadelphia, 1861, there were about 34 deaths as against 70 per 100,000 in 1903, or a little more than double the number.

In Baltimore the rate has increased three and one-half times during the past twenty-eight years, from 18 in 1870 to 63 in 1898.

It will be seen that San Francisco presents the greatest increase. The ratio in that city has increased from 16.5 cases in 100,000 of living population in 1866 to 103.6 in 1898. This represents an increase of over six times as many cases as thirty-two years ago.

Boston shows the next greatest increase, from 28 in 100,000 in 1863 to 85 in 1903, or three and one-half times as many cases as occurred thirty years ago.

In New Orleans an increase from 15 in 1844 to 82 in 1903, or five and one-half times as many cases as occurred fifty-nine years ago.

St. Louis shows an increase of four and one-half times as many cases per 100,000, as there were forty-two years ago.

Some facts are to be gleaned from the special report of cancer in Ireland by the registrar-general: "A steady increase in the recorded mortality from cancer in all these portions of the United Kingdom is very remarkable.

"In Ireland in 1864 the rate of mortality from cancer was 2.7 per 10,000 living. In 1871 it had risen to 3.2; in 1881

to 3.7; in 1891 to 4.6, and in 1901 it reached 6.5." In England and Scotland much higher, as is shown by the chart.

This increase in rate of mortality is not confined to the United Kingdom. In Austria it has, during the ten years from 1891 to 1900, risen from 5.4 to 7 per 10,000 living inhabitants; Bavaria from 8.9 to 9.9; Holland 7.9 to 9.3; Italy 4.3 to 5.2; Norway 6.1 to 9.2; Prussia 4.5 to 6.1.

In the last ten years a study of the tabulated deaths from cancer in the following cities, Amsterdam, Boston, Breslau, Brussels, Budapest, Copenhagen, Dresden, Munich, New York, Paris, Philadelphia, Prague, St. Petersburg, San Francisco, Strassburg, Stuttgart, Vienna, shows an increase per 10,000 inhabitants from 8.85 to 9.96. This increase would at sight seem small, but in computing figures it will be found that in these cities alone it adds 15,600 deaths annually.

During the past few years great advances in the treatment of cancer have occurred, notably in three directions:

1. In the knowledge that cancer is primarily a local disease and if radically treated in its inception a cure may be expected.
2. In recognizing that even in advanced cases extensive operation leads to a long period of immunity.
3. The established value of the X-ray.

In considering the value of the first two principles too much stress cannot be laid upon early and radical operation in all cases of cancer as soon as the growth is observed. Numerous cases of rapid recurrence are constantly coming to our attention where the first operation was incomplete. A nodule from the breast removed, or an epithelioma of the face excised, with too great a consideration for cosmetic effect, sacrificing thereby the golden opportunity for radical cure.

In cancer of the breast very thorough removal of the mammary gland is imperative, with an incision of the skin well away from the diseased growth. This should be done in all cases whether it is possible or not to approximate and suture the skin. Failing in this we have resource to skin grafting.

The axilla should then be cleared of all glands and fat, the pectoral muscles excised in the majority of cases, and the subclavicular glands removed if involved.

In cancer of the uterus more radical work can be done by abdominal hysterectomy than by vaginal, and it is therefore growing in favor.

The X-ray has since its introduction proven of great value in the treatment of inoperable cancer, both to retard its growth, and as a means of relief from pain. I believe also that it has a well-defined place in the after-cure of patients who have been operated upon for cancer, in order to retard or to prevent recurrence, and should be employed whenever possible. I cannot believe that it should displace surgery, but its place as an adjuvant is now recognized. I am sure that when statistics of the next decade shall be compiled, treated by early and very radical operation and subsequently by X-ray, a very great improvement will be seen. Nevertheless we are working in the dark when we attempt to combat a disease without knowledge of its cause, and when finally its mystery of inception is determined we shall in all probability be able to check its ravages by some means more effective than has yet been discovered.

It is quite time the world awoke to the prevalence and alarming increase of cancerous affection in order that medical science, fostered by public or private philanthropy, may have every possible opportunity to carry on extensive research and investigation until its cause is determined, and means of mitigation afforded.

NEED OF MORE PREPARATION AND LONGER CONVALESCENCE IN SOME OPERATIVE CASES.

BY BARBARA TAYLOR RING, M.D., ARLINGTON HEIGHTS, MASS.

[Read before the Massachusetts Surgical and Gynecological Society.]

It is important to recognize the fact that in some patients severe nervous prostration, and even serious mental disturbances may follow directly upon surgical operations. There are patients whose nervous systems are especially affected. Dr. Burr cites a case illustrative of the type possessing a neuropathic constitution. A young man of previous good health, but of a type common in America,—overrefined, overcultivated, with nerves not wholesomely blunted, but altogether too fine edged,—was suddenly seized with appendicitis. He was accordingly operated on at once, the wound healed quickly, there was no fever, and surgically the case was successful, yet he continued weak and prostrate after the operation, necessitating his remaining in bed for several weeks, and only after months of treatment did he fully recover. Many operations are performed after prolonged medical treatment has been faithfully tried, and the patient much exhausted thereby. Error in diagnosis, or the patient's unwillingness to submit to an operation, frequently leads to the wasting of much strength before the case comes to the surgeon, and he often finds his patient worn out by the secondary results of a surgical disease. The importance of post-operative care for the *undermined constitution* does not always seem to be appreciated. This precaution is especially indicated in chronic gynecological cases in which major surgery often produces, if it does not already exist, a neuropathic constitution, and it is in this latter class of cases that pre-operative care, as well, can be of so much benefit.

There is usually nothing to be lost by a delay of a few weeks in suitable cases, and much reserve strength can be accumulated and physiological resistance strengthened by a few weeks of rest, massage, baths, electricity, and open-air

treatment, and this should be done away from oversolicitous relatives.

Mummery says: "Many operations depend for their success on the way in which the treatment afterward is carried out, and many an almost hopeless case has been saved by skillful after-treatment."

The surgeon looking for immediate and brilliant results does not always appreciate fully the far-reaching shock to the nervous system. This is more pronounced on the unstable nervous system, yet I have seen several post-operative prostrations in patients who gave a history of a stable nervous system, before the operation. It is in operations upon the female genitalia which are so intimately related to her nervous equilibrium, that I have observed by far the greater number of post-operative breakdowns; and it is especially in these cases that I would urge a longer period of convalescence after operation. In the majority of abdominal sections for disorders of the female genitalia, a year of complete rest will be found none too much to allow the nervous mechanism to readjust itself, and would, if surgeons required it of their patients, greatly lessen the number of post-operative neurasthenics. The surgeon cannot go far astray in regarding every major operation, especially ovariectomy, as producing a condition not unlike railroad shock and in instituting as soon as possible systematic treatment. The following case is an illustration of good care:

Miss S., aged thirty-four. Father and mother cousins, of Spanish birth. After being exhausted by painful menstrual periods and prolonged local treatment, which was given on account of the refusal of operation, Dr. Thomas of New York recommended a course of hydropathic treatment at Dr. Baruch's institution preparatory to a radical operation. In this advice no lesser men than Drs. Tod Helmuth and Mundé in consultation agreed. After three months' upbuilding treatment a total hysterectomy was performed. Dr. Thomas, appreciating what so many surgeons overlook, placed with the

patient a competent nurse who kept her out-of-doors and gave baths and massage systematically, and personally superintended her treatment for a year, with the result that the young woman, in spite of bad family history and an intensely neurotic temperament, has remained active and well for ten years.

The following cases are types of the *lack* of post-operative care:

Miss P., aged thirty-eight, American, school teacher, neurotic. After much local treatment which reduced her strength, a double ovariectomy was performed nine years ago. She went from her teaching to the hospital, and after six weeks was recommended to go into the country for the summer, where she had no guidance other than her own judgment. In the fall, by her surgeon's permission, she was allowed to return to her teaching. This she continued with great effort up to two years ago last April, when she collapsed. All this time she had been suffering from the shock of the operation, and was a semineurasthenic. The most careful treatment has been of little avail, and she bids fair to be a chronic invalid. Had her surgeon appreciated her constitution, and insisted on prolonged post-operative care, it is very probable that more favorable results would have been attained.

Miss N., aged twenty-three, American, school teacher, menstruated at fourteen, much pain and excessive flowing. At twenty years of age was examined, and local treatment given for a year; pessary placed which gave some relief. Had to give up her work last October, and since the ligament had not contracted a double Alexander was performed. She was allowed to leave the hospital in three weeks with no suggestion of further treatment. She continued to grow worse, and now, after six months, she comes under treatment,—hysterical and severely prostrated.

Miss T., aged twenty-six, neurotic, examined at twenty-one years. Local treatment for three years. Operation a year ago. Single ovariectomy; appendectomy; ventro-suspension.

She recovered from the operation and was allowed to return home in six weeks to care for herself and do as she chose, with the result that, gradually growing worse, a year later, depressed and hysterical, she came to the institution with which I am connected, for systematic treatment.

Many other cases might be cited, did time permit. To summarize:

(1) Every hysterectomy produces shock which, like railroad shock, may not appear for several months.

(2) This nervous shock should be met by treatment similar to that carried out in other forms of cerebro-spinal exhaustion, namely,—prolonged rest in surroundings psychically congenial and free from all care and responsibility, and in conjunction with open-air treatment, massage, hydrotherapy, and electricity under a physician's supervision.

(3) The time to begin the treatment is immediately after operation, and not after the nervous system has been allowed to acquire a neurasthenic or hysterical habit.

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EXOPHTHALMIC GOITER: A CASE.

BY N. R. PERKINS, M.D., DORCHESTER, MASS.

[Read before the Massachusetts Surgical and Gynecological Society.]

As my case is not gynecological, it must be surgical. Exophthalmic goiter is a disease characterized by an enlargement of the thyroid gland, accompanied by exophthalmos, rapid action of the heart, tremor of the whole body, and excessive pulsation of the arteries of the head and neck. We may find the disease without exophthalmos, sometimes without the goiter being scarcely noticeable, but seldom without the rapid heart beat and tremor.

Some systolic blowing murmurs are heard at the base of the cardiac area, having their maximum intensity on the left side of the sternum, while at the middle of the cardiac area, or more toward the apex a soft systolic murmur is heard, not spreading towards the axilla.

The latest views of Greenfield, Starr and others are that this disease is really dependent on a disease of the thyroid itself, and a nonelimination of some toxins, which poison the whole nervous system (hyperthyroidation). It still remains a question, however, whether the disease of the thyroid is primary, or secondary and consecutive to nervous shock.

Baldwin in the *Lancet* of January, 1895, reports four cases that tend to support the theory referred to, that exophthalmic goiter is produced by some abnormality of the thyroid, probably increased thyroid functional activity.

Horsley says that exophthalmic goiter depends upon a perversion of the function of the thyroid.

Many cases are reported as a sequence of, or at least following, an attack of grippe. The proportion of cases between male and female, are 1 of the former to 2.5 of the latter. Operative treatment has been resorted to in some instances, by removing the whole or some portion of the gland, with a mortality of twelve per cent. So far I have quoted quite freely from "Bartlett's Clinical Diagnosis," and "Rockwell's Medical and Surgical Electricity."

Medicine has as yet done but little for this disease. With an increased knowledge of electricity and the possibilities of results to be obtained by its use in this and kindred diseases, more hope is held out to those afflicted, than has been heretofore, either by medicine or surgery.

One case that has been under my care I will report:

Miss M., aged twenty-one, weight 127 pounds, robust muscular development far above the average, consulted me in September, 1902, for a swelling of the submaxillary and thyroid glands. The swelling of the submaxillary glands yielded readily to treatment, but not so with the thyroid, and

in March, 1903, she presented the classical symptoms of exophthalmic goiter, pulse 120, pulsation of the arteries of the neck and thyroid, tremor of the whole body, nervous, starting at sudden noises, unable to walk but a short distance on account of dyspnea, appetite good, bowels and kidneys normal, menses regular.

The right side of the thyroid was enlarged to the size of half a small orange, the left enlarged, but not as much as the right. At this time, March 1, 1903, began treatment with the X-ray, using a medium soft tube, excited by a static machine, ten-minute sitting, all portions of the head and trunk except the region of the thyroid protected with foil.

During the months of March, April, and to the 15th of May, she received twenty-three treatments in all, at which time the pulse had dropped to 70, the tremor and pulsation of the arteries of the neck and thyroid had ceased, but the enlarged thyroid remained. May 15 she went into the country for the summer, returning Sept. 1, when she weighed 132, a gain of five pounds. She was now able to take long walks without discomfort, and during the summer had learned to swim.

Sept. 8 began treatment with the Morton wave current, by placing a block-tin electrode over the thyroid, connecting this to the positive side of the static machine, the negative grounded, and using as long a spark-gap as the patient would tolerate; this was continued until Nov. 1 at irregular intervals, with little or no effect on the size of the gland; still I believed electricity would cure the case, and with this end in view, concluded to try the high-frequency current; this was done by placing a pledget of cotton saturated with adrenalin chloride 1 to 10,000 over the gland and giving the electricity from a step-up transformer, using a glass vacuum electrode, ten-minute sitting; continued this until Feb. 1, when using the same electrode and the adrenalin as before, but connecting the electrode to the negative side of the machine direct, the positive grounded, using from one-fourth to one-half inch

spark-gap. From Sept. 1, 1903, to May 1, 1904, the electricity was given at irregular intervals, sometimes once a week, at others twice.

At the present writing the gland is nearly normal in size, and the patient is symptomatically cured; could any other treatment have done better?

REPORT OF THE MEDICAL SERVICE AT THE MASSACHUSETTS HOMŒOPATHIC HOSPITAL, JANUARY TO APRIL, 1905.

To the Medical Board :

In accordance with the established rules of this board, the following report is respectfully submitted:

Total number of cases during the quarter, 153: cured, 98; improved, 27; not improved, 2; not treated, 6; died, 20.

The deaths were as follows: circulatory, 1; constitutional, 1; genitourinary, 3; infectious, 7; nervous, 6; respiratory, 1; unclassified, 1.

Nine autopsies were held, with these results:

Mr. D. Chronic pericarditis; chronic myocarditis; pulmonary tuberculosis; chronic pleuritis; pulmonary infarction; hydronephrosis.

Mr. W. Lobar pneumonia; chronic pleuritis; chronic pericarditis; cirrhosis of the liver.

Mrs. O. Lobular pneumonia; chronic pleuritis; arterio-sclerosis; renal hyperemia.

Mr. P. Cerebral hemorrhage (from the basilar artery); chronic pleuritis; arterio-sclerosis.

Mr. S. Empyema; pneumonitis; chronic pleuritis; chronic pericarditis; renal congestion.

Mr. G. Lobar pneumonia; chronic fibrous myocarditis; chronic interstitial nephritis; serous pleuritis.

Mr. M. Meningitis (streptococci found in the pus from the brain surface); congestion of the right lung; chronic pleuritis.

Mrs. N. Myelitis; pyonephrosis; chronic ureteritis; chronic cystitis; vegetative endocarditis.

Mr. T. Acute exacerbation of a chronic interstitial nephritis; serous pleural effusion; cardiac hypertrophy; right femoral hernia (omental).

Three of the remaining patients who died were in the hospital only a few hours, being practically moribund when brought in.

While it is true that a hospital is primarily for the cure of the patients, it seems that some way should be devised for the admission of patients by a previous examination, so that they could reach the institution at least alive, and with some prospects of receiving benefit.

I wish to thank my assistants, Drs Emerson and Ruggles, for valuable services rendered; also Drs. Calderwood and Allen, for the faithful performance of the respective duties they were called to do, and which they so willingly responded to.

Respectfully submitted,

CHARLES H. THOMAS, *Attending Physician.*

ETIOLOGY OF RHEUMATISM.—Rufus Cole, working in the laboratories of the Johns Hopkins Hospital, has recently published, in the *Journal of Infectious Diseases*, a series of original observations bearing directly on this point.

The author's conclusions are that arthritis and endocarditis may be produced experimentally by the intravenous inoculation of streptococci from various sources, with results similar to those attributed to the "micrococcus rheumaticus," and that accordingly the assumption of a specific streptococcus as a cause of such lesions is unwarranted. Discussion of the closely allied question whether rheumatism is a form of streptococcus septiemia is not taken up in this paper.—*Exchange.*

 EDITORIAL.

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 THE CLAIMS OF THE AMERICAN INSTITUTE OF
 HOMŒOPATHY.

The disproportion between the number of those who are and those who ought to be members of the Institute is nothing less than surprising in view of the present state of therapeutics with its constant drift towards homœopathic experience, and the increasing support the homœopathic method and principles are gaining yearly from the progress of science at large. To the man in the street—who does not always judge superficially—it may appear that this peculiar attitude of the great majority of homœopathic practitioners either regard with indifference the advantages offered by membership in our national society or that these are not sufficiently understood. Whether or not this indifference or misunderstanding exists, it is certainly true that the cause of homœopathy and, as a consequence, every individual adherent of it are made to suffer intellectually, morally and materially from the fact that with more than twelve thousand homœopathic physicians in the land the Institute can show no more than two thousand members. It must be evident to the most casual reflection that the forces thus lost to the cause constitute a serious waste, and a danger to the high standards of our branch of the profession demanding serious thought on the part of all concerned.

This disproportion between the claims of the Institute and the active and loyal response to them is the more to be deplored since this great organization has long proved itself to be a force in the land which has enlisted the best efforts of the foremost men in our ranks and has more and more made itself felt in many important matters relating to the welfare of the whole profession, both in regard to its relation to the public and to scientific progress.

To those who do not follow the work and the development of the Institute, who hold themselves aloof from its influence by failing to attend its meetings, this power for good is not apparent. But of its existence there can be no question. It is a power exerted in many ways, directly and indirectly both upon the progress of the cause and the individual practitioner who has it at heart. In daily practice and by faithful study a man gains his experience, enlarges his knowledge and settles the principles on which he will conduct his work. But if he refuses to measure his experience, compare his knowledge and test the validity of his principles by contact and discussion with others he will remain narrow and unprogressive. On the other hand, he will extend his knowledge and powers in proportion as he seeks contact with and enlightenment from other minds against which he measures the soundness of his own convictions.

The great questions which agitate our minds, or should agitate them, regarding principles and practice are not discussed sufficiently in our local societies. There we are more apt to deal with the practical matters of daily observation. Or if larger questions are discussed, their treatment is more confined, mainly for the reason that they are treated in a narrower field. In the national society where the foremost minds of the land in our chosen field find their congenial sphere and the proper arena for the discussion of great principles, a different spirit prevails. This is easily seen in the tone and character of the published transactions, more particularly in the discussions of the ablest papers. The

sectional work of the specialists will there be seen to be of the most advanced character, and will more than repay him who consents to make even great sacrifices to attend the meetings where the exchange of experiences tends to round and mature individual knowledge and skill. But above all else, the papers and discussions on our special principles and their relation to the progress of science at large, or on the actual work done along strictly homœopathic lines, cannot fail to be recognized as of the most vital importance. We need only point out among others of equal value the papers on the "Similimum" by Dr. Hutchinson of New York, on the "Single Remedy" by Dr. Stearns, on the "Method of Study of the Materia Medica" by Dr. Byron Clark, on the "Relation of the Action of Antitoxin to Homœopathy" by Dr. Price of Baltimore, and chief of all, on the "Progress in Drug-proving" by our own Dr. Bellows. The man who has listened attentively to papers of this kind and heard or participated in the discussions following will return to his work strengthened in body and soul and with new hope and courage not alone for his daily labors, but for the cause of which he holds himself to be a part.

It is true that the attendance at a meeting of the Institute calls for sacrifices by no means trifling, particularly for the younger practitioners to whom money, time and contingent loss are grave considerations. But such sacrifices will be repaid many times, especially if he be ready to sacrifice his prejudices, those weeds which grow most rankly in isolation and too often choke the best endeavors and poison the most generous spirit.

THE MEETING OF THE MASSACHUSETTS HOMŒOPATHIC MEDICAL SOCIETY.

It is most gratifying to record so successful and, indeed, so memorable a meeting of the state society as that held on the 14th and 15th of April, the first date being that of the one hundred and fiftieth anniversary of the birthday of Hahnemann. It was fitting that on this occasion there should

have been not only an unusual attendance as regards numbers, but also that the papers should have been for the most part of a high order and the discussions following as animated and to the point as the limited time permitted.

But, in addition, the meeting was signalized by certain events of moment and great interest beyond the immediate occasion. Of these the chief one was the voting of the sum of \$1,000 towards the proving fund of the American Institute, an act by which the society demonstrated its interest in the work of reprovng our *materia medica* and its high sense of appreciation for the labor, the judgment and the devotion shown by Dr. Bellows in originating and advancing the task he has undertaken, and which sooner or later must bear fruit of the highest practical and scientific value.

No higher honor can be paid by his colleagues to a scientific man than that of promptly and effectually aiding in the support and perpetuation of such work and its results as that to which he has given his best energies and which he feels to be of lasting service to science and to humanity. Dr. Bellows has our sincere congratulations and best wishes for his speedy recovery from the illness brought on in so large a measure by his exhausting efforts to put his work into the shape in which he wishes to present it before the Institute at its next meeting.

Another occurrence of an unusual character was the presentation at the banquet of a medal to Dr. Watters for his admirable work in devising means to preserve anatomical and pathological specimens in their natural color and appearance. Only those can fully appreciate the advantages to teaching and investigation thus achieved who remember their vain efforts to learn from specimens which none of the modern technical methods had rendered clear and natural. Dr. Watters too has our best congratulations, as he merits the thanks of the whole profession. What he has already accomplished leads his colleagues to look for further successes at his hands.

May we have many such meetings and many such causes for congratulation.

LETTER FROM BERLIN.

To the Editor of the Gazette:

SIR:—To comply with your wish to have occasional news from the native land of homœopathy is attended with certain difficulties at the present busy time. The influenza is prevailing here in an uncanny manner and bringing in its train many grave sequelæ, more particularly such as are communicated to the cavities of the malar and frontal bones directly by the highly infectious nasal catarrh. These affections are commonly treated here by formidable operations, and it is not to be denied that in a limited number of cases such operations are not to be avoided where, for example, a very acute course with high temperature and danger of extension to the meninges through the cribriform plate is to be apprehended. But these are rare exceptions. In the great majority of cases the operation is superfluous; in fact, of very doubtful therapeutic value. Scarcely a week passes but cases present themselves in which the operation, several times repeated, has been unavailing. On the other hand, satisfactory results are obtained by carefully selected homœopathic remedies administered internally, and also used locally in the form of glycerin extracts. A well-devised instrumental armamentarium, and the topical application of homœopathic medicines, which effect a prompt detumescence of the swollen mucous membrane, afford effectual means of meeting these most trying grippe sequelæ. I hope to publish shortly the method of treatment here referred to.

Noteworthy are also the number of grave rheumatic cases following severe forms of tonsillitis lately prevailing. The causal relation of these two affections is well known on your side of the water. It has led me in several instances to the use of lachesis 30, with striking results where the other indications corresponded, such as the aggravation by sleep, great sensitiveness at epigastrium and neck, abnormal fetor of stools, nosebleed, etc. In similar cases anthracin 30 has proved most helpful. Its relation to the streptococcus infection

is well known. Salicylic acid I never use. It is deplorable to find this drug recommended in homœopathic journals, in the face of the fact that the large number of grave heart lesions after salicylic-acid treatment prove conclusively its powerlessness against the most dreaded consequences of rheumatic arthritis. The prompt palliative effect occasionally obtained is but an insignificant gain in comparison with the frequent heart complications.

In the cases, too, of hyperpyretic rheumatic arthritis of greatest intensity, with threatening meningeal symptoms, the drug is well known to be useless. Here I have found chin. sulph. 2x in $\frac{1}{2}$ gr. doses, and chin. arsen. 3x, together with lukewarm baths, of striking efficiency.

Regarding homœopathic hospitals in German-speaking countries, it is possible to record a distinct step onward of late. This is the more welcome since the Leipsic hospital was forced to close its doors some years ago by reason of structural defects, and funds for a new building are not yet available. In Basle, German Switzerland, a new hospital is in process of construction. Dr. Scheidegger is to be at its head. In Davos, the most noted resort for cases of tuberculosis, a sanatorium for the high-air treatment of phthisical patients has been opened under the direction of Dr. Nebel, formerly of Montreux, one of the foremost homœopathic investigators in the field of tuberculous disease. A visit to this establishment is urgently recommended for every homœopathic physician coming to the continent, more particularly since it is an easy matter to combine such a visit with a tour through the Engadin, one of the most beautiful of the high valleys of Switzerland. It is to be hoped, too, that our colleagues will bear these new advantages of Davos in mind when advising their lung cases in regard to the high-air cure, the results of which have so often proved surprisingly favorable. It may be mentioned by the way, that the venture is in the hands of a syndicate who would gladly welcome financial participation, more particularly since at the eleventh hour

the backing of the Davos Bank was withdrawn in consequence of the machinations of one of its directors, an allopathic doctor.

During the past winter the long-hoped-for Berlin Homœopathic Hospital was opened in the suburb Gross-Lichterfelde. The difficulties standing in the way of such foundations in Germany are so great for the reason that our people are accustomed to look to government for all public needs. Hence philanthropic activity is imperfectly developed, and the tendency in every new movement is to question whether it is looked upon with favor from above. Nevertheless, if the high price of real estate in Berlin is considered, the energy hown in surmounting all obstacles is worthy of all praises. The disadvantage of the location so far from the center of the town is more than counterbalanced by the advantages of salubrious surroundings, and good facilities of communication. The property is quite a large one, calculated for the extension of the plant as means for the purpose are forthcoming. The present building is constructed on the most modern principles, and presents a most attractive appearance. It contains fifty beds, in three classes, an operating-room for septic, another for aseptic cases, baths, gymnasium, laboratory and a Röntgen cabinet. The head of the hospital is Dr. Schwarz, a surgeon of distinction.

From this time forward the homœopathic physicians of Berlin will no longer be under the painful necessity of sending patients in need of hospital treatment to allopathic establishments, and strangers stricken with illness in Berlin will find a refuge with excellent nursing, care and enlightened treatment. Colleagues coming from afar, especially those interested in surgery, will find here most favorable opportunities for study.

Among other centers of medical science in Germany it is in place here to call attention to the small university of Greifswald on the Baltic, where Professor Schulz teaches pharmacology with reference to homœopathic principles, and

gladly offers to foreign colleagues opportunities for study and research.

The movement in favor of establishing chairs of homœopathy in the universities led, as you know, to the resolve on the part of the prime minister of Holland, Dr. Kuyper, to found such a chair in the university of Leyden. The negotiations with German homœopathic physicians, with a view to the filling of the position, proved unsuccessful, mainly for the reason that no fair prospects of practical activity could be offered.

The bills passed by the legislatures of Bavaria, Würtemberg and Baden for the erection of homœopathic chairs in their respective universities, were vetoed by the governments of these states after having sought the opinions of the medical faculties; that is, of the enemies of homœopathy. In how far these learned bodies were qualified to express such an opinion is abundantly shown in certain recent occurrences.

In the suit for defamation of character brought by one of the candidates for the homœopathic chair of Leyden against the editor of one of the foremost German medical journals, the *Munich Weekly Medical Journal*, one of the witnesses, called for expert opinion by the defendant, was the noted gynecologist Winkel, whose testimony was published, together with that of the homœopathic experts called on the other side, and presents unimpeachable evidence of the ignorance and frivolousness with which the authorities of the schools form their judgments concerning homœopathy. As illustration it will serve to mention among others the declarations of Professor Winkel that homœopaths administer chelidonium in hepatic affections because its juice is yellow (like bile); *i.e.*, according to the ancient doctrine of signatures, while we all know Hahnemann's attitude toward this doctrine as expressed in his provings and elsewhere.

A similar vagary was recently offered by Professor Hansemann, a pupil of Virchow, in a popular lecture on "Superstition in Medicine." The imminent pathological anatomists ventured

publicly to declare the doctrine of signatures to be the fundamental principle of homœopathy, and recited to his hearers a list of absurdities such as, "treat blindness by moles because these animals are blind."

If such is the view of homœopathy in professional minds what shall we look for in the minds of the laity?

In order to counteract these pernicious influences the German homœopaths, more especially those of Berlin, have organized the German Homœopathic League with the purpose of enlightening the public by lectures and a journal, the *Homœopathische Rundschau* (*Homœopathic Review*).

DR. F. GISEVIUS.

Berlin, Chaussee Str. 6.

THE TREATMENT OF NEVUS, OR BIRTHMARKS.—A simple and safe method of treating nevi and port-wine marks consists in exerting pressure around the nevus by an encircling ring in order to arrest the circulation to and from the part, and then slowly inject five to seven minims of rectified spirits of wine with an ordinary hypodermic syringe. The result is to harden the tissue and to cause the nevus to shrink and disappear. In treating nevi of large dimensions more than one injection could be given at the same sitting, or at short intervals of time in different parts of it; the absorption in one part could be taking place while another part was being prepared, bearing in mind the effect of alcohol upon the system. This method has the advantage of being easy of application, and there are few practitioners who are not possessed of all the material needed; if not, it is readily procurable, and with ordinary care it will not, I think, prove dangerous. Care must be used that the syringe is perfectly void of air before injecting the agent.

Dr. T. H. Holgate in Pediatrics.

SOCIETIES.

BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

The regular meeting of the society was held in the hall of the Boston Society of Natural History, Boston, Thursday evening, April 6, 1905, at eight o'clock, the president, J. Herbert Moore, M.D., in the chair.

The records of the last meeting were read and approved.

SCIENTIFIC SESSION.

Dr. Packard, after presenting a very interesting pathological specimen, also exhibited the Killian bronchoscope, a recent invention by a German surgeon. It is designed to facilitate the removal of foreign bodies from the trachea and bronchi, and is also adapted to the same of the esophagus. It consists of varying sizes of tubes for all ages of patients. The tube may be introduced by way of the mouth through the larynx, or more directly through a tracheotomy wound. With reflected light a foreign body can readily be seen, and with a suitable forceps removed.

Dr. Rice: I have been asked to say something on the autoscope and bronchoscope. The autoscope is an invention of Kerstein in 1895. Its object was to enable the observer to obtain a direct view of the larynx, and to make it possible to operate upon the laryngeal tissues in a more certain manner than by the aid of the reflected image in the laryngoscope. Such an instrument is here shown. It is something like a tongue depressor with a heavy handle, and a depressed lip at the further end. It is used by depressing the tongue, allowing the lip to engage in the glosso-epiglottic fold, and then pulling the whole structure forward. This elevates the epiglossis. The part of the instrument nearest the handle is then raised until it comes in contact with the upper teeth. The patient then holds the head a little forward, with chin elevated, and a view of the larynx is then obtained.

The bronchoscope, an invention of Killian, is to be used in connection with the autoscope. As you see, there are different lengths and different sized cannula which pass down through the autoscope into the bronchi, thus enabling the operator to observe foreign bodies, and to remove them by means of these little forceps which are made small enough to go inside of the bronchoscope. With your permission I will read a report of a few cases where these instruments have been used successfully.*

In addition to these I would like to report briefly a recent case which came under my observation. About three months ago a boy aged nine, was brought to me by his mother, who said he had swallowed an umbrella button, and that the noisy respiration which was noticeable was occasioned by the presence of the button in the throat. I learned that she had taken him to two of our hospitals, and that X-ray pictures had been taken with negative results. I took him to the Massachusetts Homœopathic Hospital, and had repeated X-ray observations made without locating the foreign body. His breathing was noisy, but not particularly difficult, and the sounds seemed to be the loudest in the infra-axillary region on the right side. The boy was kept at the hospital for three or four days, and as with rest his symptoms improved it was thought wise to send him home. The next day his mother called me on the telephone saying the boy had had an attack of vomiting that morning, and immediately had great difficulty in breathing. I sent him to the hospital at once, and went over as soon as possible. The child was breathing with great difficulty, and already was cyanotic. I immediately took him to the operating-room, and, with the assistance of Dr. N. H. Houghton, opened the trachea, making the lower incision. Breathing immediately became quiet, and, therefore, with a reflected light and small nasal speculum, a search was made through the upper part of the tracheal wound. The button was at once seen just below the cricoid cartilage,

* Omitted here from lack of space.

and removed without difficulty. The patient made a quick and complete recovery. Had these instruments been at my command it might have been possible to have discovered the foreign body when the patient first came into the hospital.

PROGRAM.

1. "The Evolution of the Bowles' Stethoscope and Its Principles of Operation." Mr. Robert C. M. Bowles.

2. "Immunity and Antitoxin." W. H. Watters, M.D. Discussion opened by John P. Sutherland, M.D., and Frederick P. Batchelder, M.D.

3. "Some Surgical Conditions of the Kidneys." Wm. F. Wesselhoeft, M.D. Discussion opened by Stephen H. Blodgett, M.D.

Mr. Bowles gave an informal account of the manner in which his instrument has reached its present form. First he became interested in an acoustic wire used by some workmen. Their instrument was a box eight to ten inches in diameter, circular in form, over which parchment, or thin metal, was stretched and the wire put through. Mr. Bowles made a box having an air chamber one to two inches in depth covered with brass one-sixteenth of an inch in diameter, and talked into it with a tube. This instrument was so sensitive, a whisper could be heard half a mile. Several years after, when experimenting, Mr. Bowles noticed that he could hear the sound of his own voice, then dropped it down on the chest, and found the heart beat was audible. This instrument was rather clumsy, being three and a half inches in diameter, and had too much surface. In February, 1891, Dr. John H. Payne gave him an introduction to Dr. Herbert C. Clapp, who tested the instrument on Mr. Bowles, but thought it was not practical in that form. About this time a heavier instrument was made, which was patented in 1893. In the fall of 1896 the *Boston Herald* had an illustration of an instrument that was exciting an interest in Europe, called the phonendoscope, which proved to be similar to Mr. Bowles' design, but as he had not a foreign patent he

compromised with the manufacturers, and it cannot be used, sold or made in this country except by paying a royalty. Meantime he got up another instrument, by which a patient can be examined without disrobing, which physicians have been unwilling to do. On account of its size a smaller one was made, but the vibrating surface was so reduced it was necessary to carry two instruments. The phonendoscope had an air chamber of nearly half an inch, while that of the Bowles' stethoscope was one-eighth to one-sixteenth of an inch. The nearer you get to the sound the less air is required. Mr. Bowles considers what he calls the flatiron the best instrument, the different size of the ends making it possible to examine a small or large surface with the same instrument. It is covered with wash leather, and has been tested by Drs. Gannett and Cabot. The reason it is not liked is because it has not been properly used.

DISCUSSION (DR. WATTERS' PAPER).

Dr. Walter Wesselhoeft: I doubt whether I can say anything to throw more light on so obscure a matter. It was discussed with great intelligence and after the most exhaustive examination of latest theories at the last meeting of the Institute where Dr. Price's paper on the subject attracted much attention. The consensus of opinion was that no relation existed between the *modus operandi* of antitoxin and that of the homœopathic remedy. Yet I cannot fully accept this view, mainly for the reason that we do not know what constitutes the actual relationship of the remedial agent to the disease in either case. The totality of the symptoms, or the keynotes and characteristics are for us no more than indications for the use of a drug, not an explanation of its action and still remain in many respects vague and uncertain.

In the same way there exists an undefined relationship between the action of antitoxin and diphtheria. It is in both cases the specific relation. Behring claims specific action for antitoxin, and we make the same claim for our remedies. The

most ardent advocates of antitoxin do not claim specific power against the whole disease, but rather against a certain condition of it. If used early it may produce all the effect claimed for it; later it is more uncertain. The same is true of our remedies. They are specific against certain pathological states, not against diseases. Hence there may be said to exist a correspondence or analogy between the homœopathic cure and that of antitoxin. There is analogy if not identity of action. In the one as in the other there is the relation of the curative agent to certain tissues, structures or organs affected in a particular manner. Hence we may say that a relationship exists between the action of antitoxin and that of the homœopathic remedy. But the subject remains very obscure, and I confess that it is made no more clear to me by what looks like an algebraic formula.

Dr. Rice: I have been very much interested in Dr. Waters' paper and in the discussion following it. I have thought much on this subject of the action of antitoxin in diphtheria, and am fairly familiar with the lateral chain theory of Ehrlich, but this and the other explanations of the action of antitoxin in the body seem to me only theoretical, and I do not believe that any satisfactory conclusions have yet been reached. At present, I think, we must feel satisfied in saying that antitoxin arouses in some way the dormant activities of the system toward combating the toxin of diphtheria, and I believe that this is as far as we can go. Dr. Wesselhoeft has just said that we did not know whether antitoxin cured diphtheria or not, but that we did know that it did not cure all cases. My belief is that antitoxin does cure all cases of pure diphtheria if given early enough, but that it is not a specific against the toxins of mixed infection, neither is it a specific in combating those conditions resulting from the continued effect of the absorption of the diphtheria toxin. We know that the diphtheria toxin produces fatty degeneration of vital organs, changes in the structure of the cells of the nerve centers, and other conditions which will of themselves cause death even when the

diphtheria toxin is no longer active, therefore, antitoxin is not a specific even if given early in all of the cases of mixed infection, nor is it a specific when given late in cases where the diphtheria toxin has produced definite pathological changes in important tissues.

Dr. Wesselhoeft: I did not intend to convey the impression that antitoxin does not cure. But if a drug or curative agent is specific in the old sense, we should expect more effect from it even in advanced conditions than I think we can justly claim for antitoxin.

Dr. Krauss: I think it might be well for us to remember that it has not been proved that antitoxins will give immunity to organisms. Thus far antitoxins have been used effectively only for the purpose of cure and not for the purpose of immunity, that is, to cause individuals to acquire a resistance to a disease which has not yet taken hold of their organism. The only thing proved to produce immunity to a certain disease is to have that disease. Some infectious diseases, after a patient has been attacked, will cause immunity against a future attack of the same disease, as, for instance, scarlet fever. Certain infectious diseases may of course occur several times. In the case of syphilis alone we may obtain permanent immunity. Once a patient has been cured, he may be said to be immune to syphilis. I do not think it would be wise to try to improve upon the fine presentation of this subject by Dr. Watters. He has covered the facts. I think we should consider that antitoxins have not been tested sufficiently to prove that they can produce permanent immunity.

Dr. Carvill: It seems to me diphtheria does not produce immunity. I know of one family where one child has had it three times. Some of the children on whom I have used the antitoxin have not had the disease. It seems to me in small doses the antitoxin does produce immunity.

Dr. Krauss: I did not say I thought that antitoxins could not produce immunity. I said that it has not been proved that antitoxins can produce permanent immunity and it has

not been proved. I do not know any case where diphtheria antitoxin has been used for the purpose of protection at a future time and that such protection was adequate and complete. The proof of antitoxin immunity is yet to be forthcoming.

Dr. Sutherland: Out of one hundred children, who were exposed to diphtheria and inoculated with antitoxin in proper doses, less than one per cent. came down with diphtheria. In the hospital nursery there have been occasionally sporadic cases of diphtheria, and we inoculated all the children there with one thousand units, and in almost all cases there was no further trouble. We can produce a temporary immunity for a few days, or weeks, but it will not last. The toxin must be neutralized before it comes in contact with the cell. We have our toxin and cell in combination. We have a union of the two, and we have the action of the toxin upon itself. A particular cell or molecule has been neutralized. Now, if we have some of our antitoxin along, it is assumed that the attraction between the binding molecule and the poison is sufficiently strong to overcome this union, leaving the toxin free. If you rid the cell of the poison, and it has sufficient recuperative power, it will recover.

Dr. Watters (in closing): Two or three things I should like to speak about. Dr. Rice will readily call to mind many cases where this immunity was attempted. The immunity has been secured in our hospital, as far as we could see, by the performance of inoculation.

There is a difference between the active and passive immunity. The active immunity is produced by the activity of the body as in vaccination. Passive immunity is where the body acts only as a repository. After inoculation, a patient may be expected to remain immune for a few days, or even a month or two, but it will not last forever.

Owing to the lateness of the hour Dr. Wm. F. Wesselhoeft's paper was not presented.

Adjourned at 9.55 o'clock.

B. T. LORING, *Secretary.*

SIXTY-FIFTH ANNUAL MEETING OF THE MASSACHUSETTS HOMŒOPATHIC MEDICAL SOCIETY.

The sixty-fifth annual meeting of the Massachusetts Homœopathic Medical Society was held in Boston, April 11 and 12, under most gratifying conditions. A feature that added greatly to the interest of the meeting was the fact that, at this meeting, the one hundred and fiftieth anniversary of the birth of Samuel Hahnemann was celebrated.

There was an unusually good attendance during the entire session and the consensus of opinion was that this meeting was one of the most, if not the most, satisfactory gatherings in recent years. Those who were fortunate enough to attend were amply repaid by the scientific tone and excellent presentation of the papers, and the prepared discussions that followed.

The society was fortunate in having as guests during this session Dr. Eugene H. Porter, editor of the *North American Journal of Homœopathy*, who gave a most interesting and withal important after-dinner speech on the "Future of Homœopathy;" Dr. Irving Townsend of New York, whose paper on the "Manifestations of Hereditary Syphilis in Childhood," received well-merited applause; Dr. Everett Flood, superintendent of State Hospital for Epileptics, and our newly honored and respected president, William E. Huntington, S.T.D., who extended greetings from B. U. S. M. to the society.

As in the past, a number of these papers will appear *in toto* in future numbers of the NEW ENGLAND MEDICAL GAZETTE. The following brief digest of important features will give the readers some idea of the value of these annual meetings held under the auspices of the Massachusetts Homœopathic Medical Society.

The meeting was called to order by Pres. Frederick P. Batchelder, M.D., who, after welcoming the guests and members on behalf of the society, turned the meeting over to Dr. Lucy C. Hill, chairman of the committee on diseases of children.

The first paper on the program was presented by Dr. F. Mason Padelford, on "Antitoxin from a Homœopathic Standpoint." Being of a technical nature, and as it will appear in an early number of the GAZETTE, a digest of this excellent paper will be omitted.

This paper was followed by one on "Gymnastics as a Therapeutic Agent," read by Dr. Helen S. Childs. A strong plea was made in behalf of young girls with the idea of preventing, if possible, and if not, the correcting of deformities by selected exercises, these exercises to be given without apparatus, in the homes of the patient. A practical demonstration of the exercises best suited for the individual case was given by Miss Seeley, a member of the faculty of the Boston Normal School of Gymnastics. This feature of the paper illustrated the points brought out by Dr. Childs,—positions necessary to control lateral curvatures, breathing exercises for the development of the lungs, prevention of round shoulders, overdevelopment of one side, lordosis, inrolling ankles, flatfoot, and kindred conditions.

The third paper of the evening, "The Manifestations of Hereditary Syphilis in Childhood," was read by Dr. Irving Townsend of New York. In a short but excellent paper he discussed the symptoms and location of the lesions, and especially those developing in the nares, nasopharynx, oropharynx and buccal cavity. The discussion by Dr. George B. Rice was equally instructive.

Dr. Albert C. Cross followed with a paper on "The Necessity for the Early Treatment of Strabismus." Particular stress was placed on the importance of the early detection of this condition so prevalent in childhood. The general practitioner should train himself to recognize this condition in its incipency, and refer the patient to a competent oculist for treatment.

The fifth paper, by Dr. Jeannie O. Arnold, on "Some Points in the Sequelæ of Contagious Diseases," pointed out the dangers that children are subjected to in the convalescence from contagious diseases. Too often the physician fails to

give proper instruction regarding the convalescent treatment. A large proportion of sequelæ might be avoided if closer attention were paid to the direction of the child's diet, hygiene and general environment.

Owing to the lateness of the hour, the paper by Dr. Henry H. Amsden, giving a "Report of a Case of Acetane Poisoning in an Infant," was read by title.

The report of the committee on clinical medicine, with Dr. Percy G. Browne as chairman, opened the exercises of the second day.

Dr. H. C. Clapp then read a paper written by himself and Dr. George M. Lapham, on "Basic Pulmonary Tuberculosis." They had made special investigations as to the frequency of this very rare location for the deposit among the 3,252 cases treated at the Massachusetts state sanatorium in the six and a half years of its active existence, including not only their own patients but also those of the other service, and also among the 6,769 applicants for admission in the last four and a half years, and reached the conclusion that true basic pulmonary tuberculosis occurs only about once in five or six hundred cases.

The "Early Symptoms of Tubercular Lesions of the Bones" was the title of the paper read by Dr. George H. Earl. Attention was directed to a few of the common symptoms of initial lesions, which are easily overlooked or misinterpreted. As for example "stomach ache" in caries of the spine, and "pain in the knee" in beginning hip disease.

The third paper, "Laboratory Suggestions," read by Dr. Orville R. Chadwell, touched on the special value of laboratory methods as a supplement to clinical observation. He pointed out the practical value of chemical examination of urine alone, and referred to several new instruments and reagents of special value to the general practitioner in performing his own analyses. A few practical points concerning the examination of urethral discharges, examination of sputum and pus for tuberculosis, also the value of blood examination in differen-

tiating certain diseases, especially appendicitis, typhoid and malaria. The importance of the examination of the stomach contents was also considered, and methods given which the average practitioner could easily execute.

The "Difficulties in Early Diagnosis of Phthisis" was read by Dr. Percy G. Browne. He laid special stress upon the importance of the recognition of phthisis in its incipient stage, and the difficulties generally encountered in doing so. One class of cases that seemed to cause trouble even when the disease is well marked is where the deposit is so situated as to obstruct the free passage of air in the bronchioles, and instead of producing vesiculo-bronchial respiration caused diminished breathing with diminished vocal resonance and fremitus. The fallacy of a single sputum examination, and the advantage of ascertaining if the patient has had a *prolonged* opportunity for infection by residence with one showing the disease, was taken up in detail. Another important feature of his paper dealt with cases giving a history of a well-marked pleurisy, which cases should always be regarded as secondary to a probable tubercular focus.

The business session which followed this bureau was of unusual importance and interest. In every instance the committee reports were favorable, and showed progress in the hands of those with whom the work had been intrusted. The treasury shows a handsome balance. The *Necrologist* reported on the death of four of the society's members: Dr. Benjamin T. Barstow of Kingston, Dr. Conrad Wesselhoeft of Boston, Dr. Francis Hugo Krebs of Boston, and Dr. Edward B. Holt of Lowell. The death of Dr. Alonzo L. Kennedy took place on the evening of the second day's session.

Under new business, the legislative committee was requested to make special effort controlling the applicants for registration to graduates only.

One thousand dollars was voted to the society for the improving of drugs, of which Dr. Howard P. Bellows was chairman. Dr. Bellows was unable to attend this meeting,

on account of sickness caused by overwork in connection with this noble piece of scientific effort, which has for its aim the placing of the homœopathic materia medica on a modern, clinical, scientific basis.

Dr. Henry E. Spalding made an appeal to the members of the society to increase the local membership, and in so doing present a long list of new members for the American Institute of Homœopathy. It is the hope of the committee on new members that, at this one hundred and fiftieth anniversary of the birth of Samuel Hahnemann, the present membership of the American Institute of Homœopathy will be doubled.

The business session closed with the report on the election of officers for the coming year: President, John K. Warren, M.D., of Worcester; vice-presidents, John H. Sherman, M.D., South Boston, and Adaline B. Church, M.D., Boston; recording secretary, Frederick L. Emerson, M.D., Dorchester; corresponding secretary, Wesley T. Lee, M.D., Somerville; treasurer, T. Morris Strong, M.D., Boston; librarian, Frank C. Richardson, M.D., Boston; censors, Frederick P. Batchelder, M.D., Boston, Eliza B. Cahill, M.D., Boston, Edward P. Colby, M.D., Boston, George Forrest Martin, M.D., Lowell, and Charles L. Nichols, M.D., Worcester.

After lunch the committee on obstetrics reported, with Dr. Ralph C. Wiggin chairman.

The first paper was read by Dr. Edwin W. Smith on "Obstetrical Asepsis in Hospital and Private Practice." Among other features he pointed out the necessity and value of up-to-date methods in the preparation of the patient, also a careful description of a well-appointed lying-in hospital. The paper was admirably discussed by Dr. Henry E. Spalding.

The second paper, "The Use of the Pelvimeter in General Obstetrical Practice," was read by Dr. Edwin P. Ruggles. The writer felt that the instrument had not been given its due place among general practitioners; that it is necessary for the recognition of cases of contracted pelves and dystocia. If the condition calls for a premature delivery, measurements

must be made early and preliminary to labor to gain the advantage of such interference. If the test of labor is given, exact pelvic measurements are of vital importance in defining limitations of such a test, or in the choice of the obstetrical operation necessary. Again, the necessity for absolute knowledge that pregnancy or labor is complicated with pelvic deformity or insufficiency is rendered more important when we consider that pelvic discrepancies do not only embarrass the passage of the child, but also give rise to remoter effects. These are often regarded as isolated phenomena and include faulty position and presentation of the fetus, unfavorable position or shape of the uterus, abnormal character of the pains, and effects produced by undue pressure upon maternal and fetal structures. He considers the necessary measurements the intercrystal, the interspinous, the external conjugate and the internal diagonal conjugate. This paper was admirably discussed by Dr. George H. Earl, who clearly demonstrated his belief in the value of the pelvimeter.

In the absence of Dr. Eliza B. Cahill her paper on "Avoidable Conditions Following Labor" was read by Dr. Mary A. Leavitt. The writer felt that almost all gynecological conditions found in married women were the result in one way or another of obstetrical errors, and that the time would come when all such cases would be under the management of specialists in this line. Dr. George R. Southwick's discussion of this paper was complete.

The committee on insanity and nervous diseases, with Dr. Eliza T. Ransom as chairman, presented two excellent papers. The first by Dr. Everett Flood, on "General Observations and Home Care of Epilepsy," dealt especially with prophylaxis, cause and care, contained very carefully tabulated sets of cases observed at Monson, a table of comparative statistics dealing with percentages of cases ranging from one to eighty years, which shows a great increase in percentage between the years of thirteen and eighteen; gave a very hopeful percentage of cures out of a possible ten thousand cases in

Massachusetts, and stated that many of us are nearer the exploding nerve-cell condition than we often guess. In conclusion he noted that "the child must be conceived in love, reared in intelligence, with every care possible to prevent the onset, but after the trouble has appeared, then (1) continued oversight; (2) methodical living; (3) perfect diet and mastication; (4) going to bed early, without excitement, in a cool, quiet room; (5) clean bowels and bladder; (6) every hygienic measure that intelligence dictates, but no fads; (7) little or no medicine; (8) self-restraint; (9) regular occupation and suitable study."

The second paper on "Nervous Diseases Treated by Electricity" was given by Dr. Frederick Strong, professor of electro-therapeutics in Tufts Medical School, who very intelligently spoke of the different types of electricity used and showed how, why and when one kind is superior to another, speaking especially strong of the treatment of inflammatory conditions by the so-called current of high frequency.

Owing to the serious illness of Dr. Kennedy the third paper was omitted.

Adjournment was made from the scientific and business session to Young's Hotel, where the evening program was carried out. The banquet hall was tastefully decorated, including a bust of Hahnemann placed at the opposite side of the room to the speakers of the evening. The invocation by William E. Huntington, S.T.D., president of Boston University, was followed by an excellent dinner.

In introducing Pres. William E. Huntington of Boston University, attention was called to the fact that Hahnemann was an educator as well as a reformer in medicine, and that in President Huntington the cause of homœopathy had a warm friend and firm supporter, especially in his relations to Boston University School of Medicine.

President Huntington in well-chosen words extended the greetings of the University, and expressed his great pleasure that a member of the faculty of the Medical School had earned

such recognition in the field of research, and also that Boston University School of Medicine was the only medical school to receive a gold medal at the recent St. Louis Exposition for its exhibit there, which he had the privilege of personally inspecting.

Dr. Herbert C. Clapp, in the presentation of the gold medal to Dr. William H. Watters, pathologist in the Medical School, gave a brief sketch of the work which had been done, and the nearly world-wide recognition it had received from both schools of medicine.

In presenting Dr. Hiram L. Chase of Cambridge, attention was called to several interesting historical facts about the rise and progress of homœopathy in Massachusetts.

The first meeting for the formation of what was subsequently called the Massachusetts Homœopathic Fraternity was held in Dorchester the evening of Dec. 25, 1840, when three physicians were present. At the time of incorporation of the Massachusetts Homœopathic Medical Society in 1856 its constitution, etc., were contained in a small eight-page pamphlet, and there was a membership of fifty, which has now increased sevenfold.

Only two members of the fraternity and charter members of the present society are still with us, Dr. Hiram L. Chase and Dr. Henry C. Angell. The former joined the fraternity Dec. 1, 1846, and has been a member for nearly fifty-nine consecutive years of both organizations. Dr. Angell joined the fraternity Nov. 5, 1853, and has a membership of fifty-two consecutive years. A message from Dr. Angell was read, expressing his regrets that his health would not permit his presence. Dr. Jas. H. Payne, one of the oldest homœopaths in New England, was in attendance.

Dr. Hiram L. Chase of Cambridge, in speaking of homœopathy fifty years ago, gave a graphic picture of the status of homœopathy during the early years of his practice. He touched upon a feature, which if carried out to-day would make the homœopathic profession a much stronger organiza-

tion, namely, the harmony and the fraternal attitude which existed between the physicians of the homœopathic faith in his day. Potency, though a disputed topic, was not carried to the extent of establishing a division in our ranks. Close adherence to prescribing according to the totality of symptoms, and the similia, was the ground taken by all those professing homœopathy; whether the tincture or the em. were prescribed, so long as the single remedy and the similia prevailed, no personal differences were entertained. He also carried us back to the time when Otis Clapp & Son of to-day was represented by one drawer full of remedies,—quite in contrast with the complete, well-organized establishment of to-day. It was indeed a grand sight to see this old gentleman carrying the standard of homœopathy with much the same zeal and energy that has characterized his work during these fifty years.

In the presentation of Dr. Eugene H. Porter of New York, editor of the *North American Journal of Homœopathy*, mention was made of the fact that this was a reciprocal action, since New York was indebted to Boston for Hans Burch Gram, the pioneer homœopathist of America, who was born in Boston in 1786, received his medical education in Copenhagen, embraced the truths of the homœopathic law in 1824, and coming to New York in 1825, took up that practice of medicine.

Dr. Eugene H. Porter, in responding to the toast of "The Future of Homœopathy," proved himself to be not only a brilliant after-dinner speaker, but a power as a teacher and exponent of the true status of homœopathy to-day. He compared the teaching of homœopathic materia medica twenty years ago with the present improved technical consideration of the subject; and with the results promised by the society for the re-proving of homœopathic remedies promises that the truth must prevail. The student of to-day receives a comprehensive picture of the remedy with an exact knowledge of its source, preparation, toxicology and symptomatology, the characteristic indications being drilled again

and again into the receptive mind. He also touched upon the question of potency, and said it was the similia that should determine the standing of the homœopaths and that the question of potencies should not interfere with a united confederation. He felt that the homœopathic school as a school might disappear, but before such an event were possible homœopathic materia medica would be represented in every medical school by competent professors.

Amalgamation, he asserted, could only take place when the regular school of practice, so called, accepted the laws as laid down by Samuel Hahnemann.

The retiring president of the society, Dr. Frederick Prescott Batchelder, in his address referred to the memorable character of the occasion, and the remarkable progress of homœopathy in America. The present opportunities and surroundings were contrasted with the privations and even hardships Hahnemann endured for the sake of the truth and his devotion thereto, as suggested in a portion of the preface to the first edition of the "Organon," where he says: "I must warn the reader that indolence, love of ease and obstinacy preclude effective service at the altar of truth, and only freedom from prejudice and untiring zeal qualify for the most sacred of all human occupations, the practice of the true system of medicine." Reference was also made to the untiring efforts of one of our members, a former president of the society in inaugurating the reproofing of one of the important remedies of our materia medica, and an appeal was made for personal contributions in addition to the one thousand dollars voted that day by the society from its treasury for the furthering of the work of the Institute of Drug-proving. The important place taken by the laity in the progress of homœopathy hitherto was mentioned, and the members were urged to interest their patrons in the New England Hahnemann Association, which aids Boston University School of Medicine, and also to awaken a deeper interest in the domestic use of homœopathic remedies in place of the alarming spread of patent and other

medicines. The needs of the Massachusetts Homœopathic Hospital were specified, as funds for a contagious ward, a new maternity department, and a large convalescent building, which can be erected on the new estate from funds to be donated by members of the laity.

The members were urged to secure at least one new member each for our society at once, and incidentally to aid in securing as many applicants as possible for the American Institute. Attention was called to the many unfilled places awaiting graduates of our medical schools and our individual duty in seeking out eligible young men and women to enter upon the study of medicine in our college.

Several needful changes in the by-laws were outlined, and the appointment of a special committee of five was suggested for a careful study of the same and any other needful changes, which could be presented at the October meeting of the society.

After the presentation of the president-elect, Dr. John K. Warren of Worcester, the society adjourned to the second Tuesday in June, when a considerable number of new members will be voted in.

TREATMENT OF IMPETIGO.—Jacobson believes in silver nitrate systematically. The impetiginous lesions are cleaned of all broken-down elements and are touched up with the silver stick, or a ten per cent. solution of the salt. The effects are often marvelous; a single application may suffice to produce a cure. At the outset there is intense pain for a few minutes; this is followed by a sensation of smarting which lasts for several hours. Some hours later the lesion will have entirely dried up. He considers this an easy, rapid and sure method of cure. Its only contraindications are albuminuria, adjacent edema and impetiginous eczema.—*Therapeutic Review*.

ABSTRACTS FROM BOOKS AND JOURNALS.

SPIRITUS GLANDIUM QUERCUS IN ALCOHOLISM.—The alcoholic is to be pitied. Anything we can do to cure such an one, or take away the craving for spirituous liquors, is a boon. We have such a remedy. It is spiritus glandium quercus. It should be administered in from ten to fifteen drop doses of the tincture three times a day. It may be taken in either water or milk. If dropsy and liver trouble are present, it will be all the more sure to help your patient. The treatment must be kept up for three or four months. I have had the pleasure of curing a number of patients with the remedy.

Dr. C. A. Schultze in North American Journal of Homœopathy.

LOCAL TREATMENT OF DIPHTHERIA.—Now if we will apply a five per cent. solution of lactic acid to the diphtheritic membrane as soon as it forms, or on our first visit, in a little while we can wipe away the dissolved membrane with absorbent cotton on an applicator. If we then with a clean piece of cotton dip the applicator in a four per cent. solution of formalin and swab out all these localities we will have them perfectly free from all kinds of germs, and there will be no danger from any new infection from the Klebs-Loeffler bacilli or from any other germ or cocci. The mouth can be kept constantly free from all germs and the local applications will hasten the healing of the denuded mucosa.

Virginia Medical Semimonthly.

FIRST PREGNANCY.—Every physician should remember in his supervision of a first pregnancy that severe toxemia is by a large percentage more apt to be her especial danger. In a series of 12,000 cases at the Sloane Maternity Hospital, seventy per cent. of the cases of eclampsia were among primiparæ. Why this tendency exists has not been satisfactorily explained. Increased pressure on the ureters is said to be one cause. But however explained or unexplained, the not infrequent history of this physical shipwreck, at a time when the woman's life seems all hope and promise, is one of the great tragedies of life of which even the layman is not entirely unaware.—*The Postgraduate.*

PERSONAL AND GENERAL ITEMS.

Two hundred suitable cases were turned away from the Rutland Sanitarium last year for lack of accommodations.

Six million pounds weight of adulterated and harmful foods were destroyed by the health department of New York during the last twelve months.

FROM Jan. 1 to April 1, 1905, there were thirty deaths in Boston from cerebro-spinal meningitis; for the entire year of 1904 there were but thirty-seven.

DR. WINFIELD SMITH of Boston and Miss Gertrude Pierce Canterbury of Brookline were united in marriage April 3. Drs. Frank Richardson and Thomas Percy acted as ushers.

DR. HORACE PACKARD of Boston will sail for Europe May 13, leaving his professional work in charge of Dr. J. Emmons Briggs. Dr. Packard will probably remain abroad several months.

THE forty-first annual session of the Homœopathic Medical Society of Ohio will be held at the Hollenden Hotel, Cleveland, on Tuesday and Wednesday, May 16 and 17, 1905. Opening session on Tuesday at 10 A.M.

DR. A. L. KENNEDY of Brookline, member of the class of 1875, B. U. S. M., died at his residence April 13. He was well known for his activity in all charitable work, and several years ago was an instructor in materia medica at the college from which he graduated.

PNEUMONIA, according to the report of the Board of Health, is the most deadly disease in Boston, it having accounted for 1,323 deaths during 1904. Its nearest competitors during the year were tuberculosis, credited with 1,269, and heart disease with 1,056, deaths.

ONE of the most important sessions at the coming meeting of the Institute will be that of the Surgical and Gynecological Society of the American Institute of Homœopathy. The offi-

cers are: C. E. Sawyer, M.D., president, Marion, Ohio; Horace Packard, M.D., vice-president, Boston; Hills Cole, M.D., secretary, New York; J. O. Chase, M.D., treasurer, New York.

NEARLY half a million babies died in the United States last year from the effects of adulterated infants' food, poisons used in coloring butter and candy, formaldehyde in milk and other impure articles of diet turned out by fraudulent manufacturers. Data to prove this assertion were produced before the meeting of the executive committee of the National Association of State Dairy and Food Departments, which met at Chicago April 1.

DR. JOSEPH MACDONALD of New York announces his withdrawal as managing editor of the *International Journal of Surgery* and his purchase of all the rights in the *American Journal of Surgery and Gynecology*, which will in future be published under the title of the *American Journal of Surgery*. Dr. MacDonald's associates will include some of the most eminent specialists in New York.

Gaillard's Southern Medicine is the name of the new journal resulting from the amalgamation of *Southern Medicine* and *Gaillard's Medical Journal*. Dr. W. E. Fitch of Savannah, Ga., is editor-in-chief, and a stock company will act as publishers.

PRACTICE FOR SALE.—In a New Hampshire manufacturing town of 1,500 population, good schools, good roads, electric lights and town water. Collections over \$2,000. \$175 buys practice, carriages, sleighs, etc. Address at once Practice, 98 Dana Avenue, Hyde Park.

FOR SALE.—A delightful home arranged especially for a physician, in one of the most beautiful suburbs of Boston. The retiring physician will include his good will in the purchase. The transaction must be strictly on a cash basis. Communicate with X. Y. Z., 98 Dana Avenue, Hyde Park.

DOCTOR'S OFFICE TO RENT.—In a private homœopathic hospital on Newbury Street. Rates reasonable. Address A. B. C., 98 Dana Avenue, Hyde Park.

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ORIGINAL COMMUNICATIONS.

CYSTITIS IN THE FEMALE.

BY HORACE PACKARD, M.D., BOSTON, MASS.

[Read before the Massachusetts Surgical and Gynecological Society, Dec. 14, 1904.]

This subject is chosen for presentation not because the writer has any brilliant results to report, but because he wishes to hear from others methods which have been followed in the treatment of this long-enduring and painful malady.

Cystitis in the female is common. I am sure that if the testimony of every physician present were heard, it would be that in the procession of patients which come and go, cystitis constitutes a material percentage. In the normal state of existence of the female the urinary tract is wonderfully guarded against the access of septic material to the bladder. This natural protection is worthy of comment, since the location of the orifice of the urethra exposes it to great likelihood of contamination from various sources. Sexual congress is far from aseptic in its operation. Daily bathing of the parts for cleanliness is not a practice universal in the human family. The near proximity to the orifice of the rectum, furnishes an unfailing source for colon bacilli and many other forms of microorganisms, and yet under ordinary conditions of life the urethral meatus is a locked and sealed gate to all microbic invasion.

The ureter interposes no barrier to progress of septic invasion. Once the bladder is infected it is a foregone con-

clusion, if the infection continues its activity unchecked, that it will ultimately extend along the ureters to the kidneys and set up a pyelitis and a nephritis. This marks the first of a slow but sure downhill course for the patient. The patient carries a slightly augmented temperature (99° F. to 100° F.), the excretion of urea is diminished, the appetite fails, the tongue becomes red and dry, and dissolution follows.

The vulnerability of the ureters is again well illustrated by the surgical experiences of the past, when they have been for some reason engrafted upon the rectum. An ascending ureteritis always follows with finally fatal results.

I think, without exception, that every case of chronic cystitis which has drifted into my hands has given a history of some illness or operation, during which or after which catheterization has been resorted to, and this marked the beginning of the bladder trouble. I am sure that it is commonly known to all present that, up to a comparatively recent date, it has been common practice on the part of the general practitioner to whip a catheter out of his pocket-case, and, without preliminary sterilizing or even washing, introduce it to the bladder. With the advent of aseptic teachings, and the training of nurses in ways of cleanliness and asepsis, a salutary change is in progress, and yet, judging from cases which are from time to time drifting into the hospital with a history of operation or confinement, accompanied with retention of urine and consequent catheterization, then a prolonged period of painful and frequent urination, there is still chance for improvement in the technic of catheterization.

A word here may not be amiss as to what the correct technic of catheterization is. I well remember the doctrine which was inculcated in my student days, that a patient should never be uncovered in the operation of catheterization; that due modesty and propriety demanded introduction of the catheter guided by the sense of touch alone. In contrast to this the method followed in the training school for nurses of the Massachusetts Homœopathic Hospital may serve as illustration of modern ideas on the subject.

1. Boil a No. 9 soft-rubber catheter.
2. Place patient in good light on the back with the knees widely apart.
3. Separate the labia, and wash the vicinity of the meatus gently and thoroughly with soft gauze, soap and water, and 1 to 500 formalin solution.
4. The nurse to introduce the catheter then washes her own hands and sterilizes them.
5. Then with the right hand the catheter is introduced, permitting hand or catheter to touch no unsterilized object.

Prevention is the best treatment for any disease. In these simple precautions of catheterization we have the best prophylaxis against cystitis.

But what shall we do with those unfortunate individuals who, through oversight, or carelessness, or ignorance have become infected? The importance of ordinary treatment is illustrated by a case which appealed to the writer three or four years ago, whose trouble began at least ten years previously following confinement, during the convalescence from which the catheter had been used. She had sought relief at the hands of many different physicians, but all to no purpose. Her life was made a burden by the almost constant urging to empty the bladder both day and night. Internal medication proved unavailing. She finally recovered after long-continued irrigation of the bladder with 1 to 800 formalin solution, and the internal administration of urotropin.

Another case, a young girl, was catheterized by her family physician incident to some acute disease. Recovery therefrom left her with a cystitis of an extremely annoying character. The whole bladder became profoundly infected, and the infection traveled up the left ureter to the kidney. The case was finally cured only by the most heroic surgical measures. A suprapubic cystotomy for drainage of the bladder was made, and a lumbar incision, a nephrotomy and drainage of the pelvis of the kidney was instituted. After prolonged irrigation of the tracts thus laid open the patient finally recovered and remains well.

Another extremely bad case involving the utmost misery comes to mind, for which nothing was accomplished. Cystoscopic examination showed a large ulcerated area upon the bladder wall, crusted over with urinary salts. The patient was unwilling to have a cystotomy performed and disappeared from observation. Upon recent inquiry I learn that she still lives and suffers, at the present having to empty the bladder about every half hour day and night.

As to medical treatment for cystitis I cannot say much for symptomatic indications. I cannot believe that internal medication unassisted by local measures will eradicate a septic cystitis. Some cases through excellence of resistive force become singularly tolerant of a septic invasion of the bladder. A sort of immunity is evolved which keeps the patient in comparative comfort until something occurs to diminish her vitality, when there is recurrence.

The internal administration of boracic acid for its antiseptic action on the urine has many times given good results.

Formula: Boracic acid, 128 grains; glycerin, 2 drams; aqua bul., 1 pint.

Directions: 1 teaspoonful in glass of water three times daily.

The commercial preparation urotropin also has been used, but its value is open to question. It produces a temporary congestion of the kidneys which is enough to condemn it in some cases. If it can be borne by the patient without injury, it undoubtedly renders the urine antiseptic, and thus checks germination in the bladder. It is a derivative of formaldehyde. It is formed by the action of four molecules of ammonia on six molecules of formaldehyde, and was first introduced to the profession by Nicolair in 1895. It is claimed that it is nontoxic, and that it is a specific for phosphaturia and cystitis. It appears in the urine as soon as fifteen minutes after its administration, and its presence can be recognized twelve hours later, after a dose of $7\frac{1}{2}$ grains. Doses have been given from $7\frac{1}{2}$ grains up to 20 grains twice daily.

After all, daily irrigation with some antiseptic solution is the main reliance, and, as a prelude to this, bacteriological study should be made to determine the kind of infection which is causing the trouble.

For colon bacillus: Use Condy's fluid (2 per cent. solution kali permanganate), or corrosive sublimate (1 to 25,000), or formalin (1 to 800).

Staphylococcus, streptococcus, typhoid bacillus: Corrosive sublimate (1 to 25,000), or formalin (1 to 800), or salicylate of soda (1 dram to 1 pint).

Tubercle 6: Zinc chloride; or iodoform emulsion.

Recipe: Iodoform, 2 ounces; glycerin, 2½ ounces; aqua distillate, 2 drams; gum tragacanth, 4 grains.

Gonococcus: Silver nitrate or argol.

Any of these above mentioned should be preceded by washing out the bladder with plain boiled water for two or three days, then followed by enough of the medicament to fill the bladder, and have patient retain as long as possible.

Many cases will be cured by these simple measures, others will improve only to relapse, still others must be subjected to drainage by vaginal or suprapubic cystotomy. Ulcerated areas of the bladder may need curetting to clear away incrustations of urinary salts.

Cystoscopic examination of the bladder to determine the extent and severity of the inflammatory invasion, the condition of the orifices of the ureters, and in limited areas of ulceration to apply direct treatment is a distinct help.

Openings made for purpose of drainage spontaneously close up after the lapse of a few weeks. After all there will be cases which tax the patience and skill of the physician to the last degree. Contractions of the bladder cavity to a capacity of but a few ounces is a not infrequent result of long-continued cystitis, and may continue and be the cause of frequent calls to urinate even after all inflammatory and septic complications have been cured by treatment.

DISCUSSION (DR. PACKARD'S PAPER).

Dr. G. Forrest Martin: I have very little to say upon what Dr. Packard has said, as he has covered the field so thoroughly and admirably, that the man who has to discuss the subject after him has little to do but to emphasize the points which he has raised.

The first point that occurred to me, which Dr. Packard has raised in consideration of this subject, is the necessity of emphasis upon prophylaxis, particularly as applied to the use of the catheter. And second, the necessity in all but the mildest cases of the combination of local and internal treatment. If we consider cystitis as it presents itself when it reaches the hands of the surgeon, or the class of cases which have gone on to pus formation, then I agree with Dr. Packard that local treatment is a necessity.

He has said little about the milder cases which are the beginnings of cystitis, but I do believe that there are cases of cystitis, and I mean by that inflammation, hyperemia, and injection of the lining of the bladder, with great suffering and tenesmus, and which begin with a chill, severe pain, frequent calls to micturition and severe pain following micturition, which are strictly idiopathic, which should not be treated with the catheter, and which I fully believe the cystoscopic and the microscopic examination would show to be without the presence of any germ whatever. I believe that such cases do occur in every general practice, and I realize that I shall be almost alone in making this statement, as authorities do not all recognize this condition. I know that cases come from chill from standing on a snowy paving watching a parade, or sitting on cold steps, where I am positive our patients are absolutely innocent of any local septic or germ disease. I have no patience with those who would point the finger of suspicion at every one of our sisters or daughters who present these symptoms at times. Those cases do not get well themselves; they need treatment. But I think the chances we take in using the catheter and sterilizing our instruments are a

source of more danger than a few days' delay to try careful medical treatment, and I think in these cases the homœopathic medication with camphor, aconite, cantharis and belladonna are worthy of careful study before we resort to any local treatment. I want to modify that statement when the case is more advanced, and pus and alkalinity of the urine are already present. These call for local attention, and those Dr. Packard has discussed were of this class, I assume.

Dr. Krauss: I want to say a few words on the subject Dr. Packard has presented, and that in my opinion there is no such thing as idiopathic cystitis. All cases of cystitis are the product of distinct pathological processes or conditions, such as gonorrhœa, tuberculosis, tumors, stones in the bladder, obstructions to the outflow of urine, or some deleterious medicines, like aniline. The subject was "Cystitis in the Female." I failed to learn what was considered to be the difference between cystitis in the female and the male sex, but there is a distinct difference and the difference is anatomical. The difference is this, that in women there is a large genital surface in close, uninterrupted continuity with the mucous membrane of the urethra, thus forming an uninterrupted path for the migration of infecting organisms from the genital tract to the bladder. Also the contiguity between the genital organs and urinary organs in the woman is such that diseased genital organs may rupture into the bladder, and thus cause cystitis. When we have a case of cystitis in woman we must, therefore, look first to the genital tract to explain the cause. Gonorrhœal cystitis is not very frequent in women, certainly rarer than in man. Gonorrhœa seems to expend itself in women rather on the genital tract. The same may be said of tumors in the bladder; they are not frequent and they are usually malignant and metastatic from adjoining genital tissues. Cystitis due to an obstruction of the neck of the bladder may be almost entirely excluded; also stone in the bladder. Stone is found in women once as against two hundred times in men. On the other hand, foreign bodies in the bladder are very frequently causing

cystitis in the female sex. These are introduced either by the person herself, in the course of masturbation, or find their way into the bladder as the result of gynecological operations. It must be remembered that masturbation is very common among women even now when the barriers of sexual restraint are continually torn down by women as well as by men. I have removed a hairpin from the bladder of a woman who declared she did not know how it got there. I have seen a silk suture in the bladder of a woman partially incrustated with urinary salts causing cystitis, as a result of uterine fixation to the anterior wall of the vagina; and I wanted to ask Dr. Emerson if in his method of uterine fixation he has not noticed certain derangements in the normal function of the bladder. A very frequent, if not the most frequent, cause of cystitis in the female sex is tuberculosis. A case of cystitis, the cause of which cannot be found in the female genital tract, and there is no foreign body in the bladder, and which does not yield to rational treatment, should be suspected as tuberculous cystitis, even though there are no tubercle bacilli found in the urine.

Dr. Martin has spoken of cystitis following a cold. That there may be symptoms resembling cystitis following a cold, I would not deny, but I think it is impossible for cystitis to follow a simple cold unless there is a pathological condition present ready to cause cystitis, for the characteristic symptom of cystitis is not simply pain or frequency of urination, but *pus* in the urine. There may be congestion, irritation, pressure neurosis, neuralgic pollakiuria, bacteriuria, without pus, but no cystitis. Many physicians content themselves treating cases for years as cystitis. I have had a case sent to me that had been treated fifteen years for cystitis. We may lay it down as an axiom that when pus in the urine does not clear up with rational treatment after a reasonable time, it is more likely that the pus comes from the kidneys rather than the bladder. In order to distinguish whether the pus comes from the bladder or the kidney, there is only one means, and that is

the cystoscope. Without the cystoscope we cannot decide where the pus comes from, with it we can decide immediately; and if the pus comes from the kidneys the lesions are around the mouth of the ureters, if from the bladder they are at the *bas fond*, on the floor of the bladder.

The treatment has been spoken of. I agree with Dr. Martin that aconite, belladonna and cantharis are royal remedies, especially in the early stages; nux vomica, mercury and pulsatilla are just as important in the later stages. I agree with him perfectly that the bladder should not be irrigated in acute cystitis, because an acutely inflamed bladder resents dilatation; but the chronic cases cannot be cured without irrigation. There is a very good method of treating acute cases by instillation, sending the medicated fluid into the bladder in very small quantities, a drop at a time.

Dr. Packard has mentioned corrosive sublimate, salicylate of soda, and formalin (1 to 800) for irrigating inflamed bladders. Corrosive sublimate is indicated only in tuberculous cystitis, and can be applied properly only by the method of instillation, and not by irrigation; for all other cases of cystitis there are only two remedies to be considered for irrigation, namely, boracic acid and nitrate of silver. A solution of boracic acid has a most soothing effect upon the inflamed bladder, and nitrate of silver is the only remedy that can restore a pus producing vesical mucosa into one that does not produce pus.

The question of urotropin has been touched upon. Now it would be necessary for us to have the four cases presented in a clear light before we can judge that the hyperemia of the kidneys was produced by the drug. Urotropin should not be used except in cases of phosphaturia and of suppuration of the urinary track. I believe that urotropin is a great medicine, and I have used it in many cases, with good results. For treatment cases of cystitis must be individualized, and unless the cause is ascertained no treatment can have any appreciable result.

Dr. S. H. Blodgett: I have known four cases of cystitis

(where urotropin was being used), and where there was hyperemia of the kidney, and the urotropin being stopped the hyperemia cleared up in about a week. It is of course a question whether the hyperemia was due to the urotropin or not, but in my opinion it probably was.

In this connection a case which came to the hospital recently for cystitis may be interesting. It was in an old lady sixty-five or seventy. For two years she had been bothered by some smarting on passing urine. After she had emptied the bladder, as she supposed, I introduced a catheter and removed twelve ounces of urine. I could find no mechanical obstruction, and no mechanical reason for this retention of residual urine.

I have never found a case before where, in a woman, a good mechanical reason could not be found for the partial retention.

LABORATORY SUGGESTIONS.

BY ORVILLE R. CHADWELL, M.D., JAMAICA PLAIN, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

It is assumed, in presenting this paper, that the average general practitioner at some time reaches a point where clinical observation alone is insufficient for the satisfactory diagnosis of a given case. It is then that he is forced to call to his aid the so-called "laboratory methods" of diagnosis. He may find himself sufficiently equipped for all his needs in this direction; if not he is forced to resort to the services of the special laboratory worker. He may possess the proper apparatus, including a good working microscope, and yet feel that his limited knowledge renders his own work unreliable for his purpose. Again, being equipped with neither the necessary knowledge nor apparatus, he may, through ignorance of certain facts, considerably handicap the laboratory man to whom he turns in making his conclusions. The suggestions contained in this paper are offered, therefore, in the

hope either to strengthen the confidence of the general practitioner in his individual work, or to assist him in giving intelligent aid to the laboratory specialist. Advantage is also taken of this opportunity to call attention incidentally to several new instruments and reagents, somewhat superior to those formerly in use, and which make it possible for the general practitioner to do well for himself those things previously beyond his apparent reach.

Probably the average busy physician most often finds need for laboratory methods in those cases where uranalysis seems advisable. Complete uranalysis requires both chemical and microscopical examination. The former may be quite satisfactorily made with a knowledge of a few simple and reliable tests. The latter requires more special training. For practical purposes oftentimes all that is necessary is learned from the chemical examination alone. The specific gravity, the amount of urea, presence or absence of albumin and sugar, and possibly an approximate knowledge of the quantity of chlorides and phosphates, are generally sufficient. Practically every physician who has graduated within the last ten or fifteen years has some knowledge of the technic for all these examinations just mentioned.

Too much emphasis cannot be placed on the fact that a satisfactory uranalysis must be one which gives information as to the general appearance of the urine over a period of twenty-four hours. No estimation of the renal function can be made without a knowledge of the total solids excreted in a day, and this knowledge is dependent on one's knowing, at least approximately, and better accurately, what is the day's total excretion of urine. If the case is to be referred to some laboratory analyst there should be sent a sample containing about one-half pint of the mixed twenty-four hours amount, accompanied by a statement as to the total quantity from which the sample was taken.

The laboratory worker is often considerably aided in making his diagnosis, if he also knows in a general way something of

the amount of food and exercise taken by the patient, and the amount of fluid ingested.

As a routine after the casual observation as to color, odor, and amount of turbidity, the specific gravity of the urine is first estimated. A good urinometer records this satisfactorily. There is, however, a urinometer on the market which has its gradations marked on a roll of paper within the glass stem. This instrument is often found to give an error of several points in the reading, due to the fact that the roll of paper is displaced by accidental jars. If one is using this form of urinometer, it may save considerable trouble if a reading is frequently taken with the glass filled with water.

In the estimation of the amount of urea most physicians have experienced considerable dissatisfaction from the older methods of preparing the hypobromite solution because of its rapid decomposition, especially where one does not have occasion to use it very frequently. There is now a method of keeping hypobromite constantly on hand with its stability unimpaired, by using the two following formulæ:

Solution No. 1

One part (by weight) bromine

One part (by weight) potassium bromide crystals

Eight parts water

Solution No. 2

Caustic soda, 40 per cent.

The two solutions are kept separate. Equal parts, approximately, are mixed in a test tube and the ureometer filled.

The ureometer in general use is that designed by Dr. Doremus. There is a modification of this instrument by Dr. Hinds which is more expensive, but has the decidedly valuable advantage of enabling one to add accurately the amount of urine necessary for the reaction. The instrument consists of a bulb with an upright graduated tube, the same as the original. Near the lower portion of this tube is a horizontal tube provided with a stop-cock, and which supports another upright graduated tube with a capacity of 2 c. c. The bulb and

upright are filled with hypobromite solution. The extra tube is filled to the 0 mark with the urine. The stop-cock is turned, and one c. c. of the urine allowed to run into the reagent. The reaction and reading is the same as in the old tube.

The presence of albumin may be determined by the use of several reagents. On the whole the nitric acid test as ordinarily employed proves quite satisfactory. Perhaps a little more delicate test, and one equally simple, consists in boiling the upper portion of a test tube full of filtered urine after a few drops of acetic acid have been added. The appearance of turbidity indicates albumin.

There is a comparatively new instrument which may be used for the nitric acid test, and also for any test in which one fluid is to underlie the other. It is known as the horismascope. It consists of a U-shaped tube, one arm of which has a diameter of about one-half inch, the other being of capillary size with an enlargement at the top. The urine being placed in the larger tube, the heavier reagent is poured into the bulb of the other side, and is made to slowly and without disturbance underlie the urine, giving in the presence of albumin a very readily detected zone. While perhaps not necessary, this is not an expensive instrument, and will be found an exceedingly convenient bit of apparatus.

In examining for sugar, the necessity of keeping two easily decomposed solutions for Fehling's test has been unsatisfactory, as in the case of the hypobromite. This trouble can be avoided by the use of Haynes' reagent, which is a modified Fehling's, consisting of one solution and this one stable. The technic consists of adding to four or five c. c. of the reagent while at the boiling point, seven or eight drops (not more) of the urine. The reaction in the presence of sugar consists of a change in color of the reagent from a deep blue to a vivid orange which, on standing, gives a red precipitate. Where a physician is interested to follow the results of his treatment

in a diabetic case, he must needs have some quantitative test for sugar. Most of the profession have had opportunity in the last few years to become acquainted with the Whitney test for the quantitative estimation of sugar. This test, while open to some criticism, gives satisfactory approximate results and is really quite simply applied.

Another method within the reach of the general practitioner consists in the use of the Einhorn saccharometer. This test is dependent on the fermentation of sugar by the yeast, resulting in the formation of a gas.

The mixture of the urine and yeast is poured into a special glass which is simply a small counterpart of the Doremus ureometer, and is so graduated that one can read on the scale after fermentation is complete the percentage of sugar. This test requires a control, but is fairly accurate, and the outfit not expensive.

The commonly used methods for determining the presence of chlorides and phosphates are generally satisfactory for approximate results. Possibly a physician sometimes overlooks the valuable aid to be obtained by an estimation of the chlorides in diagnosing his case. In a central pneumonia, for instance, with obscure symptoms, yet those pointing to the respiratory tract, and with the physical signs practically negative, there will be found almost invariably either absence or marked diminution of the chlorides. In differentiating a somewhat obscure meningitis from typhoid fever, a similar advantage is to be obtained from an estimation of the amount of chlorides.

These tests mentioned, if properly carried out, can be made to give a most satisfactory picture of the chemical constituents of the urine.

If one cares to examine the sediment, to do really satisfactory work practically demands the use of a centrifuge, and, possibly, a mechanical stage for the microscope. A great many physicians who might make a chemical examination have neither the facilities for a centrifuge nor the time for

using the microscope. Cases occurring where such examination is considered necessary would be most naturally referred to the laboratory specialist.

The laboratory worker is sometimes hindered in making his diagnosis, especially from his examination of the sediment, because a physician neglects to mention the presence of vaginal discharge, either menstrual or leucorrhœal, in the female or of urethral discharge in the male. It is wise, in the presence of these conditions, to make mention of the fact along with the other clinical data.

In sending specimens for examination of the sediment for determining the presence of the tubercle bacillus, it is very important that the specimen be a catheterized one, because of the great resemblance between the bacillus of tuberculosis and that of smegma. In fact, if smegma cannot be absolutely ruled out by staining, the only satisfactory method of diagnosis is animal inoculation. A specimen to be used in this manner should be sent to the laboratory under sterile conditions.

Occasionally laboratory men receive samples of urine to be examined for the presence of lead, from cases where diagnosis of lead poisoning is undoubtedly the correct one, but the urinary examination fails to detect the presence of the poison. Lead is excreted by the kidneys only in the form of the iodide. It is therefore necessary to administer some drug to render the lead soluble. This is best done by the administration of considerable doses of potassium iodide, but the necessity of doing this is oftentimes overlooked by the physician. Such a method, however, is not necessary in cases where the presence of arsenic is suspected.

The profession to-day is compelled to pay considerable attention to the microscopical examination of the expectorations of patients in certain diseases. If the physician desires to make these examinations for himself, he must have a microscope equipped with an oil immersion lens. If so equipped, the technic for staining sputum for tuberculosis, or

for the organisms of pneumonia and influenza is quite simple and generally understood. The stain generally used is the Ziehl-Neilson, and consists of steaming into the film, carbolfuchsin, then decolorizing with nitric alcohol, and counterstaining with methylene blue. Attention may be called here to the fact that smears for these examinations, as well as those of blood and of urethral discharges are much better made on ordinary slides than on cover glasses. The latter break very easily, and are awkward to handle; while the former can be easily stained, are much stronger, and can for that reason, if necessary, be much more safely transported by mail or express. The stain should be applied directly to the slide, and for examination with oil immersion no cover slip need be placed over the specimen.

In examination of suspected tuberculous sputum, it is generally accepted that the morning expectoration is more likely to contain the bacilli. This is so only because the expectorations of the day consist largely of post-nasal secretions. These are less active during the period of rest at night, so that the morning expectoration is quite likely to come direct from the bronchi.

There are a great many cases of pulmonary tuberculosis, where the tubercle bacilli are found in the sputum only after patient search over long periods of time, yet the physical signs may be typical, and should not be overlooked or disregarded. The presence of the bacilli is conclusive, but their absence should by no means give too strong a sense of security.

The laboratory worker dreads receiving sputum sent in on a handkerchief or other cloth in a dried condition, for it is in this dried condition that the great danger occurs in handling tuberculous material. The Boards of Health supply to all physicians wide-necked bottles containing carbolic acid into which the patient may expectorate. Carbolic acid not only renders the sputum safe to handle, but also preserves it indefinitely for examination.

As before suggested, urethral discharges are best examined

by transferring directly to a slide. The opinion which a physician is sometimes required to give as to the absolute clearing up of a gonorrhoeal discharge, may be considerably strengthened if he will take the pains to insert into the urethra as far as possible a swab of sterile cotton on a small wire somewhat similar to those used for diphtheria cultures. Old cases which may not, at the time, show discharge at the urethral meatus, may be demonstrated to be latent and not cured by the subsequent smearing of the swab on a slide, and then staining. In cases which may involve medico-legal proceedings it is well to stain the specimen after Gram's method. For ordinary staining, however, Loeffler's methylene blue is perhaps more satisfactory, and the microscope equipped with ordinary high power lens of the dry type is sufficient to reveal the presence of the organism.

A thorough examination of blood, including the counting of the blood corpuscles, is generally beyond the ken of the ordinary physician. In addition to its requiring special apparatus, it also requires considerable practice to make one's technic accurate. A great many important facts as to the condition of the blood may be learned, however, by methods well within the understanding of the ordinary member of the profession. The estimation of the hemoglobin can be well calculated by the use of the Tallqvist hemoglobino-meter. This consists of a little book containing strips of absorbent paper. This paper is immersed in the drop of blood, and its color compared with the color scale furnished in the back of the book. This instrument can be purchased for \$1.25, and will last for years. In the ordinary case, a knowledge of the percentage of hemoglobin will generally determine whether further examination of the blood is necessary or not. It is not generally realized how much may be learned from the study of a drop of blood properly spread out on a slide and well stained. An intelligent examination of well-stained blood film may be of great value. In the presence of any acute inflammatory condition, there is an increase in the number of

leucocytes in the blood stream. The increase in the number of these cells to the field would be quickly noticed if one were at all familiar with normal. Again, in these inflammatory conditions the percentage of neutrophilic cells is considerably increased. In a differential count of the leucocytes the percentage of each kind is easily determined. This fact enables us to differentiate the appendicitis or salpingitis from typhoid, where the percentage of neutrophilic cells is diminished, and the lymphocytes are increased. In anemic conditions, after the amount of hemoglobin has been estimated, the question as to whether the condition be a primary, *i e.*, pernicious anemia, or secondary one, can be answered by the study of the abnormal blood disks. The recognition of these pathological forms when present is of course important.

The presence of the malarial organism may be most satisfactorily demonstrated, providing certain precautions are taken in procuring the blood. There should be special relation between the time of the chill and the obtaining of the drop of blood. It is generally agreed that the best time is from four to eight hours before the chill is due in the tertian type of fever, and not during or immediately after the occurrence of the chill. In typical or chronic cases the chill cannot always be anticipated, but the examination of the blood will often reveal the presence of the parasite. If the blood is obtained after the chill it is well to wait at least twelve hours. The blood may be immediately examined in the fresh state where the plasmodium will be found active, or the smear may be dried, stained, and studied at leisure. The previous administration of large doses of quinine may often render all examinations futile.

The oil immersion lens is necessary for a study of blood. There are several good stains which may be used, possibly the best being Jenne's, Wright's, and Ehrlich's, in the order named. The importance of the Widal reaction is commonly understood, and no experience is needed for obtaining the necessary

amount of blood. This examination requires special bacteriological equipment.

In sending specimens of tissue, especially small pieces, to the laboratory a very satisfactory medium for their conveyance is normal saline solution or cold water. This gives the pathologist an opportunity to fix and harden the tissue as he chooses.

Concerning examinations for diphtheria, the Boards of Health have almost altogether taken it upon themselves to aid the physician in his diagnosis by cultures. Perhaps it is not generally known how much valuable time may often be gained by requesting an immediate examination of the infected swab instead of waiting for cultures. A positive diagnosis which may be of exceeding value is often possible in this way. The city bacteriologists are generally willing to make these special examinations.

Now and then in one's practice an examination of vomitus or stomach contents is necessary. The most important facts to be earned are those concerning the acidity, and, particularly, the presence or absence of hydrochloric and lactic acids. The absence of hydrochloric acid in the gastric contents is quite suggestive of malignancy. The amido-benzoil test for hydrochloric acid, giving a pink coloration in the presence of the acid, is easily performed. The phenyl and ferric chloride test for lactic acid is likewise simply performed.

The field of so-called laboratory medicine is a wide one, and this paper has touched but a few isolated areas in that field. The medical student of to-day is compelled to learn the methods which he will be constantly needing in his general work, but to those who have been longer away from college and hospital, these suggestions, although commonplace and not original, may be, perhaps, in a measure helpful.

THE REHABILITATION OF THE FAMILY DOCTOR.

BY GEORGE H. TALBOT, M D., NEWTONVILLE, MASS.

The physician must fulfil certain requirements. He must be possessed of certain knowledge and skill. The patient has a right to demand that he be well equipped, as far as possible, with a knowledge of every remedy or measure that can be instrumental in the relief of suffering, and in the cure of disease. The practice of medicine does not depend on the giving of drugs alone. It is the science and art of preserving health, and preventing and curing disease. If the physician cannot prevent disease, it becomes his duty to cure it by the safest, surest, and most expeditious method at his command.

It is said that one cannot practice medicine without a certain amount of dogmatism. It should also be said that one cannot dishonestly assume knowledge and skill without deceiving himself, and, after a time, failing to deceive the intelligent layman. A placebo is, perhaps, a form of deception, but any such tentative measure is not always to be deprecated. A vast amount of good, no doubt, has come from the judicious administration of bread pills, but still it may be questioned whether we do not give too many of them merely as placebos, because we have educated the people to believe that a remedy is needed for every symptom. Nevertheless the placebo has its legitimate and useful sphere.

The physician who administers a bread pill or a powder of sugar of milk, may do so with one or two objects in view; either as a placebo pure and simple or with an ulterior purpose. In either case a brilliant cure may follow. In the first case the result is accidental. A psychic process, induced through faith in the doctor originates in the mind of the patient, irrespective of the doctor. In the second, this same process is conveyed to the consciousness of the patient, through the mind of the physician. If, by chance, the mind of the patient, in the first instance, is so constituted as to be incapable of originating this psychic process, there can be no favorable

result; and only in the second is a good result possible, when the physician is sure of a predominance of this physical element in his patient.

If, on the other hand, the patient is drugged for mere symptoms that only exist in a disordered mind, he receives no benefit. Remedies are prescribed according to the finest indications, and no progress made toward a cure. After the *materia medica* is exhausted, the patient, probably at his own suggestion, consults a specialist; the oculist corrects his astigmatism, and probably cuts his eye muscles; the nose man finds some spurs on the turbinates and removes them with the cautery; and, in the vain endeavor to find some "reflex" cause, if the turbinates are swollen, removes them in the fond expectation that he has at last found the seat of trouble. The desired result not forthcoming, perhaps the surgeon finds some thickening in the appendix, and urges its immediate removal.

Unless the patient possesses an unwarranted loyalty to the medical profession he becomes discouraged, and drifts into the hands of the Christian Scientists, mental healers, osteopaths, or some similar form of practice and—is cured. All because the physician in the first instance failed to recognize the limitations of drug treatment.

The average physician is, by reason of his education and experience, a materialist. As a consequence, he turns to his *materia medica*, and his surgical knowledge with the utmost confidence. As a rule he overlooks the important relations of the mind to morbid processes, and is too apt to regard its influence in the cure of disease as of minor importance. It is not creditable to the great body of scientific physicians that such cures are made by these so-called mental healers. They could and should be made by those who have been specially trained for such work. It is time for the profession to acknowledge candidly that such cures are possible, and do take place in a certain class of patients, and every member of the profession should be prepared to demonstrate to the patient

that the physician who devotes his life to the alleviation of suffering, can do all and more than this class of healers, no matter by what name they are known, by simply comprehending and applying certain laws of psychology.

There are certain classes of patients that are cured by the physician, whether by the use of the crudest drugs or the most highly attenuated—by the Christian Scientists, by the mental healers or by the osteopath. A study of these cases will show that however much they may differ in their external manifestations, they are all similar in that the psychical element is in excess. The one who recognizes this and acts with proper judgment is the one credited with the cure. However learned he may be, if the physician fails to grasp this fact, a miserable failure awaits him. The patient ultimately falls into the hands of some irregular practitioner, who, perhaps ignorant of all things medical, may have remarkable success by reason of two essential elements, faith on the part of the patient and suggestion on that of the healer. However great the divergence in all other matters, this is the *sine qua non* in all psychopathic methods.

It must not be overlooked that in a vast majority of these cases, the medical man has been consulted first, and it is only after his failure that help is sought in other directions. The medical profession is more to blame than any one for the various forms of psycho-therapeutic forms of treatment that menace it, and instead of anathematizing should let them discreetly alone, and, by a careful discrimination between those cases that require drug treatment and those that do not, regain the confidence that has been lost by neglect.

In these days of specialism, the general, all-round practitioner has almost become extinct. Medical students, or at least many of them, when beginning their studies, have a definite idea of specializing in some branch, and however well they may be educated for general practice, their mind is, of necessity, on the special line of work they hope to follow, with the inevitable result that they can never become good general

practitioners. This is all wrong. With the instruction that is given in all reputable medical schools at the present time, a graduate should be well enough equipped, and capable of doing a very large part of the work that is now sent to the specialist.

While we cannot but admit that the domain of medicine is so large that no one can acquire a thorough mastery of all its branches, we must take into consideration the fact that, in an ordinary practice, the rare and unusual cases do not present themselves. A thoroughly well-qualified physician can treat at least ninety per cent. of all patients that come under his care, and if he is a conscientious man, as I am proud to say a very great majority of our profession are, he will admit his limitations and refer exceptional cases to one who, by special study and observation, is more capable than he of treating it.

A man who specializes in any branch is of necessity a one-sided man, however skilful he may be. This statement is denied by every individual of this class, but who has not had this fact impressed on him who has been in close relation with them? The only possible exceptions are in those who, after years of general practice have worked into some special line for which they were peculiarly adapted, or in which they were especially skilful. To enter into the firm appreciation and temperament of his patients, he should have gone deeply into his specialty and then extend his knowledge to every related field. Such a one is capable of general practice. But, alas! they are rare.

The consequence is, that while many bright and skilful men are doing good special work, some morbid conditions outside of their special line are overlooked. This is perhaps no reflection on their skill, but it is the almost inevitable result of specialism. So imbued are the minds of patients with the extraordinary skill of the specialist, that in a great many instances they doubt the ability of the family doctor to treat them successfully, and while they seek his advice as to whom to go, they are, usually, the ones to first suggest the specialist.

What is the consequence? If conditions do not change, there will be no such thing as the general practitioner. The practice of medicine must be on the level of trade unionism; a man must do nothing outside of his specialty:

The men who would do general practice, knowing that the specialist will be sought in the majority of ailments, will not fit himself as he should, or as his opportunities warrant, and thus the number of patients for the specialist is increased and, indirectly, those for the Christian scientist and mental healers.

I do not want to be understood as attributing to any lack of skill or attention on the part of the specialist this increase in the defection from the ranks of our patients. In the majority of cases the patients who consult him are, so to speak, transients. The specialist has no interest in them beyond his specialty, and has no opportunity to familiarize himself with any peculiarity they may possess, a knowledge of which may be necessary to a complete understanding of the case. This is particularly so unless he has had some experience as a general practitioner.

When actual pathological lesions exist there cannot be a word of criticism offered. Disease was never so successfully and scientifically treated as at the present time. It is only to these obscure psychopathic conditions that my remarks apply, and I believe this failure on the part of the medical men to recognize the futility of drug treatment in such cases is due, in a great measure, to the rapidly-increasing desertions to the charlatans. It would be more profitable for us, if we would investigate these cures; find out their underlying principles, and turn them to our own use instead of leaving them to the hands of those who, ignorant of all medical knowledge, are, nevertheless, accumulating wealth by a thorough knowledge of the credulity of mankind.

On the other hand is the danger of overlooking a real lesion because the cause is not readily seen, assuming the train of symptoms that develop to be fancied ones, and treating

them as psychological, to the great detriment of the patient as well as the physician himself. I have a case in mind. A young man of twenty-eight was in a railroad accident. One eye was badly injured, but it was not thought to be serious, and readily healed. A train of nervous symptoms followed. He was treated as a neurasthenic. A long sea voyage was prescribed with no benefit; a sojourn at a sanatorium was recommended; hypnotism was tried; his general health was built up but to no avail, and he was told that time only could cure him. He was considered a hypochondriac and treated as such for a long time, until, becoming discouraged, he abjured all medicine. One summer, while in the woods of Maine, his guide, sitting opposite him, with the camp fire between them, saw something glisten in his eye, and which was not of the eye proper. On his return home, his eye was examined by an oculist, and a small particle of glass was found in the anterior chamber of the eye. Its removal resulted in a complete restoration to health. He became a most ardent follower of Christian Science, and likewise a bitter enemy to the doctors.

In this case it would be unreasonable to blame any one, but the fact that the man who examined his eyes first, in an apparent attempt to justify himself, assured him that the irritation in the eye had nothing to do with his nervous symptoms, and that the good result following the removal from the eye was merely the moral effect of the operation, did not serve the purpose intended. This is one way in which a convert to Christian Science was made.

A woman at the climactic had a small nodule in her breast, and consulted her physician, a most skilful man, who, after examination, assured her that it was not malignant, and would disappear in time. Apparently satisfied, she dismissed the matter from her mind until a few months later, in speaking of it to a friend, she was advised to see a surgeon, not to trust such a serious matter to the hands of a country doctor. She accordingly consulted a well-known surgeon, who advised immediate

operation. Thoroughly alarmed, and not wishing to tell her physician that she had consulted another, she, at the solicitation of a friend, placed herself in the hands of a Christian Scientist. The nodule disappeared soon after, as the family physician had assured her it would. That was forgotten. The credit was given the treatment. She became a most enthusiastic devotee of the doctrine of "love" and has been the means of inducing hundreds of others to follow her example.

Now wherein is the remedy? Instead of trying to suppress this class of practitioners by laws that cannot but be unconstitutional, why not seek to make the practice of medicine so successful that there can be but a limited field in which they can work. They are not doing this thing for the pure love of humanity. Their fees will compare very favorably with ours in size. They support no hospitals or dispensaries. They do no charitable work. When the financial part of their business becomes *nil*, there will be no more "healers."

Let there be less specialism. Let the coming physician know that there is as much honor and money in the general practice of medicine as in the specialties. Have them educated so thoroughly that it will not be necessary to send their patients to the specialists save in unusual cases. Educate the people. Convince them that the family doctor is thoroughly competent to treat their various ailments and, after once gaining their confidence, the family doctor, if he is skilful and conscientious, will become not only their doctor, but also their "guide, councilor, and friend;" as in the days of yore.

The medical profession is foremost among the learned ones. Its practice involves a more exalted principle than mere routine duty, the care and comfort of the sick. Medicine as a science is founded on humanitarianism primarily. Its mission is to alleviate suffering, from the lowest to the highest. There is no distinction of sect, race, or color. No other profession has the privilege which it enjoys of ministering to mankind, of soothing the sick and suffering, of comforting the

heavily laden, of succoring the unfortunate and of lightening the path to the "valley and shadow."

The physican must have absolute fidelity. The solemn faith imposed by the patient's trust must never be forgotten. Add to this kindness and sympathy, without which science, skill, and learning avail but little.

"No matter how we may be maligned, regardless of ingratitude and the vindictive animus of antiscience and ignorance, forgetful of the railing at 'medical etiquette' and 'medical monopoly,' we must obey the command of the simplest justice, the simplest right doing and above all the truest care of the patient."

THE HOMŒOPATHIC HOSPITAL OF RHODE ISLAND.

The City of Providence is rejoicing in what is practically a new homœopathic hospital, situated at 62 and 64 Jackson Street. The building, which is hired by the trustees, is a double brick English basement-house containing twenty-nine rooms and affording accommodation for about twenty-five patients. It is very centrally located, being only about ten minutes' walk from the Union Station, and from the heart of the city. The location is admirable for the carrying on of dispensary work, which would be self-supporting; a training-school for nurses is already being conducted, and during the year in which the hospital has been in operation the income from paying patients has nearly met the running expenses.

The establishment of the hospital on a sound business basis, under the direct management of a board of trustees composed of both business and professional men, is well calculated to win and retain the support of the community, and, indeed, of homœopaths throughout the state. It is a notable list of citizens of Providence and Rhode Island that stands for the corporate body holding the new charter granted by the

Legislature to "the Homœopathic Hospital of Rhode Island," and it is from this list that that board of trustees has been made up. While as yet no medical staff has been appointed, many prominent physicians are interested in the work, and giving their time and services to insure its success. Dr. C. H. Finch, the able superintendent, also conducts the laboratory work, and acts as anesthetizer. Some of the most important and difficult operations known to modern surgery have already been successfully performed.

The present needs of the hospital are: 1. The completion of the annual guarantee fund of \$5,000, one-fourth of which has been raised. 2. Provision for dispensary buildings. 3. A liberal endowment in money, a proper portion of which could be devoted to land and buildings, and the rest invested for revenue.

It is greatly to be hoped that the work so well initiated may be encouraged by liberal bequests and immediate contributions. To this hospital any reputable practitioner may send his patients, and personally attend them. Free beds will be provided at the earliest possible moment, and judicious discrimination used in filling them. The interests of the profession will be consulted by offering them the facilities of a well-equipped institution, and the opportunities for observation and study especially valuable for the younger members. Such an institution cannot fail to be of material advantage to the cause of homœopathy, while extending its beneficent work, and emphasizing the need of a homœopathic hospital in every city. It will also make more evident to the intelligent public that the practice of homœopathy is all-embracing, and that the representative men of our school are not only capable of demonstrating the superiority of our therapeutic methods, but also of showing our proficiency in the use and application of all modern scientific methods whose merits warrant their adoption.

 EDITORIAL.

Books, exchanges and contributions—the latter to be contributed to the GAZETTE only, and preferably to be typewritten—should be sent to the Gazette Associates, 279 Dartmouth Street, Boston; personal and other news items to Dr. A. T. Lovering, 10A Park Square, Boston; subscriptions and all communications relating to advertising, etc., to the business manager, Mr. Chas. A. Boynton, Hyde Park, Mass.

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 AN APPEAL.

The committee of the American Institute charged with the elaboration of a plan to ensure and collect the most trustworthy statistics of the results obtained in our hospitals, hope to enlist the interest in their work of all physicians sincerely desirous of demonstrating the superiority of our method and the soundness of our theory. This work appears of such far-reaching importance, and is surrounded by difficulties so great, that well-considered suggestions and coöperation from all quarters are earnestly desired.

Inasmuch as the difficulties to be met arise in so large a measure from the conflict among us of individual opinion and experience, the first question to present itself is no other than the fundamental one, What is homœopathic treatment? The point once agreed upon, the solution of the remaining problems will be comparatively easy, though it call for answers to questions as weighty as those touching the limitations of our method, the indications for the particular remedy in the individual case, the range of dosage to be first put to the test; the class of cases to be made the subject for observation; the aids and secondary therapeutic measures to be constantly admitted; the length of time for each series of observations and many more of equal importance and complexity.

It will be seen at once that the presentation of these questions will precipitate the controversy on every point on which the followers of Hahnemann have differed for close upon a century. But no candid man will deny that, with every year, the demand is growing more urgent and irresistible for a well-directed and sustained effort to reach a position from which it will be possible to progress more rapidly than we have done during the last fifty years. Nor will it be denied that, with all the ability displayed in the maintenance of conflicting positions, and all the force of individual opinions, we are not in possession of such a body of clinical knowledge on which we can agree, as can be confidently taught in our schools or which can influence the profession at large. Despite our numerous and important advances, and the powerful reforming influence exerted on medical thought and practice by our principles, our position at present is more nearly that of assertion than of proof; of divergent theories, and of experiences unverified save in the estimation of individuals or parties, rather than of teachable knowledge and the genuine effort to combine in harmonious research. To divert from this unfruitful field the means and energies now expended in unorganized labor to that of rigid experimentation surrounded by every rational safeguard against error, is the aim of the committee now seeking the adoption of measures calculated to evolve a degree of certitude in therapeutics beyond the reach of current clinical methods, whether within or without our hospitals or the limits of our school.

To reach an agreement as a basis for the evolution of this greater certitude, the first requisite is the cultivation of that scientific attitude of mind which, while it abandons no sound principle and disregards no valid experience, yet holds firmly in abeyance all preconceived notions, all unsupported individual opinion, and all purely theoretical assumptions. No lasting advancement in knowledge has ever arisen save out of this strictly objective mental attitude. The demand for ac-

curate, self-sacrificing work and inquiry is in no sense to be looked upon as a challenge to any party or faction, but solely as a call for sober, patient, and harmonious research as befits a scientific investigation, notwithstanding the fact that the final aim is the determination of the comparative merits of opposing views and methods. The obstacles to be primarily overcome, therefore, are not so much those inherent in the scientific problems, but rather those inhering in the imperfection of human nature. To escape from the evils of this imperfection, which are nowhere more apparent than in therapeutics, there is but one known course, the pursuit of the scientific method ruled by the scientific spirit which vaunteth not itself, is not puffed up, is patient and thinketh no evil, seeketh not its own, and rejoiceth in the truth.

For the work proposed two modes of procedure suggest themselves. Since in the main our school is divided into two parties who—unlike the old school, in which the agreement to differ is the only agreement—agree only in getting wide apart, either the Institute may select one large hospital of which the staff declares itself ready and willing to submit to rigid rules of observation and record, or all our hospitals may rise to the occasion and pursue each its own chosen method, or, if preferred, two side by side under the same rules, and all under the control of an impartial body of supervisors charged with the frequent scrutiny of the work and the final summing up of the results.

The rules to be devised would be so framed as to insist on the most accurate diagnosis possible, allowing for obscure cases; on the clearest statement of the indications for treatment, general and special, more particularly of the indications for the drug and the dose, and for adjuvants, hygienic, dietetic, mechanical, palliative, hydrotherapeutic, in fact all measures other than purely homœopathic.

The cases to be observed might be all the medical ones presenting themselves, and such conditions occurring in surgical cases as are recognized as calling for medical treatment, or

certain classes of acute and chronic affections might be selected for continued observation through a series of years. As the object would be to show forth in the fullest possible measure the results of homœopathic treatment, the records, which must be exhaustive, would have to note clearly and undeviatingly every departure from it. Since the deplorable lack of funds in all our institutions for the adequate support of officers appointed exclusively for this detailed and exacting work, it would necessarily throw upon every existing staff the burden of labors differing in many respects from those now so willingly carried on under the stress of limited time and means. It would seem advisable, therefore, to so restrict both observations and records as to ensure work of the highest character, having about it the least possible taint of routine and vagueness.

The committee feel that the time has arrived in the history of homœopathy, indeed of therapeutics, for a great effort in the direction of unity of action in the testing of our experience, and in placing our principles on a more secure foundation than that of theory or individual opinion. Hence this appeal for support and earnest consideration of our status. Without the aid of many minds and a willingness on the part of hospital physicians to engage in the work, the committee are powerless. The confidence reposed in us by the public which so freely supports our hospitals; the crying need of our schools so largely sought by eager students looking for sound practical knowledge; the position we still occupy as a sectarian and misunderstood body, excluded in so large a degree from the scientific advantages of the profession, and last, but by no means least, the demands of science and humanity call for the initiation of a reform in our methods of clinical research, the responsibility for which we can no longer disregard. We are now called upon to realize the fact that not material progress, not the gain of hospitals, schools, and organizations constitutes advancement in knowledge, or that their possession demonstrates superior therapeutic results, but solely the character of the work they perform.

The objections to the proposal hitherto met are without weight. They come either from those who fear to disturb existing conditions, or from those who already feel themselves in possession of all attainable knowledge. They claim to have on their side common sense. But such common sense is neither wisdom nor science, and never helps a reform until the reform has helped itself.

LETTER TO THE EDITOR.

DES MOINES, IA., May 16, 1905.

My dear Editor:

Permit me to assure the readers of your journal that all the preparations necessary to make the Chicago meeting of the American Institute of Homœopathy the most successful one in its history have been completed. The chairman of the committee on arrangements, together with his enthusiastic associates, has spared neither pains nor money in securing suitable rooms for the meetings of the Institute, all its committees and affiliated societies; in securing hotel accommodations to fit the purses of all; and in securing the coöperation of the ladies of Chicago to help make the meetings of the Meissen successful and enjoyable.

The chairman of the committee on the anniversary of the birth of Hahnemann, together with his associates, and a committee of the Illinois Homœopathic Medical Society, has planned for a magnificent social entertainment with which to close the week on Friday evening.

The program of the business and scientific part of the meeting, which is already in your hands, shows that in this respect a feast is in store for us all.

The amalgamation scheme demonstrated to the homœopathic profession that the work begun by Hahnemann is far from completed, and inspired the profession with the determination to renew the battle and fight till a complete victory is achieved.

It is the same sanguine expectation of all who are in charge that at the Chicago meeting plans will be matured, orders will be issued, and inspiration furnished for a campaign which will in time carry the practice and principles of homœopathy to every city and hamlet in the land.

The *preparations* for the meeting are a success. To make the *meeting itself* a success only requires the presence of yourself and every reader of your journal. On behalf of the officers and members of the committees I extend to you this last, urgent, cordial invitation to come.

GEORGE ROYAL, *President.*

SALIVARY CALCULI.—Any condition which disturbs the usual calibre of the salivary ducts or gives rise to a thickening or roughing of their internal coat, acts as an exciting factor in this affection. Chronic inflammation in the gland itself, microorganisms in the ducts, or local irritation of the sublingual tissue are contributing causes in the production of these concretions. The chemical analysis shows these calculi to be composed principally of carbonate and phosphate of calcium and magnesium, the lithæmic diathesis certainly predisposes the individual to such deposits.

Calculi in this region are found either in the duct or gland. The submaxillary is the most frequently involved. When the foreign element involves the gland, it may exist for some time without causing much annoyance. Puzey reports a case of an adult where the calculus was present for over two years and had not caused much discomfort. Three months before its removal, an abscess formed in the submaxillary gland and ruptured of its own accord. Suppuration ceased, but the swelling in the region of the gland continued. This tissue and part of the facial artery was removed at a subsequent operation. The calculus found was one and one-half inches in length and a half inch in thickness. It weighed one hundred and fifteen grains.—*Journal of Medicine and Science.*

SOCIETIES.

BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

The regular meeting of the Society was held in the hall of the Boston Society of Natural History, Thursday evening, May 4, 1905, at eight o'clock, the president, J. Herbert Moore, M.D., in the chair.

SCIENTIFIC SESSION.

Dr. Suffa: I was called to see a case about two months ago, which had very peculiar conditions, and as far as the eyes were concerned, somewhat unusual, the main feature being a peculiar form of loss of equilibrium, due probably to either embolism or a lesion in the cerebellum. I have never seen a case like it, and do not recall a similar case. The patient, a man, was taken suddenly, with possibly a slight warning in the forenoon. While going down town to the bank he felt a tendency to fall to the right side. There was also some mental disturbance, but nothing very marked. The condition kept increasing, and when he got home he had difficulty in getting to the house and afterward was unable to control himself, could not walk, and would fall to the right side. One peculiar feature was that there was no loss of power in the hand or foot on that side, there being a loss of sensation only, with an absolute loss of equilibrium, so that he had to be assisted in order to get across the floor. The eye condition showed a vertical and lateral deviation on looking to either side, with diplopia or double vision. Prismatic glasses were ordered, and they corrected the diplopia in all positions. Whether the muscular condition of the eyes is entirely due to the cerebellar lesion, or there existed the tendency to deviate (hyper exophoria), I do not know. The eye condition has improved so that it is not necessary for him to wear the prismatic glasses at present, although he feels better with them. It is a very singular case and I do not know of a similar one where there was complete loss of equilibrium without any loss of power. Dr. Moore can give you the general symptoms better than I.

Dr. Moore: This is such an interesting case of capillary rupture or embolic infarction in a small area of the cerebellum that I have asked Dr. Suffa to report the case from the ocular

standpoint. The mischief must have been done in the area, giving rise to the third and fifth nerves, as manifested by the motor and sensory symptoms of the eye; and also in the area presiding over coördination, as manifested by the marked loss of equilibrium in the patient.

The patient is a man sixty-six years of age, and a victim of chronic interstitial nephritis. One morning after a long seance at reading his paper he found, on rising from his chair, that he had an uncontrollable inclination to veer to the right side. He persisted in his intention of going to town, and found he had great difficulty in keeping away from the right edge of the sidewalk while going to and from the electric cars.

After he returned home I was sent for, and of course put him to bed. The veering to the right had now so increased that even with assistance he had great difficulty in going up stairs but not from lack of motion, but merely from the difficulty in maintaining his equilibrium, which now was so marked that assistance was necessary to keep him from falling over the stair rail. This lack of coördination increased to the extent that for about a month he was unable to walk or stand alone.

A few hours after taking his bed marked diplopia came on, of which Dr. Suffa has spoken, one object appearing above the other. In connection with this there was a great deal of distressing headache in the region supplied by the right supra-orbital nerve.

There was marked loss of sensation in the entire left side of the body, as well as loss of heat; the left side being colder than the right both to touch and to the feelings of the patient.

The marked feature of the left side of the body was that notwithstanding the marked loss of coördination, sensation, and heat, there was no loss of power or motion in this left side; resistance of lower limb to pressure applied at the foot and the hand grip being normal, and both upper and lower limb being capable of being moved in any direction. The right side of the body, below the eye, remained normal.

As regards treatment and progress the diplopia was quickly and markedly relieved by proper lenses prescribed by Dr. Suffa. At the present writing (ten weeks from the attack) there is no diplopia with or without these lenses.

The distressing headache in the region of the right supra-orbital nerve was not relieved by the lenses, but yielded quickly and thoroughly to *actæa racemosa*, hourly doses of two drops of the 3x dilution.

Arnica in hourly doses of two drops of the 3x dilution was then prescribed against the damaged area of the cerebellum to promote absorption and allay irritation, and has been continued in two or three hour doses during the past two months.

No other therapeutic measures, such as *kali iodide*, electricity, or massage, were made use of; and from the satisfactory outcome of the case I believe *arnica* to have been of material benefit.

At the present writing the patient is able to walk about in a normal manner, some slight tendency to the old veering to the right occurring only when the attention is suddenly arrested during walking. The ocular conditions have returned to their normal. Sensation and heat of the left side are nearly normal, and the patient is in a much better general physical state than before the attack.

Dr. Sutherland: The right lobe of the cerebellum well up toward the pores, probably the anterior part in the floor of the fourth ventricle. I heard two lectures on cerebellar diseases while in London last summer, and great stress was laid on the weakness of and falling toward the side affected, with much vertigo or dizziness.

PROGRAM

1. "Some Surgical Conditions of the Kidneys." Wm. F. Wesselhoeft, M.D. Discussion opened by Stephen H. Blodgett, M.D.

2. "Occlusion of the Nasal Fossæ." N. H. Houghton, M.D. Discussion opened by George B. Rice, M.D.

3. "The Diagnosis of Early Tubercular Infection with Special Reference to the Significance of Pleuritic Effusion." George R. Southwick, M.D., M.R.C.S. Discussion opened by Jane S. Devereaux, M.D.

Dr. Wesselhoeft not being present, Dr. Houghton's paper, "Occlusion of the Nasal Fossæ," was the first one presented.

DISCUSSION (DR. HOUGHTON'S PAPER).

Dr. Rice: Dr. Houghton's paper is very interesting because it calls attention to so many facts worth consideration. The author mentions a case of occlusion of one nasal fossa completely obstructing the right post-nasal passage. I have seen only one similar case. This was that of a patient who came to me in the early days of my special practice, and who suffered from inability to breathe through either nasal passage. I remember distinctly with what trepidation I introduced a nasal burr and drilled through the bony wall of each side. This primary opening was enlarged by carrying the burr through the bony wall just above the first opening, and then connecting the two by a small gouge. The patient made a satisfactory recovery. In this case as in Dr. Houghton's, the turbinals were rudimentary and the olfactory sense obliterated. Another point which will bear emphasis in Dr. Houghton's paper is the consideration of the functions of the nose. I do not believe that the majority of physicians at all appreciate how necessary these are in the human economy. These and other recorded cases of nasal obstruction demonstrate the fact that a disused nasal organ after a time loses its functions, and with this loss of nasal oxygenation, olfaction, improper preparation of air for the lungs, obstructed phonation, interference with middle ear air interchange, and difficulties in mastication and deglutition, grave results must ensue. Fortunately, where nasal obstruction, partial or complete, is hereditary or occurs early in childhood, nature compensates these losses to a large extent by the employment of other means for the same results, but it takes years of preparation to accomplish this compensatory condition, and during this interval, the health and even the life of the patient is imperiled.

Dr. Houghton (in closing): One point I did not speak of, the dependence of the taste upon the olfactory nerve. The sense of taste is not much studied. In those cases where it was claimed the sense of taste was good, fine distinctions could not be made. Where there had been complete obstruction, after operation there was some improvement in the taste and hearing

but in none was the sense of smell improved. These cases illustrate how a man can get along and not breathe through his nose, that function going on entirely through the mouth.

DISCUSSION (DR. SOUTHWICK'S PAPER).

Dr. J. H. Sherman: With me it is a comparatively new experience that pleurisy is of tubercular origin. Not until the past year was I aware of it. It has stolen upon me like a thief in the night. I had a patient convalescing from typhoid fever when he developed shortness of breath and inclination to lie on the left side. Percussion revealed dullness of large extent in the left chest. Being satisfied that fluid was there I called in Dr. H. C. Clapp, who drew off about a gallon of serous fluid. This case was not preceded by the usual characteristic chill, nor accompanied by pain. Dr. Clapp considered it of tubercular origin.

Dr. Sutherland: While listening to the paper, I could not help thinking of the paper we heard a month ago on meningitis. It has been claimed that pleurisy was a manifestation of tuberculosis, and that seventy-four per cent. of pleuritic cases are of tuberculous origin. I do not know that I can quite agree with that statement.

Speaking of meningitis, I have never had the experience of some here, nor have I seen an epidemic of cerebral meningitis, but I have seen meningitis due to malaria and meningitis following erysipelas; also the pneumococcus meningitis, where the pneumonia took the meningeal form. I have also seen many cases of tuberculous meningitis and a few cases that were probably grippe, that is, inflammation as the result of the infection of the poison of the influenza bacilli, and listening to Dr. Southwick's statement, that some time in the future the laboratory test will show that pleurisy is not altogether of the tuberculous form, it may be proved that pleurisy is due to other forms of infection than the tubercular bacilli. I am not willing to accept the statement that most cases of pleurisy are due to tubercular bacilli, but think it will be proved sometime that it is not infrequently due to some other germ.

Dr. Southwick (in closing): Pleurisy may arise in the case of any infectious disease, the organisms of which circulating in the blood may infect the pleura. I have seen pleurisy in typhoid fever and grippe and all of us are familiar with pleurisy in pneumonia. The relation of pleurisy to tuberculosis is receiving general recognition. We should not pass by the aching side as a trivial ailment, but we should examine it carefully for evidence of pleurisy, and if fluid is found, we should examine it carefully and ascertain its character.

Dr. Moore: Is pleuritic tuberculosis any more frequent in adults than in children?

Dr. Southwick: I could not make any definite statement.

Dr. Moore: If that be so, then some of the cases of pleurisy we have been curing by homœopathic remedies may have been of tubercular origin.

Dr. Southwick: I do not see why it may not be so.

Adjourned at 9.30 o'clock.

B. T. LORING, *Secretary.*

REPORT OF A CASE OF SMALLPOX.—An infant of three years was affected with a virulent form of confluent smallpox. I was called to the case on the evening of the fifth day of the disease and second day of the eruption. The child had been sleeping in the same bed with its mother, who was in the seventh month of gestation, and none of the family had ever been vaccinated. The patient made a speedy and favorable recovery, despite the adverse prognosis of the officials. Powders of variolinum were left daily for the father and mother. The father neglected to take his, and consequently came down with the disease in a severe form just as his little son was convalescing. But the mother who slept with her sick boy and her unborn babe were both perfectly protected; for I attended at her labor in due time and delivered her of a sound healthy baby, free from all marks or blemishes of any kind.—*The Medical Advance.*

COLLABORATORS' DEPARTMENT.

MANUEL GARCIA, the inventor of the laryngoscope, 1855, celebrated his one hundredth birthday March 17. For many years a teacher of singing in London, and naturally desirous of viewing the structures so closely related to his own work, he took up the question solely from this standpoint, and as the result of his efforts succeeded in obtaining a view of the interior of the larynx and the vocal cords in action. This opened up a new field for science, and it is a curious and interesting fact that these two celebrations, the Garcia centenary and the jubilee of laryngoscopy, should be contemporaneous. In 1855 he presented to the Royal Society his paper demonstrating the possibility of seeing the larynx in the living subject, and the technical directions laid down therein for laryngology were the solution of a long-debated problem from which has grown a branch of medical science with its special literature, institutions and teachers.

Happily he has lived to see his efforts fully appreciated, and to reap the reward of his labors. The celebration in the house of the Laryngological Society in London on the 17th of March shows in what high esteem he is held by the profession in all parts of the world, and all know that the kindly feeling is cordially reciprocated by the great master.

G. B. R.

DR. M. ARAMIAN of New York City (*Medical Record*, March 4, 1905) gives the result of his experiments begun in 1894 with the extract of *dichondra* as a bactericide in diphtheria. The solution consists of one part of the extract of *dichondra brevifolia* (convolvulacea family), obtained from the seeds and stem of the plant of which there are several species growing in the United States, and three parts glycerin.

Various bacteriologists in France have proven that its peculiar toxic action is directed solely against the Loeffler bacilli and that it has no action whatever on other organisms that breed in the throat during the diphtheria period.

Its use alone and in conjunction with antitoxin has been perfectly successful. It destroys completely the bacilli of diphtheria usually within two to five days without the slightest irritation and produces no harm if swallowed, as it has no toxic properties.

Since antitoxin acts only against the toxin produced by the Klebs-Loeffler bacilli, the advantage of using this preparation in conjunction with the antitoxin is to destroy the specific bacilli that produce the toxin and thereby shorten the duration of the disease and prevent complications.

In cases where antitoxin is used alone the disease is habitually from fifteen to fifty days and the bacilli often persist much longer, thus rendering the patients dangerous as contagion bearers. Where antidiphtherin is used the symptoms subside in from two to five days, and never exceed seven in very severe cases.

The extract of dichondra put in tubes containing pure cultures of Klebs-Loeffler bacilli diminish their number and later totally destroy them. Repeated experiments on guinea pigs with cultures containing the bactericide have always met with good results.

The antidiphtherin can be applied frequently, as a rule, from four to six applications a day, and in very severe cases every two hours, and this should be continued until all redness of the mucous membrane has disappeared and until bacteriological confirmation of the absence of the bacilli is obtained.

G. B. R.

DR. J. W. GLEITSMAN (*Medical Record*, March 23, 1905), after a careful review of the literature on the subject of intratracheal injections, thereby obtaining the historical development of the method and views of the principal writers, summarizes the result of the investigations as follows:

Experiments on animals and human beings attest to the harmlessness of the procedure.

The advantage of applying remedies directly to the seat of

lesion is obvious, as shown by their beneficial effects when other measures failed.

The field is limited where injections are indicated, and most writers are adverse to their use in the acute stages of any type of inflammation.

In pulmonary tuberculosis they are useful in alleviating the dry cough in the beginning, and at a later stage may modify favorably the putrid secretions.

In bronchiectasis and blennorrhœa, injections act almost as a specific.

Many cases of asthma will be relieved, but we cannot speak of a cure of asthma proper as long as we cannot eliminate the underlying causative factor.

In chronic tracheitis and bronchitis this method is often most efficient. Other conditions in which they may be used are tracheal syphilis, pulmonary gangrene, pertussis and hemorrhage.

The general consensus is to use as a vehicle a bland, purified oil, and of the remedies that have been found beneficial the following may be mentioned: menthol, guaiacol, creosote carbonate, chlorophenol, bromoform, iodoform, turpentine and salol.

He advises the use of a hard-rubber cannula to which is attached a Hartmann ear syringe holding one ounce. By the aid of the laryngeal mirror, the cannula is introduced between and below the vocal cords. In some cases it may be necessary to spray the larynx with a weak solution of cocaine to facilitate the introduction of the cannula.

G. B. R.

ABSTRACTS FROM BOOKS AND JOURNALS.

RABIES.—At the Pasteur Institute at Paris the mortality has averaged one-half of one per cent., which is about the percentage lost by all other institutes. Of those not receiving the Pasteur treatment it is said that at least eighteen per cent. died.

During the past three years Brawner has compiled a record of about two hundred and fifty persons bitten by rabid dogs in the Southern states and by those supposed to have been rabid. Of these one hundred and seventy received the Pasteur treatment, and only one such died. Of the remaining eighty, some of whom resorted to that magical substance, the madstone, sixteen died, or twenty per cent.—*Exchange*.

THE RHEUMATISM MICROBE.—Poynton and Paine, for example, have obtained a diplococcus in pure culture from human rheumatic lesions and have reproduced by intravenous inoculation in the rabbit; endocarditis, pericarditis, carditis, pleurisy, pneumonia, nodules and a nervous condition, resembling chorea, as well as polyarthritis and inflammation of the sheaths of the tendons, and found the same organisms in the induced lesions. They also found the diplococcus in a culture from a "sore throat" in a patient with muscular pain, a history of a previous attack of rheumatic fever and valvular disease. It was isolated and cultivated and was injected intravenously into a rabbit, producing in that animal mitral valvulitis and great dilation of the heart.—*The Post-Graduate*.

RECURRENT VOMITING IN CHILDREN.—The diet should be carefully restricted and selected. In beginning the treatment all raw fruits, acid vegetables, such as rhubarb and tomatoes, salads, tea, coffee, beef-juice, beef tea and alcohol, are to be avoided, and the child should be allowed to eat but sparingly of beef and sweets. The following foods may be allowed: Milk, cocoa, vegetable soups, cereals, well-cooked vegetables, cooked fruits, eggs, fish, chicken, mutton and, occasionally, beef. Children suffering from recurrent vomiting have, as a rule, in the interval between the attacks, abnormally large appetites. They are, therefore, to be carefully guarded against taking an excess of food of any kind, and are to be made to cultivate the habit of drinking water between meals.—*Archives of Pediatrics*.

MEDICAL TREATMENT OF APPENDICITIS.—In the cases I have attended I have practically followed one line of treatment. They were first given a dose of castor oil of a size sufficient to be thoroughly active, usually from four tablespoonfuls to a teacup. Hot poultices were applied over the seat of soreness, pain and swelling, and they were frequently changed. The fever was controlled by *veratrum viride*. The diet was liquid, and it was in some of the cases entirely omitted for the first two days. Absolute quiet in bed was maintained for from eight to ten days. There was pus passed with the actions in some of the cases, with a rapid subsidence of swelling, soreness and pain. In others there seemed to be no suppuration, no pus at least was passed to show it, but the process of absorption with the disappearance of the local and general symptoms showed that the treatment was effective.

The after-treatment consisted in the regulation of the diet, the administration of some mild laxative, and an intestinal antiseptic such as the subgallate of bismuth or the sulpho-carbolates.—*Dr. W. M. Dake in Progress.*

MEASLES.—Measles is a dangerous disease—one of the most dangerous with which a child under five years of age can be attacked. It is especially apt to be fatal to teething children. It tends to kill by producing inflammation of the lungs. It prepares the way for consumption. It tends to maim by producing inflammations of the ears and eyes. Measles has carried off more than four times as many persons as enteric fever. It is therefore a great mistake to look upon measles as a trifling disease. Every child ill with measles ought at once to be put to bed and kept warm, for the mildest cases may be made serious by a chill. Measles is for this reason most dangerous in winter and spring. The older a child is, the less likely it is to catch measles; and if it does, the less likely it is to die. If every child could be protected from measles until it had passed its fifth year, the mortality from this disease would be enormously decreased. It is therefore a great mistake—because as a rule children sooner or later have measles—to say, “The sooner the better,” and to take no measures to protect them, or even deliberately to expose them to infection.

California State Journal of Medicine.

BOOKS AND READING.

Medical, literary and scientific publications will be reviewed in this department. Books and journals should be marked NEW ENGLAND MEDICAL GAZETTE, and sent to the Gazette Associates, 279 Dartmouth Street, Boston.

LECTURES ON HOMŒOPATHIC MATERIA MEDICA. By James Tyler Kent, A.M., M.D., Professor of Materia Medica in Hahnemann Medical College and Hospital, Chicago, author of the "Repertory of the Homœopathic Materia Medica" and "Lectures on Homœopathic Philosophy." Philadelphia: Boericke & Tafel. 1905. Price, cloth, \$7.00; half morocco, \$8.00. pp. 965.

The extent, not to say redundancy, of this work is indicated by the fact that it contains nine hundred and sixty-five pages, including a lecture on tuberculinum eight pages in length; another and more valuable remedy is given thirty-two pages.

In a general way the book resembles "Farrington's Materia Medica," though less readable on account of paragraphs that are but symptom lists; the author apologizes for its colloquial style, which however does not demand the repetitions found therein; he warns the students against the exhibition of very high potencies in grave conditions unless fully indicated, lest they do serious injury.

There is no table of contents nor clinical index. A. S. B.

EYE, EAR, NOSE AND THROAT NURSING. By A. Edward Davis, A.M., M.D., Professor of Diseases of the Eye in the New York Postgraduate Medical School and Hospital, and Beaman Douglass, M.D., Professor of Diseases of the Nose and Throat in the New York Postgraduate Medical School and Hospital. With thirty-two illustrations. Philadelphia: F. A. Davis Company. Price, cloth, \$1.25 net. pp. xvi, 318.

This book is an excellent guide for the intelligent care and nursing of the various diseases of the eye, ear, nose and throat. In treating such delicate organs the good results obtained depend fully as much upon the painstaking care of the nurse as upon the work of the physician himself. While written primarily for the use of nurses, students, general practitioners, and even specialists, will find it of great assistance to them.

A TEXT-BOOK OF MATERIA MEDICA AND THERAPEUTICS: CHARACTERISTIC, ANALYTICAL AND COMPARATIVE. By A. C. Cowperthwaite, M.D., Ph.D., LL.D., Senior Professor of Materia Medica and Therapeutics in the Hahnemann Medical College and Hospital of Chicago, etc. Ninth edition, with an appendix including the new remedies. Chicago: John B. Delbridge & Son. 1905. pp. 860.

While it is thirteen years since the entire text of this work was rewritten, the present volume has the great advantage over its predecessors of containing a fifty-five page appendix of new remedies, new at least to this book. We heartily wish the list had been extended. However, "Cowperthwaite" is a most useful and valued standby, and indispensable to student and practitioner alike in the materia-medica library, which requires for completeness more different volumes, perhaps, than any other department of medical literature. The ease of reference to any particular drug has always made the book in question a favorite.

A. T. L.

BOOKS RECEIVED.

QUIZ COMPEND: DISEASES OF THE EYE. Gould & Pyle. P. Blakiston's Son & Co.

TRANSACTIONS OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF NEW YORK. 1904.

TRANSACTIONS OF THE HOMŒOPATHIC MEDICAL SOCIETY OF OHIO. 1904.

TRANSACTIONS OF THE HOMŒOPATHIC MEDICAL SOCIETY OF PENNSYLVANIA. 1904.

PNEUMONIA. Robert B. Preble, M.D. Cloyd J. Head & Co.

THE MNEMONIC SIMILIAD. By Stacy Jones, M.D. Boericke & Tafel.

STUDIES IN THE PSYCHOLOGY OF SEX. By Havelock Ellis. F. A. Davis Co.

PERSONAL AND GENERAL ITEMS.

DR. WALTER WESSELHOEFT of Cambridge will sail for Europe June 20, and will return the last of August.

DR. JOHN B. MAY has associated himself with Dr. Thomas Conant at 36 Pleasant Street, Gloucester. Office hours, 8 to 9 A.M., 1 to 3 and 6.30 to 7.30 P.M.

DR. FREDERICK W. COLBURN, who specializes in diseases of the ear, has removed to 661 Boylston Street, Boston, opposite the Public Library. Office hours, 2.30 to 4 P.M. Sundays excepted.

THE Missouri Valley Homœopathic Medical Association will hold its regular annual meeting in Omaha the latter part of October. A cordial invitation is extended to all homœopaths to be present.

DR. EUGENE H. PORTER has been appointed Commissioner of Health of the State of New York by the governor. This is the most important office in the gift of the state that has ever been bestowed on a homœopathic physician.

THE Massachusetts State Board of Health has completed within the past month its inspection of the milk farms in Acton, Shirley, Carlisle, Billerica, Bedford, Harvard, Maynard, Westford, Concord, and Chelmsford. The daily press reports that of the four hundred and fourteen milk farms inspected, no less than three hundred and seven failed to obtain approval, and that one hundred diseased cattle were found.

THE prevention of race suicide, such as exists now in France, consists in decreasing the death of infants. Gustave Lejeal, in the *Revue Universalle*, shows that "of the 850,000 children who are born every year in Paris, 148,000 die during the first year, the death rate being 16 per 100." Drs. Budin and Bariot have begun to see the solution of race suicide in the establishment of the institutions known as "The Drop of Milk," establishments for the proper feeding of young infants. The pertinent comment is made by a contemporary that before a race considers the problem of increasing the number of births, it should consider the problem of decreasing the number of deaths.

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ORIGINAL COMMUNICATIONS.

EPILEPSY: GENERAL OBSERVATIONS AND HOME CARE.

BY EVERETT FLOOD, A.M., M.D., SUPERINTENDENT OF THE MASSACHUSETTS HOSPITAL FOR EPILEPTICS.

[Read before the Massachusetts Homœopathic Medical Society.]

Dr. Edward Schafer, the author-editor of Quain's Anatomy, has so accurately observed the conditions under which convulsions occur that no nearer approach to experimental epilepsy can be hoped for.

Observations beyond this must be upon the human subject, and it seems that even this field of study has been very thoroughly gleaned.

The number of epileptics in Massachusetts I believe to be ten thousand, but this estimate is much larger than most observers will admit. It depends somewhat upon how many of those having convulsions at all are fairly classed as epileptics. My estimate will be admitted in time.

The detailed investigation of minute phenomena is necessary in order to get at a full general understanding. When once tabulated they need not be reobserved again and again at a great waste of time and effort. I think that in time hundreds of these observations may be disregarded, and will influence our judgment of a case about as much as the size of the raindrop or the shape of the snowflake will in judging of the origin and course of the storm.

To the specialist in each small field will be assigned the further and minute study.

A system of medical economics would greatly facilitate results. We should accept pretty fully the observations already tabulated, as corroborative evidence is always coming in, and go on with new lines of collecting data or with some very desirable generalizations.

As an example of detail work, I cite the following observations made at the Massachusetts Hospital for Epileptics and compared with those recorded in Gowers' marvelous work on epilepsy.

In 935 cases:

	Males.	Females.	Total.
Mean age at first seizure	16+	15+	16—
Mean age at death		39	
Mean age on admission		31	
Average duration before admission		13	
How many whose cause is traumatic		96	
How many whose seizures followed infectious fevers			27
How many died of status epilepticus	18	8	26

In 953 cases:

How many insane	237	209	446
How many sane	306	201	507

In 864 cases:

How many single	400	285	685
How many married	76	58	134
How many widowed	10	35	45

In 488 cases:

How many whose seizures were preceded by syphilis	13	2	15
How many hereditary (direct)			27
How many hereditary (indirect)			37
How many hereditary (collateral)			31
How many of foreign parentage			196
How many had history of T. B. in family			31

How many had T. B.	23
How many had diabetes	1
How many had Bright's disease	10
How many had status epilepticus	36

In 488 cases:

How many had aura	31
How many had sensory aura	20
How many had psychic aura	4
How many had motor aura	2
How many had irregular aura	5
How many were hemiplegic	32

In 188 cases:

How many Catholic	53
How many Protestant	80
How many Jews	2
How many Quakers	1
Unknown
How many had High School or more ad- vanced education	6
How many had Grammar School educa- tion, or could read and write	82
How many could not read or write	46
Unknown

Ages at which convulsions began:

Massachusetts Hospital for Epileptics: 803 cases; under 1 year, 97 cases; about 12 per cent. Gowers: 2383 cases; under 1 year, 155 cases; about 6 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 1 to 2 years, 36 cases; about 4½ per cent. Gowers: 2383 cases; 1 to 2 years, 93 cases; about 4 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 2 to 3 years, 26 cases; about 3 per cent. Gowers: 2383 cases; 2 to 3 years, 79 cases; about 3 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 3 to 4 years, 17 cases; about 2 per cent. Gowers: 2383 cases; 3 to 4 years, 77 cases; about 3 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 4 to 5 years, 24 cases; about 3 per cent. Gowers: 2383 cases; 4 to 5 years, 56 cases; about 2 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 5 to 6 years, 18 cases; about 2 per cent. Gowers: 2383 cases; 5 to 6 years, 56 cases; about 2 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 6 to 7 years, 23 cases; about $2\frac{3}{4}$ per cent. Gowers: 2383 cases; 6 to 7 years, 59 cases; about 2 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 7 to 8 years, 16 cases; about 2 per cent. Gowers: 2383 cases; 7 to 8 years, 96 cases; about 4 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 8 to 9 years, 12 cases; about $1\frac{1}{2}$ per cent. Gowers: 2383 cases; 8 to 9 years, 71 cases; about $2\frac{1}{2}$ per cent.

Massachusetts Hospital for Epileptics: 803 cases; 9 to 10 years, 37 cases; about $4\frac{1}{2}$ per cent. Gowers: 2383 cases; 9 to 10 years, 36 cases; about $3\frac{1}{2}$ per cent.

Massachusetts Hospital for Epileptics: 803 cases; 10 to 11 years, 18 cases; about 2 per cent. Gowers: 2383 cases; 10 to 11 years, 112 cases; about $1\frac{1}{2}$ per cent.

Massachusetts Hospital for Epileptics: 803 cases; 11 to 12 years, 27 cases; about 3 per cent. Gowers: 2383 cases; 11 to 12 years, 112 cases; about $4\frac{1}{2}$ per cent.

Massachusetts Hospital for Epileptics: 803 cases; 12 to 13 years, 20 cases; about $2\frac{1}{4}$ per cent. Gowers: 2383 cases; 12 to 13 years, 149 cases; about 6 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 13 to 14 years, 37 cases; about $4\frac{1}{2}$ per cent. Gowers: 2383 cases; 13 to 14 years, 149 cases; about 6 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 14 to 15 years, 32 cases; about 4 per cent. Gowers: 2383 cases; 14 to 15 years, 183 cases; about $7\frac{1}{2}$ per cent.

Massachusetts Hospital for Epileptics: 803 cases; 15 to 16 years, 33 cases; about 4 per cent. Gowers: 2383 cases; 15 to 16 years, 166 cases; about 7 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 16 to 17 years, 18 cases; about 2 per cent. Gowers: 2383 cases; 16 to 17 years, 167 cases; about 7 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 17 to 18 years, 26 cases; about 3 per cent. Gowers: 2383 cases; 17 to 18 years, 133 cases; about $5\frac{1}{2}$ per cent.

Massachusetts Hospital for Epileptics: 803 cases; 18 to 19 years, 13 cases; about $1\frac{1}{2}$ per cent. Gowers: 2383 cases; 18 to 19 years, 144 cases; about 6 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 19 to 20 years, 11 cases; about $1\frac{1}{4}$ per cent. Gowers: 2383 cases; 19 to 20 years, 93 cases; about 4 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 20 to 21 years, 11 cases; about $1\frac{1}{2}$ per cent. Gowers: 2383 cases; 20 to 21 years, 79 cases; about 3 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 21 to 22 years, 15 cases; about 2 per cent. Gowers: 2383 cases; 21 to 22 years, 65 cases; about $2\frac{1}{2}$ per cent.

Massachusetts Hospital for Epileptics: 803 cases; 20 to 30 years, 99 cases; about 12 per cent. Gowers: 3000 cases; 20 to 30 years, 463 cases; about 15 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 30 to 40 years, 47 cases; about 6 per cent. Gowers: 3000 cases; 30 to 40 years, 186 cases; about 6.3 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 40 to 50 years, 29 cases; about $3\frac{1}{2}$ per cent. Gowers: 3000 cases; 40 to 50 years, 71 cases; about 2.4 per cent.

Massachusetts Hospital for Epileptics: 803 cases; 50 to 60 years, 22 cases; about $2\frac{2}{3}$ per cent. Gowers: 3000 cases; 50 to 60 years, 40 cases; about $1\frac{1}{3}$ per cent.

Massachusetts Hospital for Epileptics: 803 cases; 60 to 70 years, 7 cases; about 8 per cent. Gowers: 3000 cases; 60 to 70 years, 15 cases; about $1\frac{1}{2}$ per cent.

Massachusetts Hospital for Epileptics: 803 cases; 70 to 80 years, 4 cases; $\frac{1}{2}$ per cent. Gowers: 3000 cases; 70 to 80 years, 1 case; about 3-100 per cent.

Mean age at commencement of epilepsy:

Massachusetts Hospital for Epileptics: 803 cases, 16 years.
Gowers: 3000 cases, 15½ years.

Cases due to trauma:

Massachusetts Hospital for Epileptics: 803 cases; trauma, 96 cases, or 10 per cent. Gowers: 1665 cases; trauma, 108 cases, or 6½ per cent.

Cases due to acute fevers:

Massachusetts Hospital for Epileptics: 803 cases; 27 cases, or 3 per cent. Gowers: 1665 cases; 59 cases, or 3 per cent.

Heredity a cause:

Massachusetts Hospital for Epileptics: 488 cases; direct, 27 cases, or 5½ per cent.; indirect, 37 cases, or 7¾ per cent.; collateral, 31 cases, or 6¼ per cent.; 95 cases, or 19 per cent. Gowers: 2222 cases. Heredity in 888 cases, or 40 per cent.

The psychological study of persons, who have long suffered from epilepsy, is a protracted and fruitful investigation in an unworked territory.

The everyday experiences with persons suffering from epilepsy is of vast interest as revealing the workings of the weakened or diseased mind. They have to be studied and handled as we deal with children. No two are alike, none are helped by scolding, some exhibit remarkable native discernment and often put us to shame by their more logical point of view.

It should be clear to any observer that any one of us might have been or might now become epileptic. This being true, why should we classify on a symptom, and push off in a group by themselves, persons who are thus afflicted. As a matter of fact, they are a part of us, possibly a little weaker, a little less self-controlled; but the dividing-line cannot be fixed. It is as unwarranted to assume these persons to be wholly different from other citizens, as it is to thus stigmatize the insane or the crippled.

To one who has lived in intimate association with the mentally alienated and defective classes, the foibles, defects,

errors of judgment, and weakness of temper exhibited by the ordinary neighbor seem elementary and explicable.

We find among the epileptic in many instances gratitude and intelligent coöperation; but in some we meet with complaints, ingratitude, unintelligent conduct, even violent opposition to advice if the inaction and habitual course are altered. In most of such a make-up we soon see irrational following of habit and emotions, mental alienation, and dementia.

All this is generally aided in its retrograde movement by the unappreciative relative or friend, who scarcely considers what is best for the patient when weighed alongside of what is most galling for the caretaker.

The attitude of the parent is quite an element in the condition of the child, and should be well examined in any investigation of cause and effect. This weakness of the forbears is not alone exhibited in their dealings with the custodian; but becomes equally manifest where the real welfare of the child is concerned.

The uninformed condition of many parents is surprising. They allow indulgence in too much or improper food, especially at night when it is most harmful. Such improprieties as this will start up epileptic seizures even where there is no predisposition. Cases often go on nearly to the point of having a fit, then regain their balance.

The number of such restorations is probably very large, but wholly unrecorded.

The popular notion that the more ravenously children eat the more strength they are getting, is wrong. Mothers need to learn this. They often think that a child can always be eating.

Intelligent care of children, light meals, well chewed for thorough insalivation, little meat but ample nourishment, light suppers, no frolicking before bedtime, quiet games and reading, avoid night terrors and the initial fit which often results.

Mothers attach little importance to the fact of a child having

fits and expect them to be outgrown. Actually over fifty per cent. recover; but the fit may recur in stress of circumstances or in senility and no doubt a heritage of weakness is entailed.

The horse that has several times run away or the clock that has slipped its escapement may easily be brought to the same misdemeanor again.

It is surprising that most parents, even among the educated, do not feel the need of studying how to rear the child. They expect them to grow, not as the calf grows, however, for the calf is fed with intelligence; not as the pet bird is fed, for the mother has a book of instructions how to feed him; not even as a plant grows, for this must be handled by an experienced hand with pretty rigid rules; but just to grow anyway.

The account given by parents of the initial fit is always very interesting. Some seem perfectly inexplicable, as if a stroke of lightning had fallen out of a clear sky. All the circumstances may be of the best and the greatest intelligence has been shown. The infrequent failures under good conditions must be attributed to causes outside of our immediate control.

Such a recital as this is common.

The child fell on the back of his head, turned very pale, became rigid for an instant, then fully recovered; a soft place on the back of the head persisted for a week or two. The child has now attained adult years and is perfectly well.

In many instances the first fit has occurred at night when the child had risen to go to the stool. Often close questioning reveals an injudicious evening meal; but many times nothing of this sort is elicited.

The prognosis should not be too hopeful in any of these cases. The parents should be impressed with the importance of the matter and made to realize the need of their constant, permanent, painstaking, self-sacrificing oversight in the hope of aborting the disease.

Overstimulating food, hurried meals, pepper, salt, vinegar, etc., when none is needed, clothing too heavy or too light,

irregular hours of sleep, sleeping in a noisy or close room, or in a tobacco smoke atmosphere, and every namable kind of indiscreet and unsuitable condition at some time or other has prevailed. Thousands of such burdens are safely carried off by suffering children; but all such influences should be eliminated.

The parents' occupation should be in rearing their children, not in incessant struggle to get for them, for themselves, and an exacting irrational household things that none of them really want or need. We cannot sufficiently reorganize society to see much light in this direction.

Every case of epilepsy should be carefully examined, and all conditions that are unfavorable should be recognized and improved as far as possible. It is unnecessary to mention all the reflex conditions to which have been attributed undue influences in keeping up the fits. These conditions have weight and ought to be recognized by the attending physician. They are not often very potent causes.

There is a popular notion that a large number of cases of epilepsy are precipitated by the constant presence of intestinal parasites, especially the tapeworm. After careful investigation in a considerable number of cases we have failed to establish the presence of these parasites in a single case.

A large percentage of the cases under hospital care, who conform to the regular life and diet, who keep fairly sweet in temper and reasonable in their expectations, cease to have fits for months and years if they remain. Twenty per cent. of our cases do as well as this, and may properly be classed as recoveries so long as they remain at the hospital.

As a matter of fact, we do not so classify them as most of them go home against advice and under old conditions relapse. They then come back to us and are with difficulty restored to their old standing.

One would think that to remain at the hospital free from the terrible convulsions would be preferred to suffering them at home; but this is not usually the choice.

A few do get fully well after a few years of treatment and these constitute quite a hopeful percentage of cases that go as far as to become hospital residents.

Of the other cases, confirmed, established, and with positive dementia, all are practically incurable.

Recovery from epilepsy does not mean restoration to normal mentality in cases where defects of mind are the prominent feature.

To prevent epilepsy is ideal; but to realize this ideal would involve correct living, and correct living means the solution of all the social, political, and individual problems.

The frequency of the fits can in many instances be lessened by the administration of bromides, and this, combined with intelligent care in every detail, is unquestionably the best known treatment, if medicine is a real demand.

Often, however, when the fits are not fully controlled, these that do occur are harder.

When this remedy is purchased under its many disguises from the patent medicine vender or the advertising mercenary, the use is unrestricted, the mind does not improve, and great harm is done, unless the disorder is limited.

The fact that many cases recover while taking such remedies, and remain well for many years, is not contradictory to this opinion. It is humiliating to acknowledge that scarcely better final outcome is realized when the medical direction of strictly honorable and educated men is followed; but we do then have conscientious effort made and in the long run this will yield its just results.

General nutrition is almost always worse with the remedy than without, and of the recoveries attributed to the use of bromide many may easily be due to natural resistance, wise instruction, and consequent good habits of the patient. I believe there are hundreds of such cases recovering every year.

The ideal plan to my mind would be to so control the patient in all his habits and surroundings, that we would feel that frequent administration of drugs to reduce nerve irrita-

bility is superfluous, a state of affairs not likely to soon prevail.

The correct home treatment is easily outlined, but far beyond attainment.

1. Every care possible to prevent the onset; but after the trouble has appeared then:
2. The continued oversight of faithful, intelligent parents.
3. Methodical living.
4. Perfect diet and mastication.
5. Going to bed early in a cool, quiet room.
6. Clean bowels and bladder.
7. Every hygienic measure that intelligence dictates but no mere fads.
8. Little or no medicine.
9. Self-restraint.
10. Regular occupation and suitable study.

This is not brilliant, and will not cause great though short-lived enthusiasm in the parents; but it is honest, and the final results are the best that can be attained. All the children that can be saved will be saved by approximating this simple method or its equivalent.

To sum up all that seems to me most vital to a comprehension or the prophylaxis, etiology, and care, I believe the following to be true: Evolutionary status of the developed animal, as it has existed during many thousand years, accounts for the extreme liability to the occurrence of convulsions. Sin and its relics, shortlived as compared to evolutionary periods, have fleeting effects; but direful though they are, a few hundred years obliterates the most of them in any particular instance and evolution marches on, carrying to its culmination the perfect man, a physical and psychical development evolved to a hair-trigger balance.

“The dynamo-pregnant nerve centre” and the easily deranged, though still wonderfully tolerant aggregation of bodily cells, furnish the key to our problem, one that we can never hope to fully control until Utopia is reached.

The most promising outlook on our wide though far distant

horizon is that prevention should be ultimately possible in that the child should be made capable of withstanding unfavorable environment, should be indifferent to it, or incapable by reason of his inheritance of participating in the wrong, from the fact that he has been conceived in love and reared in intelligence.

URINARY INDICATIONS FOR SURGICAL INTERFERENCE.

BY S. H. BLODGETT, M.D., BOSTON, MASS., SPECIALIST IN RENAL DISEASES;
MASSACHUSETTS HOMŒOPATHIC HOSPITAL.

I shall speak of this subject first from the point of view of the obstetrician (and under that term I include all practitioners who attend confinement cases), as undoubtedly this part of the subject will appeal to the larger number of you.

The principal unfavorable occurrence that we try to foresee and to prevent is what we call uremic convulsions; but as you all know it is now well recognized that the convulsions are not caused by the retention of the urea itself in the system. In fact just what does cause the convulsions is not definitely known.

The theory that seems to me most easily to accord with the facts is that some toxin is developed in the blood which causes after a time the familiar symptoms. However, until the cause is definitely known let us go on the supposition that convulsions do occur, and that in those cases the mortality is at least fifty per cent. to the mother, and when the prodromal symptoms have been of some weeks' duration the proportion of living children is very slight. On the other hand my experience has been that where the toxins (let us say) have been present in the circulation for only a short time before convulsions occur, the chance for the child is better, but for the mother is worse. In other words, the cases of convulsions that occur without any prodromal urinary indications are almost certainly fatal to the mother but not nearly

so fatal to the child; while when there are prodromal urinary indications the chances of the mother are about fifty per cent., if allowed to go on to convulsions, but the chances of a living child are almost *nil*, depending on how long before term the urinary prodroma began. And I think we can safely say that if urinary prodroma occurs before the end of the eighth month, and especially if there are in addition to these clinical symptoms that we ought to consider,—shall we interfere and lose the child and save the mother in ninety-five per cent. of the cases, or shall we wait and almost certainly lose the child and save the mother in only fifty per cent. of the cases? Remember another thing; every hour's delay after clinical symptoms arise is reducing the chances of both the child and mother.

Now I do not wish to be thought to be counseling interference in pregnancy and the induction of labor from a simple urinary examination, for when the urinary examination begins to show danger ahead frequently diet, hygiene, and medicine will right the trouble, but in spite of all our care the danger signals become more numerous, then, I think, interference is not only justified but our plain duty, just as much as though we were guiding a blind man along a mountain and although we plainly saw a precipice towards which he was walking, we allowed him to walk over it because there was only half a chance it would kill him.

Perhaps I ought to ask your pardon for speaking so at length on this part of the subject, but this question has been forcibly brought home to me during the past two years by the outcome of four cases where I earnestly advised the induction of labor from the urinary indications.

In one of these cases, after two weeks waiting, labor was induced with the loss of both the mother and child. The other three were allowed to go on to natural labor, with the result that the children were all stillborn; one mother did not have convulsions, but the other two did, and one of them died.

Of course you all know that there is less excretion of urea

during pregnancy than in the normal adult, and I want it distinctly understood that I only use the excretion of urea as *one* of the indications (but perhaps the most important). When if the diet is liberal and contains the usual amount of nitrogenous elements, and the patient has a fair appetite, if the urea excretion is less than twelve gms. daily for a continuous number of days the excretory action of the kidneys ought to be attended to by diet, hygiene, and medicines, and in certain cases by the use of the high frequency current. If the urea persistently falls to ten gms. or so per day and the albumen increases, and especially if the chlorine begins to be low (three to six gms.) then the termination of labor ought to be seriously considered, and if there should be any clinical symptoms pointing to poisoning by ptomaines, labor ought to be terminated at once.

Another point to remember, that a woman with a bad urine (if I may use the term), passing 1500 to 3000 c.c. per day, stands a better chance of getting through than one having the same analysis but only passing 600 to 1200 c.c. per day.

When you get a case like this (of a "bad" analysis with a subnormal amount of urine) you will of course try to increase the amount of urine she is passing by giving her liquids, etc.; but if after doing this you find that the total amount of urine passed only increases slightly and not at all in proportion to the amount of liquids given, then look out. There is a strong indication of trouble ahead and ought to make you think of terminating labor at once.

To put it shortly, if you have a "bad" analysis of the urine and the amount is, say, below 1200 c.c. per day, there is not as good an outlook for the successful termination of labor as if you have the same analysis, but the amount is over 1500 c.c. per day. And if in the first case you try to increase the amount of urine by giving liquids and there is not an increase proportional to the liquids given, it is a strong added indication for interference.

When the albumen gets to five to eight per cent. bulk the

case ought to be watched carefully, and if the albumen increases, and especially if in addition chlorine decreases then interference ought to be considered. However, if the amount of urine keeps normal or above, and the urea and chlorine excretion remain approximately normal, although the albumen may get to ten to fifteen per cent. by bulk, the patient will probably go to full term and not have convulsions, but with an amount of albumen of anything like this a constant watch should be kept of the total amount of urine and the elimination of urea and chlorine, and if these begin to decrease below the danger line it is time to interfere.

Sugar in the urine of pregnant women is not a cause for alarm especially if in moderate amounts, say ten to fifty gms. daily, but if with the sugar, acetone, and diacetic acid appear in appreciable amounts and do not disappear by treatment (unless the patient is very near full term), pregnancy ought to be terminated. I do not consider that a pregnant woman in apparently good health is at all harmed if she is eliminating a little sugar daily, and I do not advise a diet strict enough to cause the sugar to disappear, for I have seen cases where the strictness of the diet in cases of pregnant glycosuria has caused more harm to the mother and especially to the child than a more liberal diet and the appearance of a few grammes of sugar in the urine; but when acetone and diacetic acid appear it is different.

I might mention in this connection a case which to me at least presented some unusual features as far as the analysis of the urine went. It was a case of pregnancy about the fourth month, when sugar, acetone, and diacetic acid were present in the urine. The rest of the urinary examination was very good. The pregnancy was complicated by multiple fibroids. By diet and care the sugar entirely disappeared, but the acetone and diacetic acid were present almost every day. Pregnancy was terminated after some deliberation, and after a moderate convalescence the urinary examination failed to show sugar, acetone, or diacetic acid, and after a time the

patient was so well that an operation was performed by Dr. Horace Packard, and the fibroids enucleated. I am interested to see if the woman should become again pregnant whether the old urinary symptoms will then return, or whether the fibroid complication had something to do with the abnormal elements in the urine, and the next pregnancy will be normal as far as the urinary examinations are concerned.

It might not be out of place here to speak of the routine as far as the uranalysis is concerned, in the case of all patients applying for treatment at the Maternity Department of the Homœopathic Hospital. When a patient applies she is told in addition to the regular directions to bring once each month a sample of the mixed and measured twenty-four hour amount of urine, and during the latter part of pregnancy she is required to bring a specimen each two weeks, the specimens being sent at once to our laboratory. To show how well these directions are carried out I might say that we have made during the past year over seven hundred analyses of urine from cases of pregnancy.

If any abnormality appears in any examination of the urine the patient is advised regarding treatment at home, and if anything alarming appears the patient is ordered to come in to the Maternity, where the diet and treatment may be carefully watched and the urinary examination made daily by us. Then, in considering the question of interference, it is known just how much of each class of food the patient has taken and be able to form an accurate judgment from the analysis which we have made.

In the early months of pregnancy, when there is excessive vomiting, the urinary examination will be your most reliable indication whether the patient is being properly nourished, and here your decision whether to induce labor or not will be governed almost entirely by the story told by the urinary examination. In these cases, if the excretion of urea is persistently below three to five grammes daily, and especially if it does not improve but rather becomes less, induction of

labor ought to be undertaken at once before the patient gets into a state of starvation and then succumbs to the operation.

And here let me remind you in all your cases of pregnancy to individualize each case and to consider the symptoms and urinary analysis of each by itself, and also to take into account the amount and kind of food the patient is consuming and the amount of exercise that is being taken.

After sending the title of this paper to your chairman, I realized that I should not be able to cover the whole subject in the limited time at my command so I shall confine the rest of my remarks to the subject of chronic enlargement of the prostate. These cases, as you know by your own experience, are the *bete noir* not only of the physician but also of the afflicted patient. Occurring as they do usually after sixty years of age, when the patient's powers of resistance are weakened and the kidneys often secondarily affected, the urinary examination does not indicate so clearly when to operate as when *not* to operate. And what few words I may say on the subject of enlarged prostate will be along the line of when it is *not* safe to operate, in the operable cases leaving the decision as to the particular operation to be performed to the judgment of the surgeon.

First, in the line of general remarks, I would like to impress on you, if the patient's urine contains none or only a very slight amount of pus, be very cautious about introducing a catheter or any other instrument inside of the sphincter, as often I have seen cases of so-called urethral fever and later an infected urine follow the introduction of instruments into the bladder, even where the operator had been very careful, and I have often noticed that urethral fever is much more apt to follow in cases where the urine is practically free from pus than in cases where, as the saying is, the urine was loaded with pus.

A rectal examination will usually tell you whether you have to do with an enlarged prostate, and then the urinary examination will tell you whether the case is suitable for opera-

tion or whether only palliative measures must be relied on during the patient's life.

If, from the examination of the urine, you find evidence that the trouble has seriously involved the kidneys you must try by the catheter and the other palliatives to make your patient comfortable.

When you find evidence of pyelitis and in addition an inability of the kidneys to eliminate solids properly, operation is contraindicated, and it is in this class of cases where cryoscopy (finding the freezing point of urine) is most useful.

When the patient is eating a good generous diet and the freezing point is 1° or above, the danger of an operation should be carefully considered. I think from my experience that in cases of enlarged prostate occurring as it does in elderly men, we can operate at a little higher freezing point than in other conditions in perhaps younger patients.

I have seen cases of this sort where repeated examinations failed to show any casts but the elimination of solids was very low, even when the patient was put on a forced diet. These cases will not do well if any serious operation is performed for the relief of the prostatic trouble.

Another class of cases are those where, although perhaps a fair elimination of solids is taking place, the presence of renal albumen and hyaline and granular casts make us very fearful about performing a serious operation on the urinary tract. In this class of cases a urinary analysis that would not preclude an operation in any other part of the body might be a contraindication for an operation on the prostate.

The presence of sugar, which, however, is a very rare complication in the urine (unless it is easily removed), ought to contraindicate any prostatic operation except the Bottini.

Another complication, and perhaps the most frequent one in this class of cases, that frequently ought to be considered a contraindication for operation, is a chronic cystitis, where the urine is alkaline or only feebly acid, where there is considerable mucus in the urine, large amounts of pus and usually also amorphous phosphates.

I wish here to emphasize the fact that I am not now speaking of cases which show a kidney complication, or at most only a very slight one, but only those showing the infected bladder sequelae of enlarged prostate. In these cases if the surgeon will by suitable treatment, both local and medical, get the bladder into a comparatively healthy condition before he performs any operation, he will find that he gets more recoveries and also a shorter convalescence. This point is, I find, almost invariably overlooked by the surgeon who seems to think that he can perform a prostatectomy, without any previous bladder treatment, on a case where the bladder is in the condition I have mentioned, depending on a thorough treatment of the bladder by irrigation at the time of the operation. But cases will not do nearly as well under this treatment as if proper treatment had been applied until the bladder was in a comparatively healthy condition, and then the operation had been performed. And perhaps I may add a word here about the various antiseptics which are given by the mouth for their influence on the bladder. I refer to the class of drugs that are supposed to set free formalin in the urinary tract, as cystogen, urotropin, etc.

I have repeatedly seen cases both at the hospital and in consultation where these so-called antiseptics had been freely used with no apparent beneficial effect; and on the other hand I have seen some cases that have improved while they were being used. I have also seen several cases where a hyperemia of the kidney disappeared after discontinuing their use, and one case where after seven days' use of ten grains t.i.d. of urotropin the urinary sediment showed tubule cells, hyaline casts, some of them with a cell or two adherent, an occasional blood disk and the slightest possible trace of albumen; and in ten days after discontinuing the medicine the urine had returned to normal. This case was not one of any urinary trouble and the urotropin was given to see if it had any effect on the kidney. And I also wish to emphasize the fact that it was only one case, and that I do not claim is enough to draw definite conclusions from.

I hope you will pardon me from thus digressing from my subject, but as this class of drugs is now frequently used on this particular class of cases I want to caution you to be careful in their use.

And in conclusion I want to impress on you the fact that according to Watson's latest figures about thirty-three per cent. or one third of all the deaths following prostatic operation for enlarged prostate are due to anemia or renal insufficiency, and that most of these cases could have been saved the operation; and so, perhaps, a longer life, if a proper prognosis as to the advisability of an operation had been made from a competent urinary analysis and a proper interpretation of that analysis.

SOME FACTORS WHICH SHOULD INFLUENCE OUR DIAGNOSIS IN TUMORS OF THE MAMMARY GLANDS.

BY EDGAR A. FISHER, M.D., WORCESTER, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

I cannot better introduce my subject than by an illustration which is very fresh in my memory. I have here a portion of the pathological findings from a P.M. made last month. You will see that the breast, which is the left one, is the seat of a tumor at the inner lower quadrant. The tumor is not large, but the axilla is matted, and there is infiltration of the underlying muscles and of the mediastinal glands. In addition to these purely local manifestations there was present a general carcinosis. There were areas of infiltrated skin over the whole body. The bronchial glands were infected and the liver was studded with nodules. Even the heart had spots of infection. The spleen is a mass of carcinomatous tissue, the mesenteric glands were involved and the pylorus was contracted. The patient when she died was fifty-six years old. The tumor was first noticed when she was a girl, perhaps

forty years ago; but it did not grow perceptibly until four months ago.

The history is interesting. Nearly one year ago the patient had an acute attack of rheumatism. After various parts of the body had been occupied it finally settled in the right leg in the form of a typical sciatica with excruciating pain; but with frequent remissions.

The other leg during the last months of life was also the seat of pain. Locomotion was difficult both from pain and because of a certain amount of ataxia. The legs felt numb. Digestion was greatly interfered with, and flatulence and vomiting were common, and for some weeks before her death constant.

You will notice that during at least eight months of the illness there were no local symptoms of the general carcinosis present. So far as one could see it was simply an aggravated case of neuritis, though we were on the alert for evidence of malignant involvement, because a sister had died a few years ago of cancer, and because of a knowledge of Osler's case of spinal metastasis where sciatica was for months the only symptom. Suspicion was still further aroused by the entire absence of results from medication.

In October when the nodule in the breast was reluctantly brought to my attention the patient was in no condition to stand operation, even if its futility had not been so apparent, though even at that time the tumor was but half its present size and there was no appreciable involvement of the glands.

In contrast to this case is one operated on for Dr. Nichols in December. About a year ago this patient was struck in the breast by a child. Tenderness developed and soon a small nodule could be felt. This grew rapidly, and when operated on (within four days of her first visit to Dr. Nichols) was as large as the crown of a derby hat; for the most part hard and nodular but with several large cystic areas around the nipple. The diagnosis of cysto-sarcoma was confirmed microscopically by Dr. Wetherbee. The operation was a wide enucleation,

but the axilla was not invaded as these growths recur by metastasis and not by lymphatic extension. Two cases could hardly present more divergent history than these, yet it is not by such problems that the surgeon's prognostic-ability is put to its severest test. He has to reckon with the so-called benign mammary growths which are very largely responsible for our low percentage of cures from operation for cancer of the breast. They furnish the excuse for delayed operation, for the precious time lost while the complacent doctor waits for unmistakable signs of malignancy, for those symptoms which really show that the growth has ceased to be a local affair; for with glandular involvement, fixation of the tumor and retraction of the nipple the disease, in a great majority of cases, is so widely disseminated that it is certainly incurable. With this well proven and definite fact before him, how can any conscientious man, in order to avoid so simple an operation as the removal of a small benign growth counsel the procrastination which may result in a death so dreadful! With a good technic the procedure is free from danger, the resulting scar will be almost invisible, and the breast will show no evidence of mutilation. The character of the tumor removed should be definitely determined by the microscope, and if found malignant a more extensive operation should be instituted at once.

Our prognosis then in regard to tumors of the breast is influenced more by an early or late operation than by any other factor; upon whether the surgeon is equal to the great responsibility and worthy of the confidence placed in him.

We must face the fact that no man can unequivocally state whether a mammary growth is benign or malignant when it first appears, and that in most cases it is criminal neglect to wait until a diagnosis can be made without the microscope. Maurice Richardson says: "The uncertainty of the diagnosis even on the part of the most skilful makes palliative treatment hazardous. Neoplasms wherever situated should, if possible, be removed, whatever their apparent nature."

The danger of delay is shown by Guleke, who in 884 cases of cancer of the breast, a sufficiently large number to give fair averages, found that the average time after discovery of the tumor for adhesions of skin to occur was twelve months, axillary glands involved in 11.8 months. Ulceration in 13.7 months. Gabele, speaking from the great experience of the Munich clinic, says: "Lasting cure is not to be looked for simply in a radical operation, but in early diagnosis and early operation as well as radical operation."

The radical operation, the operation of Halsted, is certainly another factor in our prognosis. The anatomical and pathological studies of the last few years have made known the wide distribution of the lymphatic connections of the breast and demonstrated the necessity for extensive dissection. Halsted insists that an incision which leaves skin enough to close the wound is not safe and he invariably closes with skin grafts.

The best surgeons all over the world are united in demanding for all favorable cases: the removal of a wide margin of skin, the axillary glands, and the pectoral fascia and muscles, and in some cases the clavicular glands. Douglas Drew (*British Medical Journal*) is in accord with this view when he says: "It makes little difference in the usefulness of the arm whether the pectorals are taken or not. In average cases recurrence in less than two years means bad work."

One who has not seen the results after one of these radical operations is prepared to find the patient with a useless arm or at best a very weak one; but strangely enough the loss of the pectoral muscles does not greatly increase the trouble, which inevitably follows the injury done the nerves in even a careful dissection of the axilla. A few years ago I saw over a score of working women who had been operated on by Halsted, from one to eight years previously. All were able to carry on their usual work without trouble; and had very little limitation of motion.

Halsted reports 341 patients operated between 1889 and 1902, with forty-seven per cent. well after three years. While

at the Heidelberg clinic, where only the gland is removed, unless the axilla shows infiltration, Mahler reports in 1900 (*Annals of Surgery*) one hundred and fifty cases, with twenty per cent. cured after three years. Fourteen per cent. remaining well after five years.

The difference between this twenty-one per cent. and forty-seven per cent. must be due to the greater thoroughness of the operation as performed at Johns Hopkins, for poor surgery would not be possible under so famous a man as Czerney of Heidelberg (Chevounetz formerly had local recurrences in from forty-five per cent. to sixty-nine per cent., while the later results with the radical operation have shown only eighteen per cent.).

In closing this brief paper I wish to urge upon your acceptance three propositions, the crux of what I have written:

1. Cancer in its beginning is a local affair and its prognosis is in our hands; but its capacity for wide and rapid extension is limitless—therefore it should be removed at the earliest possible moment after its discovery.

2. In this its favorable stage it can not be differentiated clinically from a benign growth—therefore all mammary growths removed in this stage should be submitted to the microscope at once, for a positive diagnosis.

3. In cancer of the breast there is likely to be lymphatic involvement which is only microscopically visible—therefore given a diagnosis of cancer, the extensive operation of Halsted is invariably demanded.

From a careful study of the literature of the subject, I am sure that to-day it would be difficult to find a surgeon of merit and experience who would materially modify this statement, though the future doubtless has a better solution of the problem in store for us.

NOTES.

Butline. St. Bartholomew Hospital Record, 1901: "The motility of the arm (after Halsted operation) is as good as

or better than after one of the old operations depending not on removal of muscle but on wide removal of integument."

Abbe, *Medical Record*, Dec. 31, 1904, regarding the principles of local origin, and value of wide removal, says: "We cannot lay too much stress upon their importance, but I will say but a word to deprecate the fact that there are still constantly presented to the surgeons to-day many cases operated on by men who do but little surgery and allow themselves to remove small mammary tumors without taking away the breast, or to amputate the breast without excising the lymphatics of the axilla, or pectoral muscles, or if these are done with a show of thoroughness, then to incise the skin near the tumor within the margin of safety, so as to make easy suture of the skin possible, paying more attention to cosmetic effects than justified."

CURATIVE RESULTS OF THE MASSACHUSETTS STATE HOSPITALS IN 1904.

BY ARTHUR BLAKESLEE, WESTBORO, MASS.

In reviewing each institution in their report for 1904 the State Board of Insanity give rates of recovery in several ways. Averages are given for six hospitals (including that of Boston) and for the state. Brought together the rates for the state hospitals by the first way are as follows:

Recoveries to all insane commitments:

Westboro 21.91	Taunton 13.03
Worcester 16.83	Danvers 8.05
Northampton 7.50	

Another method excludes the "cases of mental deficiency, senile insanity, general paralysis, organic brain disease, and epileptic insanity" resulting as below:

Recoveries to insane commitments less five forms:

Westboro 32.77	Taunton 18.09
Worcester 22.86	Danvers 14.00
Northampton 11.15	

Two methods make the rates upon "all insane persons within the year" and on the "average daily number of the insane."

Recoveries to all insane persons within the year:

Worcester	7.99	Taunton	3.87
Westboro	6.54	Danvers	2.62
Northampton	2.50		

Recoveries to average daily number of insane:

Worcester	12.45	Taunton	6.12
Westboro	9.66	Danvers	4.06
Northampton	3.68		

These compute largely upon the unrecoverable, on the bulk of patients who for hope of cure are much like those in the asylums. At the Worcester Asylum and at Medfield 2,338 were cared for and treated in the last year, and only two recovered.

First admissions to any hospital are now divided from the others (the recurrent), the first forming more than two thirds of all.

Recoveries to first admissions less five forms:

Westboro	37.78	Taunton	18.97
Worcester	25.78	Northampton	12.49
Danvers	12.08		

For Westboro a remarkable record is seen of first admission recoveries from the manic-depressive.

Recoveries from manic-depressive of first admissions:

	Cases	Recoveries	Percentages
Westboro	45	42	93.33
Taunton	20	12	60.00
Worcester	45	16	35.56
Northampton	48	11	22.92
Danvers	57	9	15.79

For the alcoholic the proportions are very different.

Recoveries from alcoholic insanity of first admissions:

	Cases	Recoveries	Percentages
Taunton	31	20	64.52
Worcester	98	43	43.90
Westboro	30	10	33.33
Northampton	31	9	29.00
Danvers	69	18	26.09

Two hospitals divide the alcoholic into acute and chronic. Taunton gives 21 acute with 17 recoveries, Northampton 10 and 9 recovered.

In the admissions 615 (468 in 1903) were of dementia praecox, only 22 recovering. Worcester hospital received 147 of them and 12 recovered; Westboro 74 with 10.

Of the manic-depressive with the subheads of manic, manic-delirious, depressed and mixed, 374 with 144 recoveries.

Of alcoholic insanity, 345, recovered 121; of senile insanity, 280, recovered, none; of general paralysis, 203, recovered, 1; of mental deficiency, 175, recovered, none; of epileptic insanity, 81, recovered, none; of organic brain disease, 78, recovered, none; of paranoia, 64, recovered, none; of paranoic condition, 52, recovered, 2. Many others were of smaller numbers.

Of the classified insane 2,549 were admitted. In addition, of habitual drunkards, not now included with the insane, there were 30, of the voluntary 29 (25 of them at Westboro) and 8 others who were not insane. Also 74 were not diagnosed and at Northampton 40 were "committed but not admitted" (remaining at almshouses).

Voluntary commitment: During the last ten years, as told in the Board report by "this liberal and more considerate way," Westboro hospital has received 218, Danvers 27, Northampton 18, Taunton 6, and Worcester none. At McLean hospital, having less than 200 patients, 615 were so received in the same time. Last year 46.80 per cent. of the admissions there were voluntary, four of them being held later by court process.

By law the voluntary must be of those to whom it would not

be "legal to grant a certificate of insanity." The Board say that many others are "entirely competent to give consent to treatment in a hospital." They recommend legislation to prevent for such mentally disordered patients "unnecessary hardship, needless humiliation, and useless expense."

Now also the indigent cannot be voluntary. Nearly seven eighths of the state hospital inmates are public charges. With only the check of a required State Board permit for each one the Board would have the poor admitted voluntarily.

Several other proposals for legislation are made and there is a discussion upon whether certain of the moderately insane could be favorably treated at the local general hospitals.

The report is one of unusual interest.

GONORRHEAL RHEUMATISM.—Gonorrhœal rheumatism is a distinct disease, uniform and directly the result of a gonorrhœal infection, the germs of which colonize around the joints, and like inflammatory rheumatism, very little can be done for it by internal medications. Of the various local applications only a few seem to be of benefit. Cold seems to do more good than heat; massage and the application of liniments are useless. The application of electricity, either faradic or static, increases the irritability of joints, and those which have been immobilized by splints are generally about as bad when taken out as when put up. A liberal application of antiphlogistine, however, I believe to be of benefit when a joint first becomes affected, and many times I have seen them not only soothed, but permanently relieved in a few days by it; like all other remedies, however, it has its stage and soon loses its efficacy, after which painting, with equal parts of ether, ichthyol and colodion, seem to continue the improvement.

Southern Medicine.

EDITORIAL.

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THE BRIGHAM HOSPITAL AND THE NEEDS OF THE PROFESSION.

The timely appeal of Dr. Sutherland at the recent meeting of the Massachusetts Homœopathic Medical Society, for early and insistent action on the part of the homœopathic body for an equitable representation in the wards of the Brigham Hospital after it shall have been completed, brings up a matter calling for the most earnest consideration.

In the creation, and especially in the conducting, of a new hospital by means of sums left with the purpose of relieving suffering and restoring health, there is an implied purpose on the part of the founder which the executors of his will cannot disregard, that is, the higher purpose of searching for the best methods of treatment. This is now recognized the world over as the scientific and practical aim, indeed, as the most important function of a well-equipped and well-endowed hospital, and as such it imposes upon those having the matter in charge the duty of establishing on a firm and rigidly scientific foundation a highly developed system of clinical research directed towards every quarter from which advantage may be reasonably expected. This reasonable expectation, this demand for unprejudiced inquiry is the point on the proper view of which all genuine progress depends, and the quarters

towards which it must look are to be determined on wider conceptions of the scope and aim of therapeutics than those current in the circles which claim to be the sole representations of scientific medicine. There are fields of investigation and experience which these representatives have persistently ignored, but which have established claims for recognition of a very different character from those of the evanescent systems and practices arising out of lay philosophy, mere empiricism or any other matrix of pathies and isms. Among these fields of labor, the chiefest is that of Homœopathy, which for a century has knocked at the doors of institutions in the lands of authoritative medicine, with no other result than that of a flat denial of its claims. It is true—and to the glory of American traditions be it said—that in this country Homœopathy has effected an entrance into the walls of many hospitals to the undeniable advantage of progressive thought and action, but into the minds of those who have opposed its admission and who still refuse to investigate its principles it has not penetrated. By its own inherent vitality, not by the grace, either of popular superstition and ignorance or of favors from above, it has resisted successfully every form of opposition such as ridicule, contempt, social ostracism, and polemical discussion, the most strongly entrenched conservatism would bring to bear. It has outlived, nay, lived down every calumny heaped upon it and survived even that most potent of all modes of antagonism, the attempt to kill by silence, and having grown and developed along its own lines into a quantity no longer negligible it comes forward once more with the demand to be heard.

That this demand arises from no other motives than those by which all scientific effort is inspired, is evident from the fact that homœopaths ask to have their method tested side by side with every other found worthy of rigid investigation, and ask neither for favors nor for other rules of procedure than those devised for clinical research in its purest and most fruitful form.

But another and more comprehensive demand presents itself with the opening of a new hospital. It is not the demand for the investigation of Homœopathy alone that is put forward. The time has arrived for the systematic investigation of all therapeutic methods having a strong hold upon public confidence. The laity must no longer be asked to exercise its common sense on questions as difficult as those pertaining to the cure of disease, or to determine which systems, schools, or methods shall receive legislative favors. For twenty-five centuries therapeutics has been the sport of theorists and pretenders, regular and irregular, of conjectures, subjective opinion, conflicting assumptions founded on unverified and unsifted experience. It has been an art without canons, guided by neither rules nor principles. Nowhere have means been sought to control observation or to elaborate forms of trustworthy record, no course pointed out for the reconciliation of discordant opinions and practices. Confusion and uncertainty still characterize the therapeutics of internal diseases to a degree scarcely less discreditable to the profession than that reached in the days before the advances in the auxiliary sciences and surgery of which men may well be proud. Societies for clinical research have been founded and individuals have labored in the most self-sacrificing spirit for the elucidation of single questions, but their efforts have been directed mainly towards the solution of pathological problems, as the transactions of the societies and the journals devoted to clinical medicine abundantly testify. On the results thus achieved, and on these alone, rests the optimism which airs itself annually or centennially, as though the possibilities of therapeutics had been exhausted, in addresses before medical congresses and greater or lesser associations, bringing that flattering unction to the souls of practitioners which their daily experience does not afford, and from which the suffering public would gladly accept comfort but for the pain and loss before which they see the best standing helpless. With all the advances in the sciences

bearing directly or indirectly on therapeutics, this remains without scientific status, as every candid mind must confess, and which will be denied only by those who rest securely in their "regularity" or who believe implicitly in the all-sufficiency of their unaided powers of observation.

What plans may be maturing for the character, aims, and organization of the Brigham Hospital we are not informed, but it is devoutly to be wished that the suggestions of Dr. Harold Ernst, in his address before the meeting of the Massachusetts Medical Society, may prevail, to institute at an early day a method of clinical research along the lines of comparative therapeutics. An opportunity now offers in Massachusetts, where above all other communities it should be seized, to take definite action towards reclaiming the profession from an undue and well-nigh barren conservatism, indeed from that peculiar aspect of so-called scientific therapeutics, out of which the manufacturing chemist alone reaps advantage. Here is the opportunity to show an earnest striving towards the reconciliation of apparently conflicting principles, to enlighten the public on medical matters in a manner never attempted throughout all medical history and to establish a court of last appeal for every rational therapeutic theory worthy of investigation, and for every school or system, which, having gained force sufficient to demand recognition at the hands of legislative bodies, asks for charters to teach to qualify practitioners or to found hospitals. Quackery and credulity can never be legislated or reasoned out of existence, but sane men may be enlightened by object lessons and influenced by witnessing well-considered, just, and properly-conducted methods of research.

The system, theory, or practice which should refuse to submit to a well-devised and continued test in an institution high above every suspicion of prejudice or partiality, could not complain of denied legislative recognition. But any clinical investigation into the merits of therapeutic measures should be under the most rigid surveillance of men whose

freedom from bias could not be questioned and whose judgment should be formed on data of observation and record open to the examination of all. In hospitals already established, such tests are not practicable, partly from reasons of expense, and partly from the nature of their organization. Men specially trained for exact observation and record are called for, and these should be so far removed from both the cares for daily bread and the conflict of schools that they could pursue their highly responsible and exacting labors through years in a manner and a spirit impossible in ordinary hospitals, much less in private practice.

The homœopathic branch of the profession, which may justly claim to have allied itself with every sound measure of public and of scientific advancement, is the last to shrink from such a test. Let these things be borne in mind and brought with due force to the notice of the executors of Mr. Brigham's will.

KALI IODATUM AND ASTHMA.—For asthma, kali iodatum has long and frequently been called into service as a remedial agent. In young people it is of special value for this disorder.

I have in mind two young boys subject to frequent severe attacks of this ailment. They had long been treated by the older school method and had doubtless been given this drug in large doses. The disease was thoroughly eradicated in both cases by infinitesimal doses in reasonable time.

The selection was made from the following symptoms: (1) one of the generalities of the drug, emaciation; (2) after these attacks there remained a cough, as though running into consumption; (3) early morning aggravation of the asthmatic attack; (4) the cool, a-febrile condition of the patient.

The American Physician.

BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

The semi-annual meeting of the Boston Homœopathic Medical Society was observed as Ladies' Night at the home of the president, Dr. J. Herbert Moore, 1339 Beacon Street, Brookline, on Friday evening, June 2.

Dr. Moore, his wife, and Mrs. Ruggles received the entering members and friends. After a social hour the company adjourned to a hall in the house where short addresses were made by Dr. Henry Spalding in behalf of the Institute membership, and Dr. Loring in regard to increasing the membership of the local society, preceding the address of the evening by Dr. Walter Wesselhoeft. This was an able and interesting paper, showing the doctor's perfect familiarity with the history and evolution of homœopathy as well as with the present status of affairs in the dominant school. A collation followed, and the meeting was then adjourned until fall.

DIET IN EXCESS OF URIC ACID.—In suggesting a dietary, we should advise that the total amount of meats be reduced and limited to "white" meats (veal, mutton, fowl, fish); the cellular organs (liver, kidneys, sweetbreads and brains) are now usually forbidden, out of regard to the above-mentioned views, as to the formation of uric acid. Milk and eggs may be allowed; fats and carbohydrates are to be freely given or diminished, according to the general nutrition of the patient. Green vegetables that are easily digested, such as spinach, salad, cauliflower, and asparagus, have long been regarded as especially suitable additions to the dietary. The most appropriate beverages are milk, tea, and water. In general we should not be too schematic and theoretical in our dietetic prescriptions, but should consider the individual. The quality of the food is of less importance than the quantity. By limiting the amount of food taken, we can possibly prevent very excessive formation of uric acid, and perhaps other baneful substances.—*Exchange.*

COLLABORATORS' DEPARTMENT.

Dr. Hal Foster in the *Laryngoscope*, April, 1905, reports a case of keratosis of the throat in a patient, aged forty, who consulted him in January, 1903. Six months before she complained of bad taste in the mouth, sweetish in nature, and constant tickling in the throat at the back of the tongue, which induced coughing. Examination of the nose revealed a chronic hypertrophic rhinitis. Large white spots of different sizes were seen over the tonsils, on both pillars of the fauces, the epiglottis, the base of the tongue, and the back of the pharynx. General health good aside from a mild anemia. Her previous treatment had consisted mainly of gargles and strong solutions of silver nitrate locally, which failed to benefit. The white spots projected far enough from the tissues to be easily removed by forceps. The slight bleeding following their removal was controlled by the application of a mild solution of chromic acid. A solution of permanganate of potash was given as a gargle every three hours. She made daily visits for about two months. Formalin and lysol were applied locally but the most effective treatment was the application of the actual cautery used after cocainization of the parts. Her throat has given her no further trouble.

Cases of pharyngeal-mycosis are frequently diagnosed as follicular tonsilitis and the author believes them to be much more common than formerly supposed. Cases of keratosis occur in middle life and are much more rare. Considerable time and careful attention to detail is necessary to bring about a cure.

G. B. R.

Dr. Lee Maidment Hurd in the *Annals of Otology, Rhinology and Laryngology*, March, 1905, reports a case of mycosis of the throat treated by the X-ray. J. R., aged thirty, male, consulted him in May, 1903, complaining of rawness and stiffness of the larynx and pharynx, worse in bad weather, with pain in the left ear, hoarseness, and a history of repeated attacks of acute laryngitis. About three months previous to his first

visit he noticed white tufts on the tonsils and post-pharyngeal wall. Examination revealed the presence of numerous tufts on the tonsils and post-pharyngeal wall; extending upward on the left side into the mouth of the Eustachian tube. The lingual tonsil was nearly covered with white patches and a few tufts were located on the aryteno-epiglottic fold of the larynx and extended to the false vocal bands on the left side.

Only the X-ray was used, at first ten-minute sittings twice a week for six weeks. The pain and discomfort diminished after the first few exposures, and after the fourth the smaller tufts became soft and could be easily wiped off with pledgets of cotton. The patient then went to the country for the summer and did not return until Sept. 30. The condition had remained stationary during this time. The X-ray treatment was again begun, ten-minute sittings three times a week, and by the end of November nearly all the spots had disappeared. The time between exposures was lengthened to twice a week and by the end of December no spots could be found. The tonsils and pharynx were directly exposed to the rays through a speculum. The lingual tonsils and larynx were treated with the rays from the outside through the tissues of the neck. Forty-one treatments of ten minutes each were given by means of a medium tube with a spark gap of about three inches. Most of the applications were made through the tissues of the neck. The patient has had no return of the mycosis and has been free from the attacks of laryngitis.

Dr. Hurd has only the one case to report which proves nothing, but he hopes to interest some of his colleagues to try the X-ray treatment in similar cases. The fact that the throat felt better after each exposure to the rays, and that it remained stationary during the time the treatments were discontinued led him to believe that the X-ray was the cause of the improvement.

G. B. R.

A very comprehensive and extremely interesting article by Dr. Chevalier Jackson is published in the April number of the

Laryngoscope on "Foreign Bodies in the Trachea, Bronchi, and Œsophagus. The aid of œsophagoscopy, bronchoscopy, and magnetism in their extraction." In the diagnosis and localization of foreign bodies, Dr. Jackson believes the Röntgen rays are of use in three ways: For diagnosis of the presence of the foreign body, to locate its exact position, and to enable the direction of instruments by observing the shadow of the instrument on the screen. A fluoroscopic negative report is dangerously unreliable. A negative should be made in each of two planes at right angles to each other.

The prognosis depends largely upon the location, whether œsophageal, tracheal, or bronchial, and upon the nature of the foreign body. In œsophagotomized cases it is good—far better than in cases where the œsophagus is only lacerated on removal of pointed objects. In tracheal and bronchial cases the prognosis is good with early removal, but if not seen early or if operative permission be refused the prognosis is bad. After twelve hours, in bronchial cases, the foreign body becomes buried in the swollen mucosa and there is little chance of escaping fatal abscesses, bronchitis, bronchopneumonia, and traumatic infective pneumonitis. Sharp bodies may, however, become encysted, or the body may slough loose and be coughed out into the trachea or larger bronchi. This sometimes causes laryngeal spasm which renders the prognosis bad in the absence of skilled aid.

In œsophagoscopy a local anesthetic may be used in adults, and the one important point in the technic of the operation is not to interfere with glottic respiration by the use of too large a tube.

Tracheoscopy and bronchoscopy may also be done under cocaine, but a general anesthetic is almost always necessary. The Rosén's position offers so many advantages over the others that the author has always used it. As between tracheoscopy and bronchoscopy *per vias naturales* and *per vulnerem trachealis*, the writer prefers the latter for several reasons. If in the trachea, and foreign body is quickly and

harmlessly removed without the danger of septic pneumonia, the operation can be aseptic while the method by mouth cannot. Again deep anesthesia is necessary by mouth and of course it must be chloroform. Profound chloroform narcosis, never a safe condition, especially if long continued, also adds a fresh element of danger in the abolition of the cough reflex. For these reasons tracheotomy under partial chloroform anesthesia is preferred with the patient in the inverted position. If this fails bronchoscopy is advised.

In magnetic extraction of foreign bodies four forms of magnets have been used. (a) Permanent magnets long enough for insertion into the trachea and bronchi. (b) Electro-magnets of small diameter but great length, to be passed bodily into the air passages. (c) A very powerful electro-magnet with a core extension. (d) A ring magnet, technically a solenoid, into which the inverted patient is bodily lowered, this being the one Dr. Jackson has devised.

The great trouble with magnetic extraction is the small size of the foreign body. Practically the magnetic force you can apply is in inverse ratio to the size of the foreign body, hence you must have either a small magnet closely approached to the foreign body, or a very large magnetic field. One great advantage is that the magnet will pull the free end of the foreign body, as a tack, while the point sticking into the tissues comes last, so no traumatism is inflicted.

For a magnet to be of service, it must be remembered that:

1. The body must be of iron or steel, partly or wholly.
2. The body must be free to move.
3. The attraction of the magnet for the foreign body is no greater than the body for the magnet, hence:
4. The probabilities of magnetic removal are inversely as the size of the foreign body, within the limits of size permitting mobility.
5. The magnetic force diminishes almost as the square of the distance, hence:
6. The location must be such that the core of the magnet

can be brought within reasonable distance of the foreign body. Therefore:

7. The magnet is of undoubted utility for magnetic bodies located in the trachea.

8. Prolongation of the core lessens only to a small degree the loss as the square of the distance, but to a limited extent is valuable if it enables contact.

9. Beyond contact the effective distance between foreign body and the magnet increases directly, as the size of the foreign body.

10. Magnets of small diameter for insertion bodily into the air passages can be made of only limited power because of the necessarily small area of core cross section.

11. By inversion of the patient, gravity may assist a weak magnetic action.

G. B. R.

In the *Semaine Medicale* for March 8, 1905, Cristiani reports as follows: "A woman, twenty-three years old, suffered from myxedema following a thyroidectomy. Liquid extract of the thyroid gland by ingestion produced only an amelioration of the symptoms. An excellent result was finally obtained by introducing, subcutaneously, through four incisions, a number of grafts taken from a healthy thyroid gland."

W. S.

In the *Presse Medicale* for March 4, 1905, Ferrier and Desjardins give the results of experiments with scopolamine as a general anesthetic. The advantages of this method of inducing general anesthesia are: Absence of operative apprehension and of the excitation which precedes muscular relaxation, absolute loss of consciousness and of memory, a prolonged sleep (eight or ten hours), absence of vomiting, nausea, or malaise, quietude of the patient who sleeps the following night without the aid of morphine, non-production of albuminuria, that it can be used in cases of tuberculosis, heart disease, and cachexia, and that the anesthesia persists for a long time after the patients have awakened from the sleep.

The disadvantages given are the uncertainty of its action, one patient going to sleep quietly and completely, another with difficulty and incompletely, so that a certain quantity of chloroform needs to be given in addition.

Second, a vaso-dilatation which renders very careful hemostasis necessary.

Third, a contraction of the abdominal walls which contraindicates the use of this method in abdominal operations.

As the use of scopolamine for general anesthesia has been denounced by some as dangerous to life, these authors analyze twelve fatal cases in which this drug was employed, reported by different surgeons, and try to show that death was due in each to other causes and not to the anesthetic. W. S.

In the *Reforma Medica* for March 4, 1905, Calivrai reports a case of resection of the liver in a woman thirty-six years of age for a malignant tumor of the right side of the organ. The symptoms were acute and resembled a septic cholecystitis and a gall-bladder operation was decided upon. On opening the abdomen a large, easily bleeding mass was presented, which was continuous with the liver and without a pedicle. The gall-bladder was normal in appearance, but was removed, and this procedure was followed by a resection of the tumor around which a rubber tube was placed tightly to control hemorrhage. The stump was surrounded by iodoform gauze and left in the upper part of the incision. The lower part of the incision was closed. The elastic ligature was removed in fifteen days, and as the stump contracted the gauze was withdrawn. The patient was finally discharged cured and the tumor was found to be a carcinoma derived from aberrant suprarenal glandular tissue. W. S.

In the *Boston Medical and Surgical Journal* for April 13, 1905, Drs. Lothrop and Scannell report "The results of treatment of cancer in and about the mouth at the Boston City Hospital."

These cases are taken from the records of the Boston City Hospital during the nine years from Jan. 1, 1895, to Dec. 31, 1903. In sixty-nine cases carcinoma of the tongue was found in thirty cases (43.47 per cent.); inferior maxilla in twenty-two (31.88 per cent.); superior maxilla in nine (13.04 per cent.) and tonsil and fauces in eight (11.59 per cent.).

After an interesting consideration of the many important points in connection with this interesting subject the report closed with the following conclusions:

1. The mortality of cases suffering from carcinoma in and about the buccal cavity (based on the statistics presented in this report) is extremely high, at least ninety per cent.

2. All unoperated cases die sooner or later of the disease, barring intercurrent affections.

3. The duration of life of operated cases as compared with those not operated is in favor of the former by an average of about three and one half months.

4. The comfort of the individual is distinctly added to (even if it be only temporary) by some sort of surgical intervention; such relief may be either mental or physical.

5. An early diagnosis of malignant disease about the buccal cavity is of the greatest importance, and a moderately radical excision of parts offers the greatest hope of a radical cure commensurate with the comfort of the patient and the immediate risk of life. We realize fully and appreciate the importance of a most radical excision of parts in and about the seat of malignant disease. We believe that, in general, such extremely radical measures offer the greatest hope of permanent cure. The surgical treatment of malignant disease situated in very many parts of the body should consist of most radical excision. On the other hand, malignant disease may be situated in and about certain parts where extreme radical excision is attended either with great immediate risk to life, or may so interfere with the function of the parts that the subsequent suffering and discomfort of the patient, provided he survive the operation, does not warrant such radical treat-

ment, in view of the great probability of recurrence. There are instances where the patient wishes extreme measures to be taken for the purpose of avoiding recurrence, and under such circumstances there is no objection to employing the most radical measures. We believe, however, that the risk and discomfort, together with the inability to offer much hope of non-recurrence, following the complete removal of the tongue, the inferior maxilla or more or less of the pharynx and larynx, should be weighed and carefully presented to the patient before such radical treatment is undertaken.

6. Where there is extensive invasion of the parts, excision (if done at all) should be undertaken solely with the idea of palliation, without too serious interference with physiological function and without too great immediate risk. W. S.

In the *Lancet* for April 15, 1905, Owen contributes a paper on "The Cure of Cancer," and in this article he takes a very conservative position, citing a case of apparent cure of cancer of the breast but stating that "no sign of return" is all a surgeon is justified in claiming after any operation for the removal of cancer, however successful the result may appear. W. S.

There was a very interesting paper by Pitt in the *Practitioner* for April, 1905, on "Some Obscure Cases of Cancer of the Stomach in which the Main Symptoms have been Unconnected with that Organ."

He records the fact that symptoms will vary according to the site of the growth. If it occurs at the pylorus there is usually distension, obstruction, and increased peristalsis. Vomiting, emaciation, and loss of appetite are usually present and the tumor, as a rule, may be felt. If the growth occurs in the body of the organ it may be felt, but there is no obstruction nor over-distension. The other symptoms, as enumerated above, are usually present, but the growth and symptoms may develop so gradually that a diagnosis is not made until the autopsy is performed. Several cases of this kind are reported

in which no gastric symptoms were recorded. They appeared to be: 1. Ascites and pleuritic effusion; 2. Matted intestine. 3. Intestinal obstruction. 4. Abdominal obstruction. 5. Profound anemia. 6. Iliac tumor. 7. Thrombosed veins. Pyrexia was present in several cases but was not a constant nor a prominent symptom. Edema occurred in several cases and perforation took place in two. There were no nodules of the skin or bones in any of the cases. W. S.

In the *Annals of Surgery* for March, 1905, Codman and Chase have a paper on "The Diagnosis and Treatment of Fracture of the Carpal Scaphoid and Dislocation of the Semilunar Bone."

After stating that this fracture and dislocation are much more frequent than has been thought possible heretofore, and that many cases have been mistaken for simple sprain and treated in such a manner that permanent disability has resulted, they advise a *good* skiagraph in every case, and draw the following conclusions as to the treatment of simple fracture of the scaphoid bone.

1. Cases which have not been treated or which have been treated as sprains, by a short period of fixation followed by massage, active and passive motion, seldom if ever have union of the fragments.
2. If the joint is kept fixed for a number of weeks immediately after the injury union may occur, but the functional result is not perfect, though better than in cases of non-union.
3. It is too late to obtain union if fixation is not attempted within a few weeks after the injury.
4. Excision of the proximal half of the broken scaphoid promises a better ultimate result than any other form of treatment.
5. In operation involving risk, a reasonable attempt should be made to obtain union by fixation, if the case is seen soon after the injury.
6. Operation should not be delayed many months, because secondary joint changes may occur and chronic arthritis result.
7. The advisability of operating in cases of long standing is doubtful, and must be decided by the amount of disability in each individual case."

W. S.

BOOKS AND READING.

Medical, literary and scientific publications will be reviewed in this department. Books and journals should be marked *NEW ENGLAND MEDICAL GAZETTE*, and sent to the *Gazette Associates*, 279 Dartmouth Street, Boston.

THE URINE AND FECES IN DIAGNOSIS. By Otto Hensel, Ph.G., M.D., Bacteriologist, German Hospital, New York, and Richard Neil, A.M., M.D., Pathologist, German Hospital, New York, in collaboration with Smith Ely Gelliffe, M.D., Ph.D., Instructor in Pharmacology and Therapeutics, Columbia University, Visiting Neurologist, City Hospital, New York. Philadelphia and New York: Lea Brothers & Co., 1905. Illustrated. pp. 334. Price, \$2.75 *net*.

We find here a volume very fully covering the laboratory methods employed, and one that ought to be in use in every laboratory.

As a reference book it is unexcelled, but most of the methods given are laboratory rather than clinical methods. On the other hand, the pathological examinations of the excreta now require such technical skill, and so much apparatus that it is a question whether the general practitioner can properly undertake in his office to make a thorough examination.

The descriptions of the technic in the different examinations are very clear and precise and the plates are as a rule excellent.

S. H. B.

A TREATISE ON UROLOGICAL AND VENEREAL DISEASES. By Bukk G. Carleton, M.D., Professor of Urinary Surgery in the New York Homœopathic College and Hospital, etc. Illustrated. Philadelphia: Boericke & Tafel. 1905. pp. 795. Cloth, \$5.00; half morocco, \$6.00.

This book covers the subjects indicated by its title most completely, and in it any practitioner can be sure of finding all that is latest, both from a surgical as well as from a homœopathic standpoint.

It seems to us that his quotations of Watson's figures concerning the cause of death from operations for enlarged prostate ought to have had a footnote added, saying that now by careful

oversight the cause of death from uremia should be very much reduced, in fact, almost eliminated.

In regard to the treatment of gonorrhœa and syphilis, we much regret that the author has not given us more exactly the details of *his own* treatment which, in view of his great experience, would be immensely valuable to the general practitioner.

What will make it almost indispensable to the homœopathic physician is the fact that under the treatment of each condition the author has enumerated the useful homœopathic remedies and usually in addition to this the specific indications for the use of each.

S. H. B.

DISEASES OF THE HEART. By Edmund Henry Colbeck, M.D., Chicago: W. T. Keener & Co. 1905. Price, \$2.50.

This is a work of 344 pages designed for both students and practitioners, and is admirably arranged. The author devotes a brief space to anatomy, physiology, diagnostic methods, etc., and then considers the various diseases of the heart, covering the etiology, pathology, physical signs, symptoms, and treatment very thoroughly and yet not unduly drawn out. In this second edition valuable articles on the instrumental determination of blood pressure have been added and some good illustrations of pulse tracings are shown. It would seem to be a work of value to the specialist as well as to the general practitioner.

W. F. A.

STATIC, HIGH FREQUENCY, RADIO, PHOTO AND RADIUM THERAPY. By William Harvey King, M.D., LL.D. New York: Boericke & Runyon. 1905. pp. 291. Price, cloth, \$2.50, postpaid.

This little volume is a clear, concise, and conservative statement of what may reasonably be expected of electro, radio, and photo-therapy, with a short exposition of the physics and technic of each. It contains more of value than any of several recent works on the same subject, and less of no value than any heretofore published. About the first third is devoted to theory, a chapter being given to each of the agents. The next third is given to physiological action, and instruction as to the various modes of application.

The final four chapters are given to special therapeutics, and under different diseases give the forms of treatment considered most beneficial. The illustrations are good, and the diagrams especially plain. Many authorities are cited by name, but in very few instances are more detailed references given, as is usual in a carefully prepared work of this sort. This is a minor detail, however, and as a whole the work will be of real value to those using these agents in their practice. B. T. L.

OBITUARY.

Dr. William Leavitt Jackson, a well-known physician of Roxbury, whose health for the past few years has been such as to necessitate frequent trips to Europe, died June 21, at Badnaheim, Germany, at the age of 52 years. Dr. Jackson was born at Gardiner, Me., on Jan. 23, 1853. His parents were Dr. William Francis Jackson and Abby Crocker (West) Jackson. When the children were quite young the family removed to Roxbury, where the father soon established a large practice. The son attended the Roxbury schools, including the Roxbury High, and then spent two years at the Institute of Technology. Then he entered the Harvard Medical School, from which he was graduated in 1876. The following two years Dr. Jackson spent abroad studying at such prominent centres as London, Paris, and Berlin. About 1878 he returned to this country and entered upon the practice of his chosen profession. Soon after establishing himself his father died and the son succeeded to his practice, since which time, up to 1895, when his health gave out, he had been among the most prominent physicians of the homœopathic school.

In May, 1884, Dr. Jackson was married to Miss Edith Talbot, daughter of Dr. I. Tisdale Talbot, also a well-known physician of his time. The wife and one daughter survive him, and both were with him at the time of his death.

Dr. Jackson for a long time was a member of the staff of the Massachusetts Homœopathic Hospital, and also was professor at the Homœopathic Medical School. He was especially active in Electro-Therapeutics, and was a member of foreign and American societies of that department. For the past ten years Dr. Jackson has spent about half his time abroad. The family home in Roxbury was at 76 Dudley Street.

PERSONAL AND GENERAL ITEMS.

DR. J. HERBERT MOORE will occupy, for the summer, the Wiggin cottage on Beach Bluff Avenue, Beach Bluff, formerly belonging to the late Dr. Jane K. Culver. Dr. Moore will divide his time and work between Brookline and Beach Bluff, devoting a few hours during the middle of each day to his Brookline practice.

BY the will of the late Mrs. E. C. Thayer of Keene, N. H., the City Hospital at Worcester will receive \$20,000, and its Nurses' Home, \$10,000, while the New England Hospital for Women and Children, Boston, will be benefited to the amount of \$10,000, and the Kurn Hattin Homes, Westminster, Vt., \$10,000, with \$15,000 additional at the death of one of the beneficiaries.

DR. S. H. WEEKS of Portland, Me., announced June 10 the gift of \$40,000 from a benefactor whose name was withheld, for the erection of an administration building and power house for the Maine Sanatorium for the treatment of tuberculosis at Hebron.

IN addition to a letter expressive of its appreciation of the aid and succor given to the injured and care bestowed upon the dead in the recent South Harrisburg wreck by the people of Harrisburg, the Pennsylvania Railroad Company has given \$10,000 to the Harrisburg Hospital. The gift was made to the hospital without any restrictions as to its use, that being left entirely to its board of managers.

THE number of insane persons in New York State hospitals and licensed private asylums increased one thousand during the past year, according to a report which has just been submitted to the State Commission of Insane by the State Charities Association. While this increase is smaller than the previous year, still it is in excess of other years, the total average yearly increase being 738. The total number of insane patients in state hospitals and licensed private asylums on Oct. 1, 1904, was 26,861, an increase of 927 over the previous year.

THE Contagious Hospital which the city of Malden is about to erect is planned on the cottage idea, each ward being in a separate and distinct building.

The administration building contains quarters for the examining physician, a reception room and a dining room and kitchen, together with pantries, back stairs, and all necessary conveniences. The entrances to the nurses' dining room are so arranged that all danger of infection is removed.

On the second floor are the sleeping quarters for the nurses, the matron's room, a sewing room and a general sitting room for the nurses when off duty. Toilet arrangements, bath room, and plenty of closets are provided. The third story will contain the servants' quarters and bath and storage rooms.

Each ward building contains apartments for male and female patients, as well as private rooms. There is a diet kitchen, with range, refrigerator, sink, etc. The discharging room has direct connection with the bath room, so all danger of cross-infection has been obviated. A doctors' preparing room also has been provided. At the end of each ward building a wide and comfortable veranda has been placed for the use of convalescents.

DOCTOR'S OFFICE TO RENT.—In a private homœopathic hospital on Newbury Street. Rates reasonable. Address A. B. C., 98 Dana Avenue, Hyde Park.

H. E. RICE, M.D. has gone to his camp at Rangely Lake for the summer. On his return he will open his office at 541 Boylston Street, where he will have greater conveniences.

WANTED.—Two second-hand operating chairs in fairly good condition—Harvard, Yale, or similar make. Price must be low. Address, giving terms, etc., C. A. B., 98 Dana Avenue, Hyde Park.

TO RENT.—An office, in an apartment, with a physician who has been long established. Best location on Huntington Avenue. Communicate with S. S., care C. A. Boynton, Dana Avenue, Hyde Park.

FOR SALE.—A delightful home arranged especially for a physician, in one of the most beautiful suburbs of Boston. The retiring physician will include his good will in the purchase. The transaction must be strictly on a cash basis. Communicate with X. Y. Z., 98 Dana Avenue, Hyde Park.

HYSTERICAL APHONIA, PARALYSIS OF ADDUCTION.—My first case was that of a girl, aged seventeen, who came to my clinic suffering from the classical symptoms of hysterical aphonia. After showing her to my students and demonstrating the hysterical paralysis of adduction, I endeavored to pursue the usual plan of sending a current of electricity through the larynx. My battery was out of order, so being at a loss for an agent with which to influence the patient, it occurred to me that I might accomplish the same result by suggesting that something was dislocated in the larynx which I could easily replace and thereby accomplish a cure. Somewhat to my surprise the patient recovered her voice as soon as I withdrew my finger and announced that everything was in proper order again.

Dr. H. W. Loeb in Annals of Otolology.

POPULUS TREMULOIDES IN PAINFUL URINATION.

A man (aged 38) complained of a painful urination, which had troubled him for some considerable time. There was great heat and scalding of the urine, and a large amount of irritation of the bladder and urethra. Knowing, by past experience, of the good results to be derived from the administration of populus tremuloides in similar cases, I put him upon the following:

℞ Trit. populus tremuloides 1x, gr. xxiv.

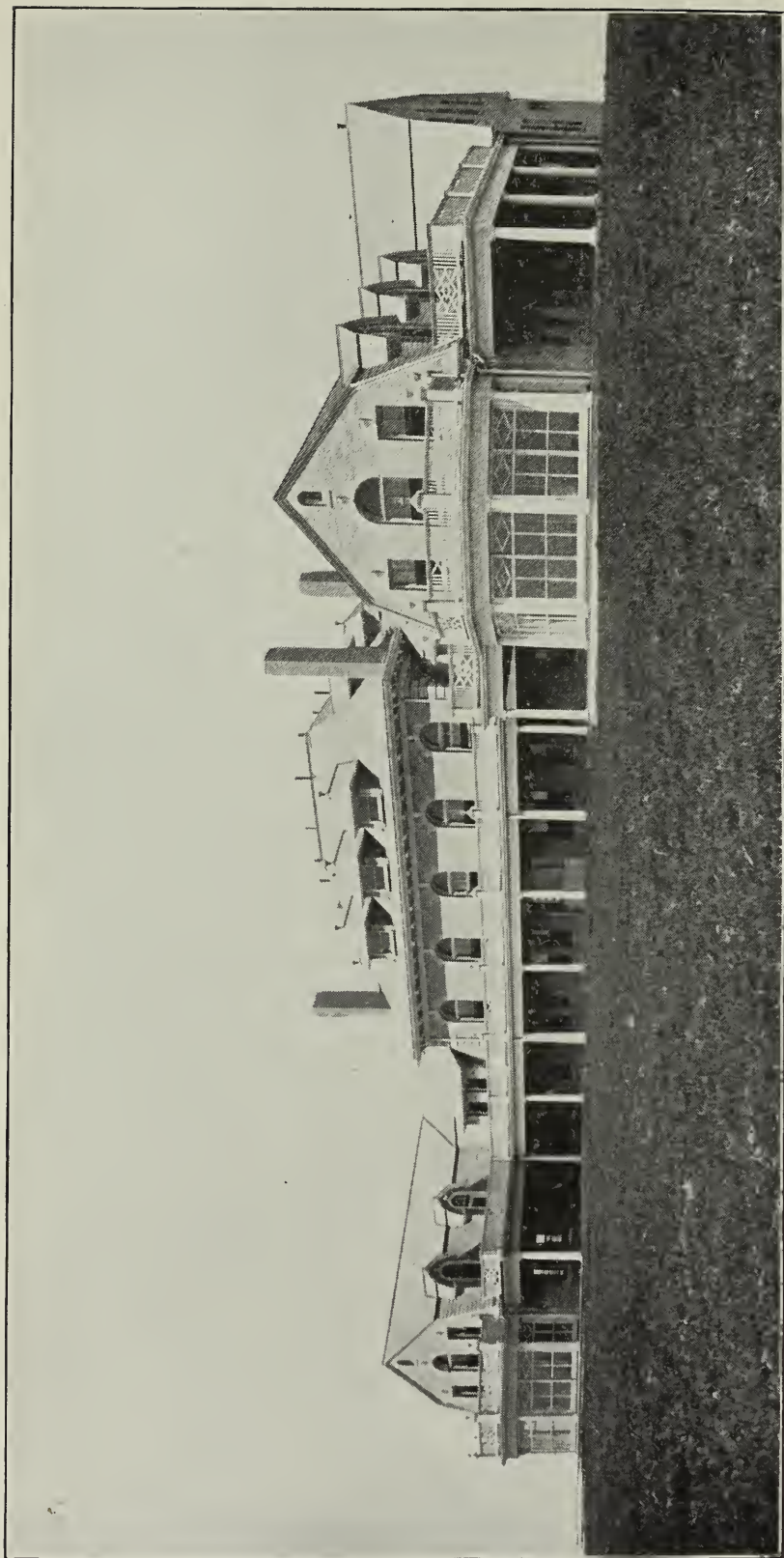
Divide into 12 powders of two grains each.

A powder to be taken every three hours.

The above, I may state, was prepared from the pulverized bark with sugar of milk, and not from the tincture. The patient got prompt relief, and, persevering with the medicine, was perfectly cured in ten days. Populus tremuloides is one of the most valuable remedies we possess in our materia medica for painful urination, attended with heat and scalding. Especially has it been found useful when these symptoms occur in women during pregnancy. It is also a remedy par excellence in catarrh of the bladder, ardor urinæ, and chronic enlargement of the prostate. It is very prompt in its action—a property that renders it of still greater value than it would otherwise be, and its effects, moreover, are of a permanent character.—DR. F. KOPP in *The Homœopathic World*.

In a paper by Dr. F. Lejars in the *Semaine Medicale* for March, 1905, he advises the following "Treatment of a Crushed Hand:"

"Anesthetize the patient, apply Esmarch's bandage, cleanse the wound and neighboring parts thoroughly, remove all foreign bodies and debris of whatever nature, bits of bone, flesh, etc., amputate any portion which has been crushed beyond hope of recovery, readjust the tissues as nearly as possible to their normal condition, suturing the divided tissues when necessary, remove Esmarch's bandage, check hemorrhage, drain freely, and apply a sterile dressing." W. S.



THE BURRAGE HOSPITAL

(See page 378)

THE NEW ENGLAND MEDICAL GAZETTE

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ORIGINAL COMMUNICATIONS.

MANIFESTATIONS OF SYPHILIS IN CHILDHOOD FROM THE STANDPOINT OF A NOSE AND THROAT SPECIALIST.

BY IRVING TOWNSEND, M.D., NEW YORK, N. Y.

[Read before the Massachusetts Homœopathic Medical Society.]

The manifestations of syphilis in childhood are by no means confined to the inherited or congenital variety, but it is this form only that I am asked to discuss, with the still further limitation to such lesions as are within the scope of the specialist in diseases of the nose and throat. The lesions of congenital syphilis usually appear early in life, in a large majority of cases before the age of puberty. Dr. John W. Mackensie states that in fifty per cent. of the cases they appear within the first year, and in thirty-three per cent. within the first six months after birth.

In early infancy the manifestations of hereditary syphilis are either of the secondary or tertiary forms, and the latter may be of such severity as to cause death, particularly if the nature of the disease be unrecognized, or antisyphilitic treatment be neglected.

The lowered vitality of the syphilitic infant is still further depressed by a purulent rhinitis, partially or completely occluding the nares, and thereby interfering with nasal respiration, so as to seriously embarrass or prevent the child from obtaining nourishment from the breast or nursing bottle.

“Snuffles” is the classical term applied to this condition, which may include everything from a persistent coryza and excoriation of the nostrils to the deeper lesions involving the septal cartilages and bones, as well as adjacent structures.

Some of the lesions follow the type of secondary syphilis, but most of them are of the tertiary form. They may, however, coexist, both varieties appearing in the same patient at the same time, the former either yielding to treatment, or disappearing spontaneously, or passing by almost imperceptible gradations into the latter, which fact, owing to their rapidly destructive nature, is of the utmost importance.

Gummatous infiltration may occur at any point within the nasal fossæ, attacking the septum and the external wall, or it may be distinctly circumscribed and confined to a small area, involving only a small portion of the outer or inner wall. Unless the progress of the disease be checked, the infiltrated tissue becomes so dense that nutrition is interfered with, and necrosis occurs.

The destructive lesions resulting from syphilitic necrosis involve all tissues, including bone and periosteum, and it is not unusual to observe a large necrotic mass made up in part of mucous and dried crusts, the remains of the septal bones and turbinates occupying the spacious cavity formed by the nasal passages. Not infrequently the bones and cartilages may be so destroyed by a periostitis of perichondritis, while the overlying tissues and mucous membranes remain almost uninjured. The septum is the part most likely to be attacked, and in the bony portion, viz., the vomer and ethmoidal plates, their destruction is usually extensive and sometimes complete.

The turbinates may or may not be involved in the infiltrative process, but when affected, are likely to be destroyed. The bony floor of the nose, or the *alæ nasi*, may be the site of gummatous invasion, in which case the necrosis may cause a perforation of the hard palate or a sloughing ulcer resulting in deformity.

The rapid destruction of tissues and the cicatricial contrac-

tion resulting from syphilitic necrosis is productive of deformities most appalling, and which may only be duplicated in lupus or carcinoma.

Congenital lesions in the pharynx are perhaps as common (although less important from a cosmetic standpoint) as those found in the nose, but in many cases they coexist, as local expressions of the systemic disease, in the form of gummatous infiltration, or the deep sloughing ulcer produced by the breaking down of the gummatous deposit. The hard palate is most frequently attacked, and unless promptly treated such cases are likely to result in perforation. The soft palate is often involved as well as the posterior wall, and the adhesions formed between the soft palate and the posterior wall occasionally produce partial or complete occlusion of the nasopharynx.

Analogous to the secondary manifestations above referred to we may find erosions resembling mucous patches on the lips, margins of the tongue, the faucial pillars, and in other parts of the oro-pharynx.

The classical indications of congenital syphilis, viz., "Hutchinson's Teeth" and hypertrophy of the epitrochlear glands, formerly regarded as *diagnostic*, are now considered in the light of *presumptive evidence* only. Enlarged glands in any part of the body may be found in syphilitic and nonsyphilitic subjects, and the various kinds of imperfect teeth, described by Hutchinson, may result from nutritional defects independent of the syphilitic taint.

While the lesions in the nose and throat are most typical and characteristic, the correct diagnosis often requires a careful study of the family history, and the previous and present condition of the patient, as well as the knowledge elicited by the following investigation:

1. Examine mouth, throat and nose for lesions, such as destruction of the nasal septum and flattening of the nose, perforation of hard or soft palates, ulcers, mucous patches, gummatous swellings, and cicatrices.

2. Examine the skin for scars, the genitals for the primary scar, and for syphilitic atrophy or enlargement of the testicles.
3. Examine the bones (tibia, clavicle, and cranial bones) for nodes or necrosis.
4. Examine the teeth (for Hutchinson's sign) and the eyes for iritic adhesions or corneal opacities.
5. Examine lymph glands for general enlargement and induration.

After exhausting every diagnostic sign of congenital syphilis in a suspected case, the final and supreme test still remains, viz., a course of mercurial inunctions and potassium iodide. Much as we deprecate the indiscriminate use of these drugs, it must be admitted that in some obscure cases their administration brings order out of chaos, and serves to make a hitherto uncertain diagnosis a certainty.

The range of professional opinion varies from those who ignore completely the most obvious signs of syphilis to those who maintain that the syphilitic taint is universal. It may be safely assumed, we believe, that one extreme is as irrational as the other, and that while the manifestations of syphilis are frequently overlooked, it is by no means the common heritage of a large majority of the human race.

Practitioners are prone to disregard destructive lesions in the nose and throat, in the belief that they will yield to constitutional treatment alone. This often happens, but sometimes these lesions are the *only marked manifestations* of the disease, and unless the examination of these parts be carefully and thoroughly made at proper intervals, a valuable means of marking the progress or subsidence of the disease is lost. It has been our experience not infrequently to find extensive ulceration in the nose and naso-pharynx, in patients whose course of treatment had recently been completed or at least discontinued, with the assurance that they were cured.

Doubtless many of you can recall cases of supposed "catarrh" in infants and young children where there were no signs of syphilis, except that the symptoms failed to respond to the

usual treatment, until, accidentally or otherwise, a correct diagnosis was made.

We shall not attempt to recite the histories of cases of so-called eczema, scrofula, marasmus, scurvy, purulent rhinitis, "catarrh," nervous and intestinal disorders, rheumatism, and diseases of the bones and joints, which have promptly recovered after the application of antisypilitic treatment, when the patients presented few or none of the classical symptoms of congenital syphilis.

It may not be inappropriate in closing to emphasize the importance of becoming thoroughly familiar with the various manifestations of this disease, as they occur in the mouth, nose, and throat, for it is here that the most typical lesions are to be found, which, if recognized early, will be invaluable guides to future treatment.

We will not tax your patience by a further description, nor by quotations from the various authorities, but will merely call your attention to a few drawings and illustrations showing some of the most characteristic conditions resulting from congenital syphilis.

BASIC PULMONARY TUBERCULOSIS.

BY HERBERT C. CLAPP, M.D., BOSTON, MASS., VISITING PHYSICIAN TO THE MASSACHUSETTS STATE SANATORIUM, AND GEORGE N. LAPHAM, M.D., RUTLAND, MASS., ASSISTANT PHYSICIAN IN THE SAME.

[Read before the Massachusetts Homœopathic Medical Society.]

This affection is very rare. Very little has been written on the subject, probably because it is so rare. Most of the books contain nothing whatever about it, and perhaps it is just as well that they do not, for this reason. In the vast majority of cases *pulmonary tuberculosis begins at one apex*; and this fact is really by far the most important point in the early diagnosis of the disease. Now we all know that very early diagnosis and proper modern treatment mean in three quarters of the cases life, where a late diagnosis means probable

death. Because we find the apex partly solidified, we are justified on this very account, in the vast majority of cases, in diagnosing pulmonary tuberculosis, whether we find tubercle bacilli in the sputum or not. Not so, however, with basic affections. Here the chances are that the trouble is non-tubercular, and we are very reluctant to make a diagnosis of tubercular disease, unless tubercle bacilli are present in the sputum, or unless a reaction follows tuberculin, no matter how suggestive are the physical signs, no matter how much destructive disease is found in the lung, no matter how much fever, weakness, and wasting there may be. In other words, a kind of consumption may be present, but not tubercular consumption.

In calling attention to the base of the lung as a location for the deposit, we are very anxious to have its *exceptional* character very prominently brought forward. We emphasize this fact particularly from the knowledge, gained in teaching, that the human mind, by a queer process, unless it is warned, is very apt to remember exceptions almost as well as the rule, and sometimes even better. And we realize that this paper will be worse than useless, unless by calling attention to the extreme rarity of the exceptions it serves to prove the well-nigh universality of the rule.

As to just exactly how rare this disease is, the few statistics which are accessible do not always agree. Louis, in his classic work published at Paris, second edition, 1843, "*Recherches sur la Phthisie*," p. 2, reported two cases out of 123; Dr. Walsh gave one in 60 or 80, Dr. Cotton two in 1,000.

Dr. Pollock, in his famous "Prognosis in Consumption," 1865, p. 135, gave 64 cases (50 males and 14 females) in 4,530 (or one in 70) where the physical signs were most marked at the base from the commencement. He states that just one half, or 32, had also signs of incipient disease at the apex when examined.

We must remember that all of these investigators lived and wrote before the discovery of the tubercle bacillus, and un-

doubtedly from the symptoms often considered cases as tubercular which we now should class as nontubercular on account of sputum negative on repeated examinations during life, or on account of the absence of the bacillus in the tissues at a post-mortem.

Four years after Koch's discovery, Dr. Percy Kidd published an interesting article on this subject in the *London Lancet* for October, 1886, pp. 615 and 665. He very properly refused to classify as basic those affections of the apex of the lower lobe which are not infrequently met with. He reports two cases with autopsies as the only examples of true basic tuberculosis he met with in 412 cases, in all of which he made the post-mortem examinations himself. This would give one in 206. He thought it very likely, however, that a larger number of autopsies would still further reduce this proportion, and that probably one in 500 would not be far wide of the mark. He added that sometimes where during life he had found no clinical evidence of apical disease in these cases, small scars were found which he thought had resulted from an old process which had probably antedated the basic lesion, showing that the case was not strictly basic.

We come now to the consideration of the statistics which we have recently gathered from the records of the Massachusetts State Sanatorium for Consumptives, at Rutland, Mass.

This institution has treated 3,252 patients during the six and one half years of its active existence. Among these were only five patients (three men and two women) whose disease, as indicated by the physical signs, was located only at the base of the lung, and in whom at the same time the tubercular nature of that disease was proven to our satisfaction—in four by tubercle bacilli and in one by the tuberculin test. Two of these were our own patients, and three belonged to the other service. Through the courtesy of Drs. Bowditch and Dunham we were allowed to extend our investigations to their service, and thus to render available for our purpose the statistics of the whole institution. A number of cases of what at first

seemed to be basic tubercular disease were excluded from our list because, although they had the symptoms and physical signs of phthisis, we could not, in the absence of tubercle bacilli or of the tuberculin test, be really sure of their tubercular nature, as we practically could have been had the diseased portion been apical.

Some of the basic diseases which simulate tuberculosis are unresolved chronic pneumonia of the lower lobe, the pneumonic condition and bronchiectasis resulting from a foreign body in the bronchi, collapse of the lower lobe and cirrhosis following pleuritic effusion, empyema opening into the lung, etc. Any one of these, however, may subsequently receive tubercular infection, so that the search for the bacilli should be continued at proper intervals.

Some of our cases had both apical and basic patches at the same time, but were not counted because of the difficulty suggested by the autopsies of Dr. Kidd, who found, as already stated, that sometimes when the physical signs had indicated a more advanced condition at the base, the older lesion, perhaps partly healed, seemed to be found at the apex.

We have no post-mortem appearances of our own to report for the very good reason that we very rarely have a death—perhaps two or three in a year—ours being a curative institution, where one of the rules is to discharge patients who after a proper time retrograde or fail to improve.

Our five cases out of 3,252 give a ratio of one to 650. Thinking that this proportion may be a little unfair, for the reason that we are apt to discriminate somewhat against basic cases in admitting patients, on account of a feeling that their prognosis is less favorable than that of the common kind, we have counted up the number of basic cases among the 6,769 consecutive *applicants for admission* during the last four years and six months. We were obliged to omit the consideration of the applicants in the first two years, because the reports of their examinations are in such a condition that some of them are not for the present readily accessible. Out

of these 6,769 we found 32 cases where the physical signs indicated basic trouble. Of these 32, however, only eight showed tubercle bacilli in the sputum, although eight more had had hemoptysis in connection with other phthisical symptoms.

Just here we met another difficulty. A large proportion of those who apply to us for admission bring no sputum report whatever, and some state that it was negative (often after one or two trials only), while those who actually enter the Sanatorium have their sputum there examined systematically.

Subtracting the eight with bacilli from the 32 basic applicants above mentioned, we have 24 with sputum not examined or reported negative. Some of these 24 probably had bacilli. Assuming, as we think we can, that at least one quarter, or six, out of this number would have shown them if they had entered, and had thus given us a chance to examine their sputum repeatedly, we have 14 tubercular basic cases out of 6,769, or one in 483 applicants.

Even with very large numbers it is impossible and perhaps unnecessary to get an exact proportion in such an investigation, but probably we should not be very far out of the way in estimating that tubercular disease of the lungs begins at the base instead of at the apex in one case out of five or six hundred, roughly speaking. Very few general practitioners, even among those who lead busy lives, treat more than this number and therefore have little occasion to dread the danger of making a mistake from this cause.

Abstracts of the reports of our five cases are annexed.

Case No. 300 B. Jacob R., entered May 23, discharged Oct. 19, 1900. Aged forty-three. Father and mother probably died of phthisis. Eight years ago he raised a teaspoonful of blood. Cough five and one half years. Now has short breath on exertion, fever, capricious appetite, indigestion, weakness. Coarse rales in left base front and back, and questionable rales at right base back. At Rutland he gave a tuberculin reaction of 101.4°. He improved rapidly in all

symptoms except cough and expectoration, which decreased much more slowly. His temperature often reached 99°, and his pulse ranged from 70 to 90. Physical examination made from time to time showed but little change from the original signs, and at his discharge the rales, though fewer, were still present. He was marked "Very much improved." He had gained eleven pounds in weight.

The following subsequent reports were received from him Dec. 30, 1900, at San Antonio, Texas: No symptoms except slight cough and expectoration. Had lost four pounds.

March, 1902. Cough and expectoration had entirely disappeared. He felt perfectly well in every way, although he had lost eighteen pounds in all since leaving Rutland. Occupation, "riding around."

Case 912 B. Mrs. Margaret C., entered May 14, discharged Sept. 30, 1901, thirty-two years old. Cough for two months. Tubercle bacilli, dyspnea on exertion, night sweats, hemoptysis two ounces, costive, weak, dilated pupils. In lower left back at base of lung dullness, broncho-vesicular respiration and bronchophony, with some crackling rales. Also a few scattered sonorous rales throughout both lungs, which latter cleared up later. Three or four months later there appeared a slight dullness in right apex front.

In the Sanatorium all her symptoms gradually improved; but at her exit her condition was not such as would impress one with the idea of a probability of permanent cure. Still at her discharge she had no cough, no sputum or tubercle bacilli, and her gain in weight had been thirteen pounds.

Subsequent history, March, 1905. In Springfield, feeling "sick and not at all well."

Case No. 1738 C. Francis L. C., twenty-three years old, entered Jan. 15, left Sept. 22, 1903. Meat cutter. A brother was also a patient in our Sanatorium. More or less addicted to alcohol and tobacco. Two years ago he had two soft chancres. Tubercle bacilli found in the sputum before entrance. Cough eleven months, and pain in left lumbar region. His physical signs at entrance were sibilant and fine bubbling

rales through the lower half of the left lung. He was five feet, eleven inches tall, and had lost ten pounds from one hundred and eighty. During his third month at Rutland he developed tubercular pleurisy, the initial rise in temperature being to 105° , gradually decreasing to normal in three weeks. Sixty-five ounces of straw-colored serum were taken away at one time by aspiration, and thirty-nine ounces at another.

In July a rare and interesting tubercular disease of the tongue developed, which will be reported in detail at some future time. This gradually increased until it caused his death at his home three months later.

Case No. 1991 B. Katherine A. C., twenty-eight years, entered June 13, 1903, discharged April 18, 1904. Leather worker. Cough five months. Tubercle bacilli in sputum. In May, 1903, raised several mouthfuls of blood. Temperature 99.2° , pulse 100. Physical signs at entrance were dullness, fine crackling rales, and a suggestion of bronchial breathing for an area three inches in diameter at lower angle of left scapula. This patient made a very satisfactory recovery, gained thirty-two pounds, lost her bacilli, cough, and other symptoms, and a few months ago reported to the Sanatorium that she had kept well outside.

Case No. 3026 C. W. C. H., entered Dec. 28, 1904. Teacher, thirty years old, wife had died of phthisis, and he had been very devoted to her. Six feet tall, weight about two hundred pounds, the perfect picture of health. Generally feels perfectly well. Would not have applied for examination but for his wife's case and a slight cough and expectoration. Nothing was found in any part of the lungs at any time on repeated examinations except dullness, bubbling rales, and weak broncho-vesicular respiration over an area of about four inches in diameter below the angle of the left scapula. He still feels well, his cough is practically gone, likewise the bacilli. If he neglects to rest during quiet hour, his temperature is likely to go as high as 99.2° or 99.4° . The physical signs are now diminished, and it looks as if he would make a good recovery.

AVOIDABLE CONDITIONS FOLLOWING LABOR.

BY ELIZA B. CAHILL, M.D., BOSTON, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

The avoidable conditions following labor are so vast that but for them there would be far less need of the gynecologist than is true to-day. It is so rare to find a woman well a year after the delivery of even one child, that the physician is open to criticism who does not examine every woman who has borne a child no matter for *what* ache or discomfort she consults him.

Why a woman whose pelvic dimensions are normal fails so often to deliver normally, rests no doubt with a faulty nervous system. When we as physicians comprehend more fully the inorganic nervous disturbances as a complicative factor in *all* organic conditions, we shall the more successfully avoid them; for, with all the tremendous advance in medicine in the last decade, we have still much to learn of the nerve disturbances, knowledge of which will go far to eliminate medical charlatanism.

In this day and generation, aseptic labor is intended and expected, and certain conditions following parturition are promptly accepted as septic and are being eliminated steadily from our lying-in wards. But are other conditions being as intelligently controlled? For instance, sub-involution, often caused by a normal patient getting about with over-rapidity, the uterus still heavy, sagging, retroverting, and retroflexing; then in weeks or months the usual run of symptoms, back-ache principally, and then leucorrhœa and general debility, constipation, and "nerves." If this patient calls her physician within a few weeks, she of course makes prompt recovery; but the symptoms, always insidious, usually ascribed to lifting the baby, often continue months and sometimes years, until the enlargement of the fundus may closely resemble fibroid in its denseness, only careful examination revealing a large, heavy, inflamed uterus pressing into the cul de sac, apparently bound down with inflammatory adhesions, and which often fails to yield successfully to local treatment, or if

responding, is only improved to the point of replacement and a support which, if the tissues are too lax, proves ineffective, and ventral suspension alone renders the cure.

The submucous tears of the cervix, overlooked for years and giving rise to nervous symptoms by the score, rendering a woman incapable of her family duties, are of all the pelvic ills, in my experience, the most frequently overlooked. Upon digital examination the case is evident enough, but visual contact is often disquieting in its insignificance in this diagnosis, and if there be little or much cervical erosion the panacea of local treatment is usually resorted to and relieves; the patient feels herself well, goes from you, falls into varying hands from time to time, and often goes through a long life more or less under the care of physicians who have certainly failed to cure her. And who can say that any cervical laceration may not prove the foundation of that dread disease, cervical carcinoma, so insidious, so frequently hopeless when it falls into the hands of the surgeon.

The perineal ruptures unrecognized even to-day, the rectocele and cystocele that follow, vesical irritations, the rectal disturbances, the prolapse of the pelvic organs with their train of reflex nervous disturbances, the inflammations of the endometrium, the versions and flexions which often come to the woman performing her natural maternal functions, it is small wonder that from the point of invalidism alone women dread childbirth, and in my experience more women have expressed this than any other apprehension or unwillingness. Our private practices, hospitals, and clinics, are full of those sufferers in all social grades; often women growing stout from physical dread of exercise because of back ache, legs ache, headache, stomach symptoms, etc.; florid from defective circulation and too many stimulating "tonics" to allay "that tired feeling;" half sick, depressed, irritable, generally miserable; and often—nay, usually—going from doctor to doctor until finally they fall into surgical hands and are operated and cured, but left often with a post-operative neurasthenia,

lasting for weeks and months and often years, and rendering the patient still an invalid. Were it not for this same post-operative neurasthenia, I for one would advise every patient to be operated upon, if it were possible to eradicate her difficulties by that means, as the quickest method of cure; but the symptoms are often so profound after the surgeon has done a perfect *best* that we physicians who see the afterwards of these cases are feeling that operation is only for the cases that cannot make symptomatic medical cure.

The pity of all this is that so much suffering comes from maternity, a natural function, and surely avoidance rests with the physician almost entirely, first of all in his acquirements, and secondly in the use of them.

More generous education to the laity, better to the physician, not alone in his care before and at parturition, but afterwards; so many of these cases come from good physicians who have not examined late enough after confinement to really know the cervical condition, for instance, and then the ability of the physician to diagnose what he does find.

The surgeon would not have so many extreme pelvic cases did not the physician fail in early diagnosis. When we specialize obstetrics much ill will be avoided. It is marvelous to me to note the frequency with which women meet the answer to their query of the obstetrician's fee with, "Well, it would be better no doubt to have the attendance of a specialist and avoid the after hospital and surgical bill that most of my friends have had to meet."

In the course of the next few decades the practice of medicine will all be distinctly specialized, and there will be no room for the poor workman of which the world has too many, and then there will be fewer sick women and fewer sanatoria.

GYMNASTICS AS A THERAPEUTIC AGENT.

BY HELEN S. CHILDS, M.D., BOSTON, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

Dunghlison defines gymnastics as "That part of hygienic medicine which treats of bodily exercise" and a "gymnast" one whose profession is to prevent or cure disease by gymnastics.

We have, therefore, good authority for claiming the therapeutic value of physical exercise. Nature, also, proves her belief in the same theory, by making one of the first positive proofs of life, action of the child in utero; all through life it is the active man, woman, or child that we find the more healthy.

Through the growing period of childlife a wise course of gymnastics will do much to prevent the physical defects, which are now so frequent among our American-born children, more particularly in girls.

At the last Radcliffe examination the large percentage of lateral curvatures was alarming, and the same report comes from most schools where a medical examination is given. Statistics show that most of the American girls have some defect in posture, due primarily to poor muscular development.

I do not propose, in this paper, to enter into any discussion as to the relative merits of any particular school, or method of gymnastics, but endeavor to impress on the general practitioner the great necessity of a more active life for our growing girls.

A few conditions to which I would draw your attention and to which gymnastics will be found to be particularly well adapted are lateral curvature, with one shoulder and hip carried higher than the other (and just here let me say that it is a rare thing to find a deviation in the line of the shoulders, without some corresponding curve in the spine), round shoulders, narrow chest, prominent clavicle, and scapulæ, lordosis. Inrolling ankles and flat feet may be found in the framework of the patient. Internally, we find poorly developed lungs, shallow respirations, weak hearts, intestinal inactivity, im-

perfect metabolism and faulty elimination, from which our dermatologists tell us that such skin disorders as acne and eczema arise.

Heubner says, "That most of the severe constitutional disturbances associated with gastric disorders in childhood are due to auto-intoxication from improper elimination, with accompanying symptoms of migraine, neuralgia, and possibly the gastric crisis of tabes dorsalis."

Gray says, "That it is a fact of practical importance and one that seems to be almost universally overlooked, that profound malnutrition may be a cause of epilepsy." If to disturbed metabolism such grave disorders may be due, how important it is for the physician to prevent what if overlooked is sometimes impossible to cure.

We cannot leave gymnastic instruction entirely to the care of our public schools, as in most of our grammar schools exercise is given in the schoolroom. A microscopical examination of the sweepings of one of our schools recently made, would seem to prove that any very active exercise in the average schoolroom would not tend to marked benefit of the pupils. We hope the day is not far distant when every school will be fitted with an out-of-door gymnasium. If there is not land enough around the school building, why not utilize the roof?

It is between the ages of nine and fourteen that most of the deformities begin, and when the pupils reach the high school corrective rather than preventive work has to be given, and instead of normal gymnastics, medical gymnastics are required. Preventive work can be given in classes, but corrective work must be given individually, to be of benefit.

Much has been accomplished in arrangement of desks and chairs by the school committee, to make and keep the position of the growing child what it should be, but there is still much in the way of reform and improvement needed.

It has occurred to me that perhaps some demonstrations of exercises, in which the physicians can instruct their patients

to carry out in their own homes, might be of interest. Miss Seeley of the Normal School of Gymnastics has kindly consented to give you a few demonstrations, breathing exercises for the chest development, shoulder exercise, straightening spine, abdominal exercise, flat feet, etc., for inrolling ankles and lordosis.

I should like in closing to report three cases taken from the records of the girls' camp last year in Ossipee, N. H.

Case 1. Miss S., aged eighteen; height, five feet, six and one half inches; weight, one hundred and fourteen pounds; chest measurement, thirty-one inches. Respiratory murmur weak and shallow, lateral curvature, lordosis, menses once in twelve months, unable to walk any distance without being exhausted. No appetite.

Ten weeks later. Height, five feet, nine inches; weight, one hundred and thirty-four pounds; chest measurements, thirty-four inches. Respiration eighteen, deep and regular. Spine nearly straight. She walks six or eight miles without being tired, swims, exercises, and dances; appetite excellent. Have learned from the physician that she has taken the full college course during the winter and is in good general health.

Case 2. G. C., aged fifteen years, six months; height, five feet; weight, eighty-nine pounds; chest measurement, twenty-eight inches. Respiratory murmur weak; right scapula protrudes; chest narrow, clavicle prominent; right lung compressed from old pleurisy.

Ten weeks later. Height, five feet, two inches; weight, ninety-eight pounds; chest measurement, thirty-one inches. Neck full, shoulders straight, respiration clear, full.

Case 3. V. C., aged twelve years, eleven months; weight, seventy-one pounds; height, four feet, ten inches; chest measurements, twenty-nine inches. Respiration, faint, rapid. Has always been subject to lung affection and spent winter South.

Ten weeks later. Height, five feet; weight, eighty-five pounds; chest measurement, thirty-two inches; respiration, clear and regular.

No case had medicine of any kind. Just plenty of good, nourishing food, milk, water, gymnastics in the pine woods, swimming, and an out-of-door life. They all increased in height, weight, and chest measurement and greatly in endurance. If we are to choose between medicine and gymnastics let us try exercise first, and many times even homœopathic remedies will not be required.

THE USE OF THE PELVIMETER IN GENERAL OBSTETRICAL PRACTICE.

BY EDWIN P. RUGGLES, M.D., DORCHESTER, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

In relation to science in general, Professor Huxley said: "Science is, I believe, nothing but trained organized common sense, differing from the latter only as a veteran may differ from a raw recruit. The vast results obtained by science are won by no mystical faculties, by no mental processes other than those which are practiced by every one of us in the humblest and meanest affairs of life. The man of science, in fact, simply uses with scrupulous exactness the methods which we all habitually and at every moment use carelessly."

It is not enough for the physician to know that a woman is pregnant; that in the usually allotted time she will give birth to a child, and, if she does not, to have it then begin to dawn upon him that she cannot; then to have to call in a specialist when the health, possibly the lives of both, have been compromised.

While in obstetrics progress has been made, still, in our every-day practice, how much of what should be carefulness and intimate knowledge is left to mere chance. You will agree with me that when we give a word of comfort, or attempt to prognosticate the end of what is precious near to a young mother's heart, it should be from an intimate knowledge of the conditions present acquired by every means or method that science has given us.

I believe that the use of the pelvimeter is to many, perhaps most, general practitioners, a neglected means of gaining a knowledge of the field of operation, and upon which much may depend as to the outcome. I speak not for the multitude of cases, where the practitioner is a mere looker-on at the substantial methods of nature, but for the minority of cases that enter the realm of preventative medicine, and in which early recognition of the difficulty stamps the physician as being awake and alive in this important branch of medicine. If the general practitioner will recognize the cases of contracted pelvis, or expected dystocia early, much suffering and possibly the lives of both mother and child would be saved.

As the antitoxin syringe has taken upon itself the discarding of the tracheotomy tube, so the pelvimeter, rightly used and given its just appreciation, has been the means of laying aside the perforator, cranioclast, and the cephalotribe.

In the preliminary obstetrical examination, for there should always be such, particularly of primiparæ, the relative size and shape of the pelvis should be definitely estimated. In many of the multiparæ one will have the history of difficult labors, still-born children, etc., to guide him in definitely locating the trouble, and possibly in avoiding it. I do not mean that this should be done under the shadow of the maternity hospital alone, but in one's own daily practice.

It has been said that the pelvimeter is an unused instrument in America, comparatively speaking, particularly in general practice. The lack of its use may be due to various causes. In all probability it is due to the fact largely that we have been led to believe that contracted pelves were rare, whereas the reverse is true—that there are more cases than we are aware of.

Knowing that there is danger to the mother without help, when the matter has gone on to labor, the exact pelvic measurements are of vital importance in the choice of the obstetrical operation necessary. Unless this is done early, and preliminary to labor, the advantage of a premature delivery

has been utterly lost. Even before the choice of an operation becomes necessary, a comprehensive knowledge of the pelvic condition, together with the relative size of the fetal head, with its position, is absolutely necessary to recognize early any delay, and to act accordingly. This should be carefully done because fatalities have resulted from carelessness and errors of judgment.

Attempts have been made by Muller, and modified by Kerr, to estimate the relative disproportion between the pelvis and the fetal head of the case in hand. But these are not always trustworthy, and the use of the cephalometer of Perret and Budin, by which the bi-parietal diameters are supposed to be accurately measured, is not reliable. Thus we have to resort to the expedient of giving the patient the test of labor. How much wiser to have accurate measurements, supplemented by other data that one may obtain, upon which the length of this test may hinge.

Again the necessity for absolute knowledge that pregnancy or labor is complicated with pelvic deformity or insufficiency, is rendered more important when we consider that pelvic discrepancies do not only embarrass the passage of the child, but give rise to remoter effects. These are often regarded as isolated phenomena, and may include faulty position and presentation of the fetus, unfavorable position and shape of the uterus, abnormal character of the pains, and effects produced by undue pressure upon maternal and fetal surfaces.

The large floating population, with the admixture of racial characteristics, makes the subject of more practical interest to those engaged in large cities or smaller manufacturing places, than to those in smaller country practices. In the latter case, the question of frequency is overridden by the fact of the isolation, and the unpreparedness of the physician, and all the more care is necessary in diagnosing the trouble.

As to the frequency of the condition with which we have to deal, authorities are somewhat at variance. While much statistical matter on this subject is available, it can hardly be

said as yet that we possess any trustworthy information, nor can any gain be made in this direction until some standard of agreement is reached by obstetricians throughout the world. Not only is there absence of harmony in measuring these pelves, but there is even failure to agree upon what a contracted pelvis really is. Litzmann, whose standard of measurements are supposed to underlie most statistics, considered all pelves contracted where the true conjugate measured 9.5 cm. or less in flat, and 10 cm. or less in generally contracted pelves. From this standard he found about 14.9 per cent. contracted pelves. Leopold abroad, and Davis of Philadelphia, in our own country, who used external measurements alone, give us an abnormally high percentage, 24-25. Winkel, in some of the larger cities of Germany, found that from ten to fifteen per cent. of child-bearing women have contracted pelves, but that in only five per cent. is the obstruction serious. The recent work at the Paris and Liepsic clinics, upon labor in contracted pelves, shows that this percentage obtains to-day as well. There can be no doubt that the proportion of technical contraction in Central Europe is higher than the figures obtained in America or France.

In our own country Crossen of St. Louis reports eight per cent. in eight hundred cases. Reynolds, in Boston, measuring those pelves in the cases requiring operative interference alone, and leaving out those in which labor ended spontaneously, reports 1.34 per cent. contracted pelves in 2,227 women. With routine pelvimetry and inclusion of all mild degrees of contraction, his percentage would be brought up to nearly seven per cent. Edgar, in an extensive report of 1,200 consecutive cases, reports contracted pelves in nearly four per cent., with very careful measurements. He classified, as contracted, all flat pelves having a diagonal conjugate of 11 cm. (4.33 inches) or less, and all generally contracted pelves, having a diagonal conjugate of 11.5 cm. (4.5 inches). In all his cases, the external pelvic measurements were made with the pelvimeter, and the diagonal conjugate was measured

with the finger in the usual manner. The percentage of American-born women in his report as having pelvic contraction was forty-five per cent. He reports that the generally contracted pelvis was the most frequent deformity met with in New York; that there were twice as many generally contracted as flattened pelvises. He also reports in his private and consultation cases, over a period of ten years, a somewhat higher percentage than the results obtained from the hospital cases.

Williams, at the Johns Hopkins Hospital, in 2,123 cases has drawn these conclusions. He found an average of 13.5 per cent. contracted pelvises, which corresponds to the German statistics. This may be due to a larger proportion of negro women, the percentage in white being nearly seven, while in the black women nearly nineteen per cent. He found one case in nearly fourteen cases in white women, which compares with Reynolds and Crossen. His percentages of the different forms of the contracted pelvis agree somewhat with those from Edgar,—that those generally contracted were more prevalent, particularly in the black, while the simple, flat pelvis he found were slightly more prevalent in the white woman. He agrees with Edgar in the necessity for routine measuring because of his findings.

From these statistics it would appear that no one can practice obstetrics without encountering a certain number of cases. No general practitioner in a large city, at least, can hope to avoid such cases, and it is likely that each year will afford him one or more examples.

The X-ray has been used to investigate the shape and size of the pelvis, but owing to the fact that one side lies much closer to the sensitive plate than the other, the nearer portion of the pelvis is enlarged out of all proportion to the opposite. Thus it is impossible to use the radiograph for purposes of mensuration. Thus pelvimetry is our only course.

There are two kinds of pelvimetry—complete and practical. Complete pelvimetry means the measurement of the pelvis

in all its dimensions as precisely as possible. This is not practical, either from the patient's standpoint or the physician in general practice. By practical pelvimetry is meant the taking of a few simple measurements which, in the present state of knowledge, are enough to guide one in practice. These measurements are external or internal. The former are usually taken with the Schultze or Martin pelvimeter, and the three important ones are the intercrystal, the interspinous, and the external conjugate. The internal one is the diagonal conjugate.

The interspinous diameter is the widest distance between the anterior superior iliac spines. This diameter is best estimated by holding the tip of the pelvimeter between the thumb and first finger directly upon the process, preventing the tip from slipping too far inside. Some authorities use the outside of the process as the point of contact, rather than directly upon the process. The average of this measurement is between nine and a half and ten and a half inches in normal cases.

The intercrystal diameter is the widest interval between the iliac crests, and is measured from the most prominent portion of the crest. This average is from ten and a half to eleven and a half inches. These measurements answer the requirement of practice to determine whether there is a diminution of the transverse diameter of the pelvic inlet which cannot be measured directly.

The third diameter, and over which there is considerable disagreement, is the external conjugate. This is perhaps the most important measurement, and the most difficult to be accurately obtained. We have to consider three diameters or planes of the inlet:

1. The anatomical plane or conjugate, which extends from the promontory of the sacrum to the top of the symphysis pubis.

2. The obstetric or true conjugate, the plane extending from the promontory to the upper border of the symphysis,

crossed by the *linea terminalis*,--that is, about three quarters of an inch below the upper margin. This is the least distance between the posterior surface of the symphysis and the promontory, and it is the available anterior posterior space of the inlet for the passage of the child.

3. We have, also, the diameter or plane, the diagonal conjugate which is the distance from the promontory to the under edge of the symphysis.

The point of contact at the back, to obtain the external conjugate, is agreed upon as the depression just below the spine of the last lumbar vertebra, which is a point about one inch above the line drawn between the posterior spinous processes. This point can be found easily by placing the middle finger and thumb of one's left hand upon the posterior spinous processes as the woman lies in the left lateral position. The forefinger can then be carried up into the depression under the spine of the last vertebra.

In obtaining the anterior point of contact, some obstetricians will measure from this point in the back to the upper margin of the symphysis, that is, corresponding to the anatomical conjugate. Others will measure from the point in the back to a point just below the brim of the symphysis, that is, corresponding to the true conjugate. Still others will obtain the measure from the back to the lower border of the symphysis. This, I believe, is the best of the three for these reasons:

1. It is as easy to estimate the relation of the external diagonal conjugate to the true conjugate as it is to determine the relation of the external anatomical conjugate with the true or obstetric conjugate.

2. The point of contact anteriorly is much more clearly and accurately defined than is the upper border.

3. If the conjugate diameter is modified by the inclination and position of the symphysis, I believe that the diagonal conjugate is much more detrimentally influenced than is the anatomical, and this would appear in the measurements.

4. The plane of the external diagonal conjugate is directly

in the plane of the internal diagonal conjugate, and one would thus have an additional factor to prove one's accuracy.

The average length of the external conjugate in normal case is about eight inches. If there is any discrepancy between the external conjugate measured to the upper border of the symphysis and the external diagonal conjugate measured to the lower border, it is very slight,—possibly the diagonal is one quarter to one half an inch longer. The average measurement of the true conjugate is four and one half inches. To find the anterior posterior measurement in any given case, deduct about three and one half inches from the external measurements.

While these measurements do not give accurate information always of the true obstetrical conjugate, they serve to indicate with tolerable certainty the variety of pelvis with which one has to deal. If the measurements are approximately normal, and the child's head fixed in the brim, internal measurements are not necessary. The internal measurement which we are anxious to arrive at is as near the true conjugate as possible, and if necessary this can be estimated by measuring the internal diagonal conjugate, the distance between the promontory of the sacrum and the lower margin of the symphysis, and making a deduction of one and a half to two cm. or three quarters of an inch to obtain the true conjugate. The technic of this is familiar. Pass two fingers within the vagina, reaching the promontory with the tip of the little finger, and the point of contact with the lower edge of the symphysis should be marked for measurement. The depth of the sacral cavity, the condition of the coccyx, and the width of the pelvic outlet can be estimated at the same time.

Let me illustrate in a brief manner by reporting two cases in the same family under different care.

One sister by preliminary examination was found to have a generally contracted pelvis, with measurements of eight and a quarter spines, nine crests, and an external diagonal conjugate of six and three quarters inches. Labor was brought

on at about twelve days before term with a resulting normal labor, with smaller child. With her second pregnancy which terminated a week ago, she was allowed to continue for two hundred and eighty days after conception with the result of an occipital posterior presentation, with a larger child, which necessitated forceps and instrumental delivery, the child showing the pressure of the promontory upon the parietal bone. Both are doing splendidly. The mother received no laceration.

The other sister was allowed to continue a period of at least one week or more over her full time, and then labor was delayed. The result was a large child, a hard head, and occiput presentation going on to a face presentation because of an insufficient pelvis, podalic version with even then a failure to extract the head, even with forceps, and necessitating a mutilating operation with a severe laceration of maternal structures. It needs no comment.

It follows that an ability to recognize these conditions of the female pelvis is a necessary equipment for every practitioner of medicine who may be called upon to attend women in confinement, and that a knowledge of pelvimetry is as essential to the intelligent and successful practice of obstetrics as are percussion and auscultation to the practice of medicine.

EDITORIAL.

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THE AMERICAN INSTITUTE OF HOMŒOPATHY. SIXTY-FIRST ANNUAL SESSION.

June 26, 1905, was a busy day to the homœopathists assembled in Chicago. Fortunately the weather was cool, and permitted strenuous efforts. The preceding day had been as sultry, hot, and close as the most unbearable of summer days ever are. Those traveling thitherward, sweltering in railway cars with a temperature in the nineties, did not look forward with particularly pleasing anticipations to spending a few days or a week in a busy, packed, hot, and noisy city, with all the disagreeable qualities of a big inland city in hot weather. But during the night of the twenty-fifth, a heavy thunder-shower swept over the city and across the lake, leaving in its wake a deliciously cool atmosphere, dust thoroughly laid, and a temperature that was invigorating. The Auditorium Hotel had been selected as the Institute headquarters, and here one found the center of all the activities making up the Institute. Capacious rooms, halls, and foyer had all been placed at the disposal of the local committee of arrangements, and the wants of bureaus, sectional societies, committees, officials, and Meissen had all been provided for. During the forenoon desks were being placed for registrar, treasurer, censors, information bureau, post-office, railroad

officials; boxes were being opened, and commercial exhibits arranged for display, and a few "educational exhibits" were being unpacked and prepared for inspection. A room of generous proportions had been assigned the medical schools for purposes of making such demonstrations of equipment, and the results of their laboratory and other work, but this year only two schools made any exhibit. A few schools had "headquarters" where old classmates could meet and exchange experiences and gossip, and these "headquarters" seemed to be appreciated. The Cleveland school had an attractive exhibit consisting of photographs, some gelatine mounts, and a generous display of histological specimens (normal and pathological) and demonstrations of microscopical technic.

Boston University Medical School made a somewhat elaborate exhibit from its pathological and physiological departments chiefly, consisting of normal and abnormal tissues, and products, appendices, gall stones, gall bladders, carcinomatous organs, etc., mounted by the gelatine method, and numerous photographs and tracings—sphygmographic, cardiographic, chest, pantographic, etc., from the physiological laboratory. The unfeigned interest taken in these exhibits by a large number of visitors, the questions that were asked concerning methods used in preparing specimens, the words of praise spontaneously uttered were gratifying and encouraging to those having the display in charge. In Cleveland, Boston, Niagara, and Chicago our medical schools have done creditable work along these lines, and it is to be hoped they will all be represented in the grand educational exhibit that will surely be gotten up for the International Congress to be held in 1906.

Profiting by experience, and learning wisdom from criticisms, our Chicago colleagues planned most wisely concerning the "Commercial Exhibits," which were assigned to admirable and commodious quarters in the foyer of the Auditorium

Hotel, completely separated from any of the halls used for the meetings, and in no way whatever interfering with the scientific sessions. It is to be granted circumstances were such that this most desirable arrangement easily could be made in Chicago, but it is to be hoped that other local committees will be able to follow the good example thus set them.

The halls at the disposal of the Institute were numerous and adequate, and, for the most part, quiet and accessible. The necessity for arranging for three to five concurrent bureau and sectional society meetings, and two or three committee meetings, taxes the facilities of even the largest hotel; so hereafter, with increasing Institute membership, and larger and larger meetings, the annual sessions of our national organization are destined to be held in large cities or large resorts.

Immediately preceding the opening session of the Institute, the state societies of Illinois, Wisconsin, and Iowa held short business meetings; after which they adjourned to merge their forces with those of the Institute.

Promptly at four o'clock P.M., June 26, President Royal called the meeting to order, and declared the sixty-first (61) session of the Institute open for the transaction of business. A large gathering had assembled, and with the precision and smoothness of a well-constructed piece of machinery the wheels of business started, and without delay of any sort the Institute settled down to the week's work.

It is quite unnecessary to go into minute detail concerning the program for the meeting. Enough to call attention to a few points, and make a few comments on the work done.

Attention, for instance, should be called to the results of the year's efforts to increase the membership of our national organization. A special committee for this purpose was appointed a year ago, and certain of the state societies took hold of the matter in an energetic way, with the result that at

the opening session the chairman of the Board of Censors presented the names of one hundred and forty-eight (148) candidates for membership. This number was added to day by day until the unprecedented total of three hundred and fifty (350) was reached. Apropos of this subject Dr. Spalding, chairman of the special committee, says:

“While the number of new members elected was less than the special committee on new members hoped for, it exceeded that of any previous year in the history of the Institute, and was six times the number elected in 1904. This being the first year under the new rule requiring membership in the state societies before one is eligible to membership in the Institute, lessened the number of applications very materially, probably about one half. At the present time the Institute holds the anomalous position of being dependent for members upon societies with which it has no official affiliation. Except as a matter of courtesy it cannot obtain their lists of members. It was only after repeated requests that some of the lists were obtained this year, and from one state society all efforts on the part of the committee to get the membership list failed.

“To overcome this difficulty it is proposed to so amend the by-laws of the Institute that the secretaries of the various state societies shall be ex-officio auxiliary secretaries of the Institute. And it is hoped that the state societies will so amend their by-laws as to make it a duty of their secretaries to send to the secretary of the Institute lists of their members the first of January each year.

“Not including the newly elected members there are some two thousand members of the Institute. There are four thousand five hundred (4,500) members in the state societies. During the last ten years there have been graduated four thousand five hundred (4,500) homœopathic physicians. It is estimated that not more than one third of these are members of their state societies, and not more than one fourth of them members of the Institute. This suggests that earnest work in bringing physicians into our state and national socie-

ties has begun none too soon, and now commenced it must be carried on persistently and vigorously.

“That all this means a good deal of actual effort is indicated by the facts that the chairman of the special committee on new members sent out more than nine thousand (9,000) personal and circular letters during the past year; that other members of the committee with their *aides* did large and effective work in the same line; and that the secretary of a recently organized ‘Woman’s Club’ sent out more than five hundred (500) letters to the women physicians of the country urging them to join the Institute.

“This important work must be done year after year, and the special burden of building up the state societies, and forming new ones, now devolves upon the Institute, for upon the state societies the Institute will have to depend for its renewal of life blood.”

One of the leading sentiments prevalent throughout the week was that members of state organizations should be identified with the national association. Some scheme for close affiliation is sought, but the work must be seriously undertaken by the state societies themselves, which should see to it that every homœopathic practitioner in the state should be a member of the society of his own state. In these days of universal commercialism there are physicians who are prone to ask, “What special benefit will accrue to me from membership in local or national societies?” The question itself is suggestive of a selfish attitude of mind not creditable to a profession that is noted as a whole for its philanthropic work. Medicine is not yet a trade, in spite of some modern tendencies, but if it is to keep its place among the dignified and noble professions selfishness in all directions must give way to altruism. There are numerous duties every physician owes his profession; there are many benefits he directly or indirectly derives from the profession; his citizenship in the profession calls for but a small tax on his time and income;

his experiences and the lessons taught by them should be communicated for the sake of humanity to his professional colleagues; the possibilities of widening his own horizon and acquiring some useful knowledge is not to be lost sight of. At this latest meeting of the Institute, for instance, there were on the program fifty-seven (57) papers on a wide variety of subjects, and nearly seventy-five (75) on the programs of the sectional societies, distributed as follows: There were sixteen (16) papers on very practical subjects in the bureau of clinical medicine; thirteen (13) interesting papers in materia medica; eight (8) on subjects connected with the propagandism of homœopathy, some of which are likely to give rise to activities of great importance to the cause; ten (10) on pedology; and ten (10) on sanitary science and public health. The Surgical and Gynecological Society offered a feast of twenty-six (26) papers, plus clinics at the Hahnemann Hospital. The Obstetrical Society, under active and energetic leadership, presented an unusually attractive list of ten (10) papers. The Society of Physical Therapeutics had seven subjects on thermo-, kinesi-, radio-, and electro-therapy; and the O. O. and L. Society had as usual a full program that occupied seven sessions in reading and discussing. In addition to the papers themselves there were the oftentimes earnest and instructive discussions they gave rise to; discussions which to a marked degree frequently enhanced the value of the papers. No one could listen to a title of these papers and discussions without learning something that would increase his own knowledge and thus add to his usefulness as a practitioner of the art of healing.

A week spent at a meeting of the Institute forms a sort of post-graduate course in a school in which, by way of novelty, one listens to a lecturer and then hears the lecture criticized or its salient points emphasized.

Sometimes, as happened in Chicago, the clinics are of unique value. The Bureau of Clinical Medicine, for instance, discussed among other things the very practical subjects "ec-

zema" and "syphilis," and in connection with the essays there were brought before the audience some fifteen or sixteen atypical and typical cases which illustrated very impressively the ideas of the essayist. Every one present in the hall had the opportunity to carefully inspect and interrogate the patients, and the essayists gladly welcomed questions from the audience. This feature of holding clinics in the bureau of clinical medicine has been a favorite idea of the chairman, Dr. E. B. Hooker, and the success attending these clinics should prove gratifying to him and his New England colleagues, as well as to the Institute.

These are but a few of the points to be thought of when one considers the question of making application for membership in the Institute.

To the faint-hearted and pessimistic, and there are such everywhere, attendance at the recent meeting of the Institute would have proven a tonic. No one in the possession of eyesight and hearing could possibly attend such sessions as those held by the bureaus of materia medica, of homœopathy, and of clinical medicine without realizing that strong confidence in, and positive enthusiasm for, the therapeutic law of Hahnemann was still prevalent. The atmosphere of these meetings was stimulating, and it was encouraging to note that when surgery and obstetrics, and other specialties were attracting crowds of enthusiasts, such subjects as homœopathy and materia medica could draw audiences of three hundred (300) to three hundred and fifty (350).

While New England delegates were not present in as large numbers as usual, representatives from New England were on hand, and about fifty (50) applications for membership came from this section of the country. There were very few sections of our broad land that were not represented. From Maine to California, from Wisconsin and Minnesota to Florida and Alabama, delegates came to bear each his share of the

burdens of essay and debate, to teach and to learn, and to show by his presence his interest in the welfare of our common cause. The total registration of members and guests exceeded one thousand (1,000).

Among the more social and festive features of the week mention must be made of the formal opening exercises on Monday evening, which were followed by a large reception and ball, the music, dancing, and collation evidently being enjoyed by the assembled crowds. The social event, however, which will stand out prominently in the annals of this sixty-first meeting of the Institute is the banquet which was held on Friday evening, the last night of the session. This banquet was in honor of the one hundred and fiftieth (150) birthday of Samuel Hahnemann, the semi-centennial of the Hahnemann Medical College of Chicago, and the fiftieth (50) anniversary of the Illinois Homœopathic Medical Society. Seven hundred and fifty (750) or more guests were seated at the tastefully decorated and illuminated tables, and the banquet hall itself was resplendent with bright colors, electric lights, floral decorations, and brilliant evening dress. A good orchestra furnished music of a popular character which was much enjoyed by the multitude. The service was well trained and of the best, and went far toward making the banquet a great success. It is an undertaking of no small magnitude to quickly and deftly serve so large a number of guests, and that it was so admirably done reflects much credit on the management of the Auditorium. A memorable feature of the post-prandial exercises of the evening was the reminiscent sketch of Hahnemann by Mr. Wood, who in 1838 to 1840 was a patient of Samuel Hahnemann in Paris. To the founder of homœopathy Mr. Wood gratefully claims he owes his life.

Much of the work of the Institute is done by committees, for the members of which attendance at an Institute meeting does not mean a season of rest. One of the important com-

mittees is the intercollegiate, which during the past year has been investigating various questions of importance connected with medical education, and which as a result of this work made the following report to the Institute:

"The Intercollegiate Committee of the American Institute of Homœopathy during the past year has been investigating the subject of attendance at our medical schools, and discussing plans whereby said attendance may be increased. As a committee we are agreed that

"1. The admission and graduation requirements of our medical schools are not too high.

"2. That the established standards should not in any degree be lowered to attract students.

"3. That the recent decrease in the number of students in our schools is not attributable to lack of interest in, or loss of enthusiasm for, homœopathy on the part of the laity through whose influence to-day are being supported more dispensaries, more public and private hospitals, more sanatoria, more joint-staff hospitals, more state institutions under homœopathic control, than ever before.

"4. That the profession is not overcrowded with good doctors, there still being a large and increasing demand for homœopathic physicians, a demand larger than our colleges are able to supply.

"5. That a small percentage only of homœopathic students give up the study of medicine.

"6. That a scarcely measurable percentage of our students *voluntarily* leave homœopathic medical schools to enter old school colleges.

"7. That the laity, and more especially the rising generation, should be *educated to know* what homœopathy is; how effective and how trustworthy it has always been.

"8. That homœopathic medical schools must teach ALL useful knowledge that other medical schools teach, and MUST HAVE SOMETHING BETTER to offer students than other schools have.

“9. That our medical schools HAVE that “SOMETHING BETTER” in the possession of a scientifically founded knowledge of drug pathogenesis, and a reliable therapeutic formula.

“10. That homœopathy is to-day, as it has always been, a *specialty in drug therapeutics*; that it is the only method of administering drugs on a positively curative basis; and that at the present time it is in homœopathic medical schools only that the opportunity is offered students to systematically acquire a practical knowledge of the principles and practice of homœopathy.

“11. That the attractiveness and success of surgery and the specialties have detracted decidedly from the study of drug pathogenesis; and that it is the paramount duty of the entire homœopathic profession to devote renewed energy to the further development of our knowledge of drug pathogenesis and homœopathic therapeutics.

“12. That in view of these facts the intercollegiate committee recommend the adoption of the following:

“WHEREAS, We, as homœopaths, may have paused so long in contemplation of achievements and victories that it is time to turn to new efforts in fields yet unknown; and

“WHEREAS, One such field undoubtedly is the establishment of our medical schools on the firmest possible basis of ample endowment and *attractiveness* to would-be physicians.

“*Resolved*, That we enter on renewed efforts to further develop our materia medica by the study of drug pathogenesis in accordance with the most modern and scientific methods; and

“*Resolved*, That we neglect no legitimate opportunity to impress on the minds of the laity by personal interview and literature the fact that homœopathic medical schools to-day offer the sole organized opportunity to learn the principles and observe the results of the action of the only positive law of curative drug administration.”

The Trustees of the Institute of Drug Proving were able to report progress. There is a reawakening of interest in this

vitaly important department of homœopathy. During the past year a proving of chionanthus, under suitable control tests and thorough supervision, was made by a class of Prof. Royal's students in the homœopathic department of the University of Iowa. While this proving was not done directly under the control of the Trustees of the Institute of Drug Proving, it was made by one of their number partly to test methods which doubtless will be made use of in future work under the auspices of the Institute. To satisfactorily conduct provings under the approved modern method requires a certain financial outlay that was not entailed by the older methods. The trustees, therefore, have been interested chiefly in "Ways and Means," and were able to report a list of subscriptions amounting to nearly \$3,000. In addition they have been considering the necessity of being incorporated in order to hold and manage funds, and from their report the following quotations are made:

"The following bill has received the approval of the Trustees of the Institute of Drug Proving, and the hearty coöperation of the Institute members is requested to secure its passage:

"A BILL TO INCORPORATE THE AMERICAN INSTITUTE OF DRUG PROVING:

"*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following named persons, to wit, J. B. Gregg Custis, of Washington, District of Columbia; George Royal, of Des Moines, Iowa; Charles Mohr, of Philadelphia, Penn.; William Dewey, of Ann Arbor, Mich.; Benjamin F. Bailey, of Lincoln, Neb.; John P. Sutherland, of Boston, Mass.; and Edwin H. Wolcott, of Rochester, N. Y., their associates and successors, duly chosen, are hereby incorporated and declared to be a body corporate by the name of the American Institute of Drug Proving, and by that name it shall be known and have perpetual succession.*

"Section 2. That the objects of the corporation shall be:
(a) To study the effects of drugs upon animals and healthy

persons, and to preserve a record of such experiments, and the results thereof, in such form and manner as shall make them available and useful in the treatment and cure of disease.

“(b) To disseminate the knowledge of the results of such experiments by lecture, printed document, or otherwise, as may be deemed best.

“(c) To purchase such property, real and personal, and to provide and maintain or aid in the equipment of such laboratories as may be necessary to carry on the work of the corporation.

“(d) In general to do and perform all things necessary to promote the objects of the Institute.

* * * * *

“Section 4. That such board of trustees shall have full power from time to time to adopt a common seal, to appoint such officers, members of the board of trustees or otherwise, and such employees as may be deemed necessary in the carrying out of the objects of the corporation, at such salaries or with such remuneration as they may deem proper, and with full power to adopt by-laws from time to time and such rules and regulations as they may deem necessary to secure the convenient transaction of the business of the corporation, with full power and discretion to deal with and expend the income or funds of the corporation in such manner as in their judgment will best promote the objects herein set forth, and in general to have and use all the powers and authority necessary to promote such objects. Said corporation shall report annually the result of its scientific experiments and its receipts and expenditures to the American Institute of Homœopathy.

“Section 5. That the said corporation may take and hold donations, grants, devises, and bequests which may be made to it in support of the said corporation.”

* * * * *

Election of officers for the ensuing year, and the selection of the place in which to hold the next meeting passed off without exciting incident. Dr. W. E. Green, of Little Rock, Ark., was

elected president, and Atlantic City, N. J., was selected as the next meeting place. Apropos of next year the Institute heartily and unanimously adopted the recommendation of the Committee on the International Congress to hold said Congress in September, 1906, and to merge the scientific sessions of the Institute with those of the Congress. This change in the date of meeting from June to September was made in deference to the desires and requests of our British and Continental confreres, many of whom are anxious to attend the Congress, and will find it more convenient to come in September than in June. It is expected that the institute members will plan from the present moment to make the International Congress the largest and most successful convention ever held by homœopathists.

DR. WILLIAM L. JACKSON.

In the death of Dr. Jackson the homœopathic profession sustains a severe loss. His father having been one of the leading lights in the earlier history of homœopathy in Massachusetts, and having built up an extensive practice in the Roxbury district, the son by inheritance came into the possession of many qualities and opportunities which, with his own careful and conscientious preparation, gave him an admirable start in his chosen profession. For some years he ministered with remarkable success to a large clientele, and proved himself to be the beloved and trusted physician in many families. But unfortunately he also had a rheumatic inheritance, which frequently prostrated him, and finally produced a valvular disease of the heart which gradually crippled him, so much that in the later years his patients and his associates in the profession have been deprived to a considerable extent of his services and of his wise counsel.

Could he have maintained a fair degree of health, there is no doubt whatever but that he would have been universally considered one of the foremost members of the profession.

While he did practice, his success was due, not only to his scientific skill, but also to his kindly and sympathetic nature, which made each patient feel sure that he had his welfare particularly at heart. He was especially a lovable man. No where was this more evident than in the long years of his tedious invalidism, which he bore with Christian patience and with such a remarkable sweetness as to impress all his friends. Fortunate indeed was he in having the unremittingly faithful and able ministrations of a noble companion, who was the daughter of the general-in-chief of the homœopathic forces for many years in New England, if not in the United States.

In spite of his many disablements, with his many noble qualities his life ought to be an inspiration to the rest of us who have been physically more fortunate.

THE BURRAGE HOSPITAL.

Our readers will be interested, we feel sure, in at least a brief reference to this thoughtful and wise charity which has been in successful operation since 1902. Founded by Mr. Albert C. Burrage, and maintained by his generosity, it is giving to children ill with non-contagious diseases, and especially to crippled and deformed children, care and treatment otherwise beyond their ability to secure. Not only this, it is giving these advantages under the very conditions which make for renewal of mind and body. The hospital on Burrage Island, in Boston harbor, has an elevation of over eighty feet, commands a beautiful view for many miles, and enjoys an unlimited supply of pure sea air. The liberal management provides an abundant and nourishing diet for the little patients, with trained attendants, and pleasant and cheerful surroundings.

The building itself, of which an excellent illustration is given in this number of the GAZETTE, has four large wards on each floor, each ward containing fourteen beds with space for

more. Adjoining these wards are four more rooms containing three to five beds.

Well-equipped operating, etherizing, sterilizing, bandage, and recovery rooms are situated on the second floor, as also a number of smaller rooms where patients in critical or special cases may be placed by themselves. A clever device of an inclined runway, which by long easy slopes leads from floor to floor, makes it easy for crippled children to get from one part of the building to another, and admits of invalid chairs and the ambulance being pushed up and down.

The hospital was opened this season the middle of June, and its patients now number over one hundred children. There is no time limit, but those admitted are kept as long as the Medical Board thinks necessary, even until the end of the summer. The resident physician, Dr. Howard Moore, is a graduate of Boston University School of Medicine, and the chairman of the Medical Board is also an alumnus, our well-known orthopedic surgeon, Dr. George H. Earl, whose active service and constant coöperation have so much aided in securing the continued success of this noble work.

The homœopathic profession should take much interest in what is being accomplished on Burrage Island, for the staff of physicians is chosen from their ranks, and qualified young men, who are just entering upon their professional career, here have opportunities from season to season to observe a class of cases deserving of the utmost betterment that beneficence and skill can compass. The founder and maintainer of this wise charity is rendering a personal and valuable service to the community, for it is a work eminently practical, and is conducted under his constant supervision.

We would add that admission blanks, with full information, may be obtained on application to Mr. Burrage, 85 Ames Building, Boston, or communication may be had by telephone, Main 5828. Patients are taken to the hospital by steamboat from the wharf at 400 Atlantic Avenue every Wednesday at 10.30 A.M., a hospital officer being at the wharf to receive them half an hour before sailing time.

COLLABORATORS' DEPARTMENT.

Lie reports on Leprosy in the Spinal Cord and Peripheral Nerve that out of twenty cases of tuberculosis and maculo-anesthetic leprosy, that, in the tuberculous form, the bacilli are more widely distributed in the skin, while in the other form they are most numerous in the nerves. J. L. C.

Karl Kreibich reports (*Archiv. f. Dermat. u. Syph.*, 1904, V. 71, p. 3) under Infective Granulomata the fifth case of lupus pernio. This disease is interesting because recent opinion tends to class it as a manifestation of lupus vulgaris rather than lupus erythema, although there are no tuberculous bacilli found yet. J. L. C.

In the *Journal of the American Medical Association* for April 15, 1905, Channing W. Barrett gives a report of the vital statistics of Chicago for the last fourteen years with special reference to appendicitis. He finds that one per cent. of the mortality from all causes is due to this disease. The first consideration is an early diagnosis. All troublesome appendices should be removed without waiting for an acute attack, and all acute cases should be operated on without waiting for pus, rupture, adhesions, or a possible interval. Perforation or gangrene with localized abscess should be operated on without drainage or removal of the appendix, according to the judgment of the operator, and operation is the more necessary if there is no walling off of the abscess. Acute appendicitis should be operated on whenever the patient's condition permits, unless he is clearly convalescing. In that case wait until the acute symptoms are over. Healthy appendices should be left alone. The above counsel does not contraindicate rest, stomach lavage or the withholding of food, any of which measures can be employed as needed or without operation. Lastly, life is not the only question; time and after-conditions are also important. Adhesions may be

temporarily life-saving and later deadly. The waiting treatment favors them. After operation the patient is usually up in from ten days to three weeks. The rest treatment takes a much longer period of time.—*Medical News*, May 6, 1905.

The above statements, if made a few years ago, would have aroused considerable opposition from a large number of American practitioners, but it is doubtful if, at the present time, any criticism would be made of still stronger claims for the benefit to be derived from immediate surgical interference in all cases of appendicitis. The American ideas are crystalizing on this subject and I think it is neither unfair nor savoring of conceit to claim that the finer points regarding the pathology and treatment of this protean disease have been promulgated in the United States. The following "London Letter," taken from the Foreign Correspondence column of a recent issue of the *International Journal of Surgery*, would certainly seem to bear out these statements:

LONDON LETTER—APPENDICITIS.—"An important discussion has been carried on through three meetings of the Royal Medical and Chirurgical Society, on the operative treatment of appendicitis, particularly in relation to the subsequent course of cases. The discussion was initiated by Sir Frederick Treves, and was continued by most of the leading authorities on the subject in London. A large amount of statistical work specially prepared at the hospitals for the debate added greatly to the value of the discussion. Among the many points raised and conclusions arrived at, one may specially mention the following:

"1. In cases of perityphlitic abscess, it was generally agreed that it is as a rule best not to attempt the removal of an appendix imbedded in entangled adhesions.

"2. Failures and subsequent complications are often due to imperfect excision of the appendix, *i. e.*, the appendix not being removed at its very origin from the cecum.

"3. The much vexed question of when to operate naturally came under consideration. Many advocates were found for

the more advanced teaching that abscess formation should, if possible, be anticipated by operation, but especial emphasis was laid on the importance of dealing with the appendix in the so-called quiescent period of appendicitis. - On the other hand, it was recognized that the operation might be undertaken too lightly and become too much a routine practice. The operation should not be performed, unless a careful and reliable diagnosis had been made during the attack. There was no doubt that many healthy appendices had been removed, leaving behind the malady from which the patient had been promised relief.

“4. It was generally agreed that ventral hernia and other troubles might be avoided by attention to the smaller details in the technic of the operation, and especially by separating rather than dividing the muscular fibres of the abdominal wall.”

It is very doubtful if a majority of American surgeons would support the first of these propositions, and the treatment of the stump has become such a matter of routine that post-operative difficulties from this source have long since ceased to occur. Dr. Barrett, in the paper mentioned above, has sufficiently answered the third conclusion, while the method of incision—as short as possible—a little to the inner side of the middle of the line connecting the umbilicus and anterior superior spine of the ilium so as to incise the anterior aponeurosis about one half inch inside of the outer border of the rectus muscle, has practically disposed of the objections and post-operative difficulties mentioned in the last conclusion.

W. S.

In the *Journal of Cutaneous Diseases* for July, 1905, there is a very good article on Leprosy by Dr. Isadore Dyer, a well-known authority on that disease. He says that Dr. Gregory reports concerning leprosy in the colony of Cape of Good Hope that during the twelve years, 41 cases have been discharged as arrested leprosy. The average death rate during this time

is 16.9 per cent. More than one half of the lepers during the twelve years were removed to an asylum. Dr. Gregory also declares that there is no support for the fish theory. In view of the fact that there is to be a leprosy colony established in Massachusetts, the following ordinance governing the leprosariums at the Cape of Good Hope may be of interest.

ORDINANCE.

The governor shall have the right to inspect every leper home, whether supported by the government or by any other person or persons.

The medical inspector and the procureur-general are the two persons to whom the governor gives authority for these inspections.

All doctors are obliged if, in their practice, a person whom they have reason to suspect of being afflicted with leprosy comes to their notice, to immediately report the case to the medical inspector and to the procureur-general.

Each parish registrar, should he suspect any person living in his parish, shall immediately report the same to the proper authorities, and all schoolmasters and schoolmistresses are under the same obligation.

Every householder is obliged to report any person living upon his premises whom he has reason to suspect.

If any person is so suspected, if living in a district, the district commissary, and if in town, the procureur-general, shall appoint a doctor to go to the place and examine the person, and the doctor so appointed will receive a fee from the government for his services. The doctor will report to the official by whom he was directed to make the examination whether or not the person examined is leprous.

The governor has the right at any time to order an inspection of any part or the whole of the town as he may deem proper.

Every policeman is obliged, if he find a leper in a public place, to take him to the commissary of police, who will appoint a doctor to examine him.

The commissary of police has the right also, should he

suspect any person of being a leper, even though the person may not go into public places, to take the person from his house and have him examined. After the doctor reports that the person is leprous, the person shall be taken to the leper commission, which will be composed of the medical inspector as president and five members chosen by the governor each year. The government shall pay each member of this commission a certain amount for each time that they meet for the inspection of suspected lepers; the commission reports after each examination to the procureur-general, and if the person is proved to be leprous, he is at once sent to one of the homes provided for such cases.

In case that any leper of his own free will may wish to be isolated he would need write or send to the president of the commission and make known his wish and the commission will be assembled to make the necessary examination.

Every person found by the commission to be leprous shall have the right to choose the home to which he will be sent.

The governor has the right to have disinfected or destroyed any place where a leper has been living or any property that a leper may possess, but the owner of the property has the right to claim indemnity for the property so destroyed; but if any dispute should arise as to the amount of loss sustained the governor shall have the right to fix the amount of loss.

If any one in one of the leper homes should wish to be transferred to another home, he shall have the right to claim such transfer, and any leper may obtain permission from the government to leave the colony, should he so desire.

Otherwise, all lepers are obliged, as long as they are infected, to be detained in one of the leper homes.

If it is thought by the head of one of the leper homes that a leper has recovered, the case should be reported to the commission who will examine the person, and if he has so recovered, he will be released.

Any child born at any one of the homes shall at once be reported to the commission who will inspect the child and

determine what course is to be pursued regarding its detention or release.

Every government officer who may be sent to one of these homes still has the right to his pension.

Any person taken into one of the leper homes must relinquish all intercourse with the business and social world, all authority as parent or guardian, all property and business rights, being, from the time he enters the home until the time of his release, to all intents and purposes dead.

The moment any married person becomes an inmate of any one of the leper homes, the other party to the marriage has the right to claim a divorce immediately.

PENALTIES.

Any person, as mentioned in the above ordinance, who knowingly neglects to report any suspected case of leprosy shall be punished by imprisonment, with or without hard labor, from one day to six months, or a fine of from one to one thousand guilders, or both.

Any one causing any person to be taken to one of the leper homes without his being first declared leprous by the leper commission shall be liable to the same punishment as above.

Any one aiding an inmate of any of the leper homes to escape is liable to the same punishment as above.

Any one who may prevent the doctor appointed by the commission from examining a suspected leper is liable to the same punishment as above.

All homes existing at the time of the enforcement of this ordinance shall have six months' time in which to obtain the necessary permission from the government to continue. Bethesda and Gerardus-Majella Stichting are excepted.

This ordinance shall be known as the "Leper Ordinance," and will be enforced at a time to be fixed by the governor. The moment it is enforced all previous Leper Ordinances shall become void.

The reports from Iceland in 1904 tell us that of the 133 cases (73 tubercular, 60 anesthetic), all are isolated in a leprosarium. There is no leprosy in Greenland. This is interesting because the Esquimaux eat a great deal of fish.

J. L. C.

PERSONAL AND GENERAL ITEMS.

THE recently elected Lord Mayor of Melbourne, Australia, is Charles Pleasance, the sole proprietor of one of the leading homœopathic pharmacies in the British colonies.

CEREBRO-SPINAL meningitis continues epidemic in parts of Germany, and a communication from Berlin reports a large number of cases occurring during the early part of July.

THE Boston Floating Hospital made the first trip of the season July 6. Dr. Robert W. Hastings is the physician in charge.

It is reported that the number of deaths due to Fourth of July casualties is the largest this year of any year since 1898, and of wounded since 1893.

DOCTOR'S OFFICE TO RENT.—In a private homœopathic hospital on Newbury Street. Rates reasonable. Address A. B. C., 98 Dana Avenue, Hyde Park.

WANTED.—Two second-hand operating chairs in fairly good condition—Harvard, Yale, or similar make. Price must be low. Address, giving terms, etc., C. A. B., 98 Dana Avenue, Hyde Park.

FOR SALE.—A delightful home arranged especially for a physician, in one of the most beautiful suburbs of Boston. The retiring physician will include his good will in the purchase. The transaction must be strictly on a cash basis. Communicate with X. Y. Z., 98 Dana Avenue, Hyde Park.

MAYOR COLLINS has signed the order which has passed both branches of the city council, calling for an appropriation of \$30,000 for an emergency hospital in East Boston. To this appropriation will be added \$11,000, the bequest of the late Ann E. Taggard, who stipulated, in her will that the money be used for hospital purposes in that district. The hospital is to be built under the supervision of the trustees of the City Hospital.

ON July 6, the Boston Association for the Relief and Control of Tuberculosis opened a camp at Parker Hill, Roxbury, for the day treatment of tuberculous patients. The initial

number received was fifteen. The camp consists of three roomy tents, the largest being used for recreation and the serving of meals. The patients will be met by carriage each morning at eight o'clock at Roxbury Crossing, and during the day be benefited by the open-air treatment and proper diet, and will return to their homes at night. Dr. Edward O. Otis, president of the association, is in charge of the work.

WANTED.—Male junior medical assistant at the Westboro Insane Hospital. Must be a graduate of Homœopathic Medical School. Write or apply personally to Geo. S. Adams, Superintendent, Westboro, Mass.

A PRACTICE of thirteen years in town of 8,500 population, on main line of Boston & Maine Railroad, eighty-six miles from Boston. Good roads, schools, churches, electric cars, lights, paid fire department, and everything that makes up a small city. Will sell practice for \$250, and will remain long enough to give introduction. Address, Cash, 98 Dana Avenue, Hyde Park.

FOR SALE.—House, stable, and practice in a growing city of 12,000 population, situated in northern New England. No homœopathic competition. A live man should collect at least \$3,000 yearly. Price, \$5,000. Terms reasonable. For particulars address "Practice," care of the *Gazette*, 98 Dana Avenue, Hyde Park.

THE TREATMENT OF NEVUS, OR BIRTHMARKS.—A simple and safe method of treating nevi and port wine marks consists in exerting pressure around the nevus by an encircling ring in order to arrest the circulation to and from the part, and then slowly inject five to seven minims of rectified spirits of wine with an ordinary hypodermic syringe. The result is to harden the tissue and to cause the nevus to shrink and disappear. In treating nevi of large dimensions more than one injection could be given at the same sitting, or at short intervals of time in different parts of it; the absorption in one part could be taking place while another part was being prepared, bearing in mind the effect of alcohol upon the system. This method has the advantage of being easy of application, and there are few practitioners who are not possessed of all the material needed; if not, it is readily procurable, and with ordinary care it will not, I think, prove dangerous. Care must be used that the syringe is perfectly void of air before injecting the agent.—*Dr. T. H. Holgate in Pediatrics.*

TACHYCARDIA IN PULMONARY TUBERCULOSIS.—Patients in whom tachycardia is a constant symptom, while at rest should be kept in a recumbent position, even though no evidence of dilatation is present, and it goes without saying that the more nearly absolute the rest, the greater are the prospects of overcoming this symptom. The disregard of this indication will sooner or later lead to disaster, either on the part of the heart directly, or by the advent of advancing destructive changes in the lungs sufficiently often that recovery or radical improvement will constitute a rare exception. When once the symptom of constant tachycardia has been overcome, properly supervised exercise, combined with general hygienic management, becomes a curative measure for patients with a weak second pulmonary sound, except in those cases in which, by rapid progress of the disease in the lungs and advancing obstruction in the pulmonary circulation, an unfavorable course is conditioned.

In cases in which the right ventricle is laboring under tension, and tachycardia is not a symptom when at rest, exercise cautiously regulated to prevent any undue strain is rather calculated to prevent degeneration of the heart muscle and to favor the occurrence of hypertrophy, if not already present. But in these cases also the heart is liable to yield to strain under the most careful management, when intercurrent pulmonary inflammations, extension of the tuberculous disease in the lungs, pleural effusions or marked fever of long duration supervenes.

In addition to rest or limited exercise, as indicated in the individual case, the diet should be given especial attention. In many instances I have observed attacks of tachycardia to follow the ingestion of large meals or unsuitable food. The amount of food taken at a time should, therefore, be small, and the intervals of feeding more frequent. Albuminous foods should predominate in the diet, and articles liable to cause fermentation should be avoided. Daily evacuation from the bowels should be secured. Such patients should be brought into the open air whenever possible, and in cases in which the maintenance of the recumbent position is essential, the patient may be transferred to a cot without rising, and carried thereon to an open piazza, or the bed may be brought near to an open window.

To favor the cutaneous circulation, cold rubs in suitable cases may be employed and massage may be resorted to. In distressing attacks of palpitation an ice bag applied over the heart frequently affords relief. Alcoholics and tobacco are strictly to be prohibited. The usual cardiac tonics are only occasionally of benefit, and often appear to do harm by deranging the digestive organs.—*Medical Record.*

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ORIGINAL COMMUNICATIONS.

WHY DO PEOPLE DIE FROM PNEUMONIA?

BY JOHN P. SUTHERLAND, M.D., BOSTON, MASS.

[Read before the American Institute of Homœopathy, June 27, 1905.]

During the year 1904 there were in the city of Boston 10,757 deaths. Careful examination of the list at the registration office showed that of this number 1,388 were returned as pneumonia. That is, 12.89 per cent., or nearly thirteen per cent., of all the deaths for the year were from pneumonia. This is a very large percentage to be ascribed to any one disease, a mortality certainly terrible enough to warrant the inquiry, "Why do people die from pneumonia?"

I have heard it said by physicians of long experience and supposed veracity, that in all their experience they had not lost a case of croupous pneumonia. My own experience unfortunately does not wholly coincide with theirs; but among the most satisfactory statistics recorded in our literature are those found in Hughes' "Principles and Practice of Homœopathy," page 555, which state that Fleischmann treated 377 cases of pneumonia with only nineteen deaths, the last seventy-eight of the series all recovering, a mortality of very little under five per cent. The report does not tell us what varieties of pneumonia were treated, but it is only fair to assume the diagnosis was correct and covered those conditions which are usually called pneumonia.

Careful examination of the records of the Massachusetts

Homœopathic Hospital shows that during the last six and a half years there have been treated in the hospital 219 cases diagnosed as pneumonia. Of this number 48 died, a percentage of 21.87, or nearly 22 per cent.

I will not attempt to say why there should be such a difference between Fleischmann's statistics and those obtained in Boston. It is well known that diseases vary in their severity, and consequently in their mortality during different years and in different climates. It is also known that many cases are admitted to general hospitals in a most forlorn and frequently moribund condition. It is well known that Fleischmann used one drug, phosphorus, almost exclusively, whereas in Boston, many drugs were used, the selection being based as far as possible upon the indications, and these drugs were bryonia, hepar sulphur, iodine, phosphorus, tartar emetic, and occasionally other drugs, as belladonna and opium, if they seemed to be called for by the symptoms. Oxygen was also administered by inhalation when needed, and such adjuvants were used as seemed in each case to be called for. We cannot get at the detailed reports of Fleischmann's cases, but the reports of the Massachusetts Homœopathic Hospital are accessible, and they have been carefully reviewed with the idea of determining, if possible, why the mortality was so great.

Reports of 43 of the 48 fatal cases were accessible. Analysis of these 43 reports shows the diagnosis of "lobar pneumonia" or simply "pneumonia to have been used 11 times"; of "double pneumonia" without complications, 6 times; of pneumonia with the adjective "typhoid," 2 times. In the remaining 24 cases (or rather more than 55 per cent. of the reports examined), complicating conditions existed or developed, which were probably of a sufficiently serious nature to determine the outcome. These complications were meningitis, 3; nephritis (acute or chronic), 4; peritonitis, 1; appendicitis, 1; myocarditis, 1; chronic pleuritis and arterio-sclerosis, 1; and simply sclerosis (report does not say of what),

1; alcoholism, 3; diabetes, 1; chronic dementia, 1; syphilis, 1; broncho-pneumonia in tuberculosis and tubercular pneumonia, 2; streptococcus infection, 1; and heart failure, 1. The diagnosis "pleuro-pneumonia" is found two times. The term "broncho" or "lobular" pneumonia was not used except in a combination diagnosis. All the hospital cases were seen by more than one physician, each of whom had the opportunity of making every necessary physical examination. Many of the cases also were examined ante- or post-mortem by the hospital pathologist. Therefore the probability that the diagnoses represent the actual state of affairs is much greater than is the case with diagnoses which are made in private practice, unconfirmed by consultation or pathological examinations.

The reports that are found recorded in the registrars' department of the Boston Board of Health Office are simply accepted by the health officer, who has no means of verifying the diagnosis. Most of these "returns" are made by thoroughly competent diagnosticians, but many of them doubtless are made by those who are distinctly incompetent. They are therefore not altogether reliable, but they may be looked upon as sufficiently accurate for my purpose. Analysis of the 1,388 certificates returned to the health office during 1904 as representing the fatal cases of pneumonia shows that only 715 of these cases were uncomplicated. Of this number 571 are attributed to "pneumonia," "acute," "croupous," and "lobar pneumonia;" and 144 to "broncho," "catarrhal," and "lobular pneumonia." Nearly one half of the entire number, or 673, certify to the existence of some "contributing" cause of death. These complications may be classified as follows, not to go too minutely into details:

Alcoholism	24	Asthma	5
Appendicitis	7	Asthenia	7
Apnea	3	Anemia	5
Arterio-sclerosis	6	Apoplexy	2

Abscess	4	Influenza (grippe)	15
Asphyxiation	1	Infectious Diseases	
Burns	1	Measles	} 74
Cardiac		Whooping Cough	
Carditis	} 123	Scarlet Fever	
Endocarditis		Chicken Pox	
Myocarditis		Jaundice	1
Pericarditis, etc.		Laryngitis	1
Cerebral		Lead Poisoning	1
Edema	} 6	Locomotor Ataxia	1
Softening		Mastoiditis	3
Hemorrhage		Marasmus	6
Concussion		Meningitis	14
Carcinoma	3	Otitis	2
Cholera Infantum	1	Osteorthritis	1
Convulsions	11	Post-operative	4
Cholecystitis	1	Puerperal	1
Diabetes	3	Pulmonary Edema	4
Diphtheria	5	Paresis	1
Dementia	1	Pernicious Anemia	1
Diarrhea	3	Pleurisy	19
Empyema	7	Paralysis	3
Embolism	2	Pregnancy	2
Emphysema	1	Phlebitis	1
Erysipelas	2	Peritonitis	4
Exposure	2	Renal	
Epilepsy	3	Acute and Chronic	} 15
Exhaustion	50	Nephritis	
Gangrene	3	Interstitial Nephritis	
Hepatitis	3	Diffuse Nephritis	
Hypostatic	3	Pyelo Nephritis	
Intestinal		Ruptured Urethra	1
Indigestion	} 21	Rheumatism	3
Enterocolitis		Ricketts	5
Ileocolitis		Senility	49
Enteritis		Syncope	7
Gastritis		Syphilis	2

Sepsis	4	Trauma	
Stricture of Esophagus	1	Fractured Fibula	} 1 2 2 {2
Toxemia	5	Fractured Hip	
Tuberculosis	19	Fractured Ribs	
Typhoid	9	Fractures	
Thrombosis	2		

“Evidently, then, the complication” is a matter of great importance in pneumonia, and the prognosis is to be governed to a great extent by this fact.

The extent of lung involvement is not a reliable criterion of the severity of the disease. People do not die from pneumonia “for want of breath” as some would facetiously say.

The temperature of a case of pneumonia does not bear a definite relationship to the mass of lung tissue involved or the severity of the attack, and does not seem to markedly affect the issue.

It is very widely acknowledged that alcoholics are pre-eminently early and easy victims of pneumonia.

It is perhaps as widely acknowledged that age is the most important factor in determining the fatality of the disease. True, many of us can cite from personal experience cases of octo- and even nonagenarians who survived a fierce attack of pneumonia, but the disease is admittedly more and more fatal with the increasing decades.

The condition of the heart gives great anxiety during the course of a pneumonia, to the friends and to the physician of the patient, and this anxiety not infrequently strongly and even dangerously affects the treatment.

The condition of the kidneys is second to nothing in point of importance in the recovery from a pneumonia, and I believe we do not hear enough about this phase of the subject.

Why do we get distressing dyspnea quite regardless of the extent of lung involved in a case of pneumonia?

Why do we get sometimes an unreasonably high temperature with a small mass of hepatized lung tissue?

Why do we often see alarming mental symptoms in typical cases of pneumonia?

Why is it that pneumonia is so universally fatal among elderly people?

Why is it that alcoholics fall such easy victims to pneumonia?

Why is it that cases of heart failure occur so frequently in pneumonia where only a small amount of lung tissue is involved?

The answer to all these questions and to all related questions is one and the same. It is the peculiar toxemia that exists in what is called pneumonia, that is responsible for the fatal issue, the toxin itself being in some mysterious manner connected with the long since recognized pneumococcus. What the poison is may not be known, but that the toxin does exist, and that it is responsible for the fatality of pneumonia does not admit of any doubt in my mind. The young and the vital may possess resistance enough to overcome the so-called disease. The decrepit either from senility, or alcoholism, or dissipation, or overwork, or from possession of organs weakened by previous illnesses may not possess, and too frequently do not possess, sufficient resistance to withstand the onslaughts of the peculiar toxin of this disease. The virulence of this toxin may not be universally recognized, but is there any other hypothesis that fits the facts so well? Why do the young and strong resist, and the aged and weak succumb, to the disease?

The answer to this last question is the point I wish most to emphasize: Because the young are able to eliminate the toxin, while the infirm are incapable of this important function. A man of eighty-five, who would be called "old," may have a sound heart and relatively young kidneys, and as a result may be able to eliminate this pneumonia toxin. Age, faulty diet, overuse of alcohol, overwork, diphtheria, scarlet fever, rheumatism, and many if not all diseases, sometimes heavily tax and frequently weaken the kidneys, the great organs of

elimination, so that when they become burdened with the difficult duty of excreting the pneumonia toxin, they may find the burden too heavy.

Time is not allotted me in which to offer extended argument in support of my thesis, but I earnestly beg you to give it practical consideration, for I believe it merits investigation. I will not weary you with the recital of numerous cases illustrative of my explanation, but I ask your indulgence while briefly outlining the following case. Man; six feet, three inches tall; weight, two hundred and ten pounds; age, fifty-four; ill a few days with physical signs of pneumonia; temperature, 104°; pulse, one hundred and twenty-four. A copy of a urine analysis was handed to me by the physician in charge of the case. It read:

March 15, 1905. Twenty-four hours' quantity, 21 ounces (620 c.c.); color slightly high; turbid; acid reaction; specific gravity, 1023; total solids, 33.23 grammes; urea, 17.98 grammes; uric acid, .94 grammes; chlorides, 6. grammes; phos. acid, 1.79 grammes; indoxyl increased; albumin trace; sugar, none.

Sediment: Amorphous urates; few tubule cells; few epithelial cells; few (coarse) granular casts; few bladder cells; mucous shreds.

The laboratory comment was that this was practically "all right;" but in my opinion the patient was hovering over a danger. The urine may have been relatively normal, but it was dangerously insufficient. A man of two hundred and ten pounds with a temperature of 104° F. must pass more than twenty-one ounces of urine in twenty-four hours; must excrete more than thirty-three grammes of solids, and more than seventeen grammes of urea. The danger in that case was not a small patch of hepatized lung; not the asthmatic dyspnea; not the bloody expectoration; not the pneumococci even; not the high temperature, the rapid heart action, the nervous restlessness and perturbation. The real danger lay in the absolutely insufficient elimination of waste products; unrecognizable toxins among them.

Another case. Miss A. J. C. Pneumonia of apex of lower lobe of right lung. Hepatization very slow in development; very marked, but not a large mass involved. An indolent case beginning in mid January and continuing till March before convalescence was established. Characterized by high temperature, reaching 104.6° F., and holding it for many days; constant and severe headache, with eventually semi-comatose and other symptoms simulating meningitis; extreme emaciation; involuntary micturition and defecation; altogether a threatening and unpromising case. Many urinary analyses invariably showed a large twenty-four hours' quantity (two quarts or so); a low specific gravity ranging from 1006 to 1010 by balance; naturally a low output of waste products, and a total urea excretion of only 9.5 to 13 grammes. One would have been justified in the diagnosis of chronic interstitial nephritis, and yet the patient had never suspected the existence of renal insufficiency or difficulty. It was this very deficiency, however, that made her case painfully prolonged and seriously dangerous. And yet the case was one of pneumonia! Possibly the early recognition of the danger that threatened her helped somewhat to direct her path toward convalescence and health.

The two points then that I wish to emphasize in this very imperfect presentation of the subject are:

1. It is the toxemia that forms the grave danger in pneumonia; and
2. The free and unopposed elimination of waste products and toxins via the kidneys is the objective point in treatment.

THE SCIENTIFIC SPIRIT OF INVESTIGATION.

BY EDWARD BEECHER HOOKER, M.D., HARTFORD, CONN.

[Sectional Address before the Bureau of Clinical Medicine, American Institute of Homœopathy, Chicago, June 27, 1905.]

However interesting it might be to study the advances made in medicine during the past year, I shall devote very little time to such review, but confine myself almost entirely to a consideration of means of better utilizing the knowledge we already possess, and have possessed for many years. I shall also attempt to make clearer some of the many problems which confront us, both as physicians in practice and as members of the Institute, and if in illuminating the problems I can, in even small measure, throw light on their solution, the time will not have been spent in vain. A paper of this kind could well have place in the Bureau of Homœopathy, for it will deal with homœopathy, but from the practical, clinical point of view. It would not be out of place in the Bureau of Homœopathy this year when, I rejoice to observe, the propagandism of homœopathy will be discussed by some of our ablest members, and, I am bound to believe, by some of the rest of us as well. I hope to do a little propagandism in this address. There are several things in medicine which I strongly desire to see brought about, and to their accomplishment I would like to contribute what within me lies. One of these is the unity of the medical profession—if, mind you, *if*, with that unity comes a proper recognition of the value of the homœopathic principle of the art of healing, and I am optimistic enough to believe that such unity and such recognition are not impossible—not immediately, but in the future, not necessarily a union of organization, or even of affiliation,—but a union of ideas. But we must do our part, and one of the problems which we face is that of making our own methods so reasonable, so clear, and so convincing, that they will appeal to open-minded men not yet of our belief.

I was much struck with the sectional address of Dr. Lambert, chairman last year of this bureau at the Niagara meeting.

I hope you have all read it. It is a model of brevity, keen observation, common sense, and independence. I quote a few lines from it:

“One year is too short a time to outline and establish a successful bureau report. The organization should be more permanent and thus it will possess better working facilities.”

He then suggests that a permanent organization, a clinical medical society, be formed similar to the other auxiliary societies now a part of the Institute, and closes with these words:

“Surely some advancement has been made since we were last together, and that we shall comprehend from the essays which are to be presented. We still hold to the law of similars, but we have learned to apply it more for its scientific value than for its dogmatic assertion. We have found it to be a safe working principle in practice, but our experience has taught us it is not inimical to other scientific truths. It has been and ever will be a beneficent influence in medical achievement. We have learned also that the best reform may begin at home and to perform a good work we should always be ready to correct our own mistakes. Our law has been verified by time and experience, and it will always stand for what it is worth. As we are freed from a narrow environment we shall understand its application with a more telling appreciation. Our constant aim should be to save the sick and in doing this we should not object to any therapeutic help which science or experience may offer.”

Whether or not it may be wise to organize a new society to take the place of this bureau I shall not attempt to say. It is, however, true beyond question that the work done by this bureau is in a way fragmentary and incomplete, falling short of the attainment it ought to reach, because of lack of continuity. But it rests in large measure with the chairman of the bureau to overcome this under our present system without any change of organization. I have planned the present program with that idea in view, and two subjects at least will

be considered which were taken up last year and which provided most interesting discussion—rheumatism and pneumonia. Moreover, in order to bridge over the interval that has passed between the two meetings, I am going to briefly quote from the discussions of last year that you may be in a degree in possession of some of the salient thoughts then brought out. I believe it would be an excellent idea if the chairman, each year, would review and comment upon the work of the bureau in the previous year. It would certainly be of value to him to do so, and I believe it would make the work of successive bureaus more harmonious and continuous and of greater value. While the discussion of homœopathy is perfectly in place in this bureau, when therapeutics are under consideration, it is especially applied homœopathy which should be discussed, for this is the bureau of clinical medicine first of all, and here we bring out bedside experience and from that experience draw our conclusions. We should cultivate the true scientific spirit of investigation, and dispassionately make our clinical observations and discuss them without prejudice here. It is a great gift to be able to see clearly—to see things as they really are, and not as we want them to be. Without that clear vision no true progress can be made.

The paper last year on Rheumatic Infection, by Dr. W. B. Hinsdale, and that on Optimism versus Pessimism in Therapeutics, by Dr. W. C. Goodno, called out very interesting discussions which turned largely upon the efficacy of homœopathy in dealing with diseases of germ origin. This is a very important question, probably the most important in therapeutics which we have to face. But we should not be afraid to face it. Indeed, we should not be afraid to meet any question that arises, and we should honestly seek to find the correct answer, for we are scientific men sincerely seeking for truth, and while we believe that the homœopathic method of healing will always have a place and an honorable one in the art of therapeutics—more honored I verily believe in the

future than it has been in the past—yet our love for this principle should not blind our eyes. We must have the clear vision.

Dr. Goodno in his paper took the position that in pneumonia the homœopathic method is to the present time the most satisfactory method of treatment, but that it is our duty to investigate any measures which hold promise of greater efficacy by directly attacking the germs which cause the disease, and that in the carbonate of creosote, salicylate of sodium, quinine hydrochlorate, etc., we have drugs which appear to possess antitoxic and antiparasitic powers worthy of investigation.

I shall not attempt to discuss the usefulness of these and similar drugs, for that will doubtless be fully covered in the symposium on pneumonia this evening, but this paper and the instructive discussion which it brought out to illustrate several points well worth our careful consideration. In order to study carefully the effect of remedial agents upon a disease, it is essential to know fully what the uninfluenced course of that disease is, for every change is not necessarily due to the remedies employed. Errors arise from a too confident belief that every unfavorable change is due to a selection of the wrong remedy or to an aggravation from one well chosen, and that every favorable change is brought about by the action of the right medicine. On the other hand it should be emphatically affirmed, that a disbelief in the power of remedies to effect any change whatever is equally erroneous, and even more fatal to progress in therapeutics. What we need is keen insight and careful discrimination.

The discussion already touched upon brought out clearly the reasons why, in the light of the most recent knowledge in biology and bacteriology, there is solid foundation for the belief that the homœopathic method will always prove efficacious in the treatment of bacterial diseases. I cannot do better than quote the words of Dr. J. Herbert Moore, whose bureau of materia medica made such a splendid report at the Niagara meeting:

“I want to emphatically testify in favor of the efficacy of homœopathic remedies in bacterial diseases. Clinical experience has taught us this, if it has taught us anything therapeutically. We should not only recognize such efficacy of action, but we should examine into the *modus operandi* of our remedies in bacterial diseases; for in such method of action we shall find much to testify to the scientific status of homœopathy in the light of the findings of bacteriology and of the action of antitoxin.” . . .

“There is no department of bacteriology more interesting than that relating to bacterial immunity, and none which is being more thoroughly investigated at the present time. Whether Metchnikoff’s phagocytosis theory or Ehrlich’s chemical side-chain theory be accepted, the fact remains that the action itself takes place in the protoplasm of the cells. I want to emphasize the fact that there is a *vis medicatrix naturæ* in the bacterial diseases as well as in the diseases of non-bacterial origin. In response to the invasion of the toxins nature does throw out certain anti-bodies or the like to combat these toxins. If this power of nature did not exist bacterial diseases would be fatal.

“The point of especial interest to us is that our potentized remedies also act upon this same protoplasm of the cells in their action in assisting nature to overcome the invasion of the toxins, and we shall find that the process which the protoplasm undergoes in response to the curative action of homœopathic remedies is very much allied to that taking place as the result of nature’s *vis medicatrix* or of the biological curative agent of antitoxin.”

Another speaker made this point:

“In a disease which is serious, and may be fatal, owing to the development of toxins, and the case is to be treated by the administration of massive doses of medicine, as prescribed by our old school friends, how do we know that this treatment does not destroy the anti-bodies of the blood and so do positive harm? In pneumonia, when I have it myself, I will take my

chances with the homœopathic remedy every time. It helps the cell to send out forces which enable the body to cope with the morbid agent, whatever it may be."

Most of the discussion was in a broad spirit, exhibiting an enlightened belief in the power of homœopathy to deal with bacterial diseases, yet showing a willingness to examine the claims of other measures, worthy of investigation. On the other hand, some of the discussion was a striking illustration of the unscientific method of investigation and deduction. No one can fail to agree that, in the discussion of the therapeutics of pneumonia, or any other disease whatsoever, it is absolutely necessary in order to correctly report experience to first make a diagnosis. What is the value of an alleged experience in diphtheria if part of the cases reported are tonsillitis? How valuable are the conclusions drawn from the treatment of an epidemic of pneumonia, when it is practically certain that many or most of the cases were influenza or bronchitis? During the discussion which we are reviewing, one of the speakers asserted that in an epidemic of pneumonia in 1878, in which the average death rate was thirty per cent., he had lost but two cases out of two hundred and eighty-six, a death rate of only seven tenths of one per cent., and that, on an average, he had to make only three or four calls in each case. When pressed for the evidence on which he based his diagnosis, he admitted that he did not always make a physical examination, or, if he did, that his remedies cured the cases so quickly that no signs of any consolidation were to be found. To quote his own words:

"Of course, the old dodge of saying there was a mistake in diagnosis will come up, but if you could not take my diagnosis take that of fourteen other physicians, all old school, who were there and treated in the same epidemic. Nobody questioned the diagnosis; it was recognized by all. I did not trust to my memory in making prescriptions, but did straight repertory work."

Now a statement of this kind is worth examining carefully

for several reasons, and we should approach it in the right spirit, not with the implicit faith which accepts it in full, because it is something which we should very much like to believe, nor with the over-critical spirit which would utterly discredit it on its face as beyond reason. In the first place, the performance of this physician in that epidemic was very greatly to his credit—he did splendid work, saving life where others lost it, and it was a victory for him and for homœopathy which must justly have raised both high in the estimation of the people among whom he lived and whose lives he had saved. There is no reason for doubting, even after a lapse of twenty-five years, and although the report was made from memory and not from record, that it is correct, so far as it relates to the number of patients treated, and the number who died. But when this report is examined in the light of establishing the value of a certain method of treating *pneumonia*, it is not convincing, mainly for the reason that there is no satisfactory evidence that the disease was pneumonia. Were careful physical examinations made in every one of the two hundred and eighty-six cases? No. Was there evidence of the characteristic physical signs of pneumonia, on which alone a certain diagnosis can be made, in the cases which were examined? No, for the remedies worked so marvelously that a cure was wrought before the physical signs appeared. On what was the diagnosis based? On the subjective signs of fever, shortness of breath, soreness of the chest, and a dry skin, and, further, on the fact that fourteen old school physicians said it was pneumonia, and everybody recognized it as such. Did the fourteen examine his two hundred and eighty-six cases? They did not. I go into these details for the purpose of showing the need we have of better training ourselves to make more accurate observations when we attempt to investigate the value of any method of treatment in relation to a particular disease. And at the same time I have a great respect, I may say admiration, for the man who goes through such an epidemic, no matter what the disease, and makes such

a highly creditable record. This experience illustrates both the strength and the weakness of homœopathy—its strength in that it is able to heal the sick irrespective of the diagnosis, because it deals with the patient himself rather than the disease with which he is afflicted; its weakness, because such healing does not carry the convincing weight that it would if a diagnosis were absolutely a prerequisite to treatment.

I conceive that it is a part of our duty in this Institute, and especially in this bureau, to conduct our deliberations so that we shall not only add to our own knowledge but we shall also do something to help the propagandism of homœopathy, and one of the most important means to commend it to fair-minded men is not to claim too much. There is enough that is honestly ours—enough of eternal verity to convince open-minded seekers for truth—and there are such to be found outside of our school—without claiming that which we cannot prove.

But to come back for a moment to the treatment of diseases of germ origin. It is very interesting to note that while we have for years been successfully managing these diseases before we knew that they were caused by bacteria, there is now exhibited a tendency—natural enough under the circumstances—to seek for greater success by using means to destroy these germs in the system, rather than to rely on the old way of reinforcing nature, so to speak, to overcome them herself. But still more interesting is the trend of opinion among most thoughtful investigators, outside of our ranks, that there may be a better way of destroying germs which have gained entrance to the body than applying germicides directly to them, since there is danger in so doing of injuring the vitality of the tissues affected, and thus actually doing more harm than good. Nowhere is this better shown than in the surgical management of cases of pus infection, especially that involving the cavities of the body. In appendicitis, which has, through lack of attention or lack of knowledge, gone on to suppuration, either with or without general peritonitis, or in local or general peritonitis from tubal infection,

my observation teaches me that the most thoughtful and conservative surgeons, after finishing the operative procedures, no longer use bichloride or hydrogen dioxide, or even saline solutions, but content themselves with gently wiping the tissues involved, and establishing thorough drainage and then leave the rest to the restorative forces of nature. Nor is this idea of giving nature the best chance, without irritating and weakening the tissues through which she works, by any means confined to the surgeon. The therapist is working along the same lines, shown mainly by the production of the various antitoxins, but also by the recognition of the danger of attempting to treat the local manifestations of a general infection by germicides, the lungs in tuberculosis being the most striking example. A recent writer of wide observation and experience in an article in the *Medical Record* called "Let the Lungs Alone in Consumption," uses the following language:

"We have learned by bitter experience that we must practically ignore the bacillus in our treatment of the consumptive. Are we not coming to the same point of view with regard to the lungs? It is certainly a most curious paradox, that, while fully and firmly convinced that the bacillus tuberculosis is the cause of consumption, and that without it consumption could neither be transmitted nor developed, we yet find ourselves utterly unable to utilize or even to recognize this important and fundamental fact in any way in our treatment of the patient himself, invaluable as, of course, it is in the problem of prevention and transmission. To this position, however, we have been driven by the remorseless logic of events, and our utter inability to discover as yet any drug or agent which will check the development of tubercle bacilli within the human body without injuring the tissues more than it does the bacillus. Valuable as the different serums are for diagnostic purposes, and helpful as some of the later forms appear to be in hastening the recovery of the patient under the open-air treatment, yet it must be said that they have as yet achieved no specific or reliable position in the treatment of this disease.

And a few which do hold the confidence of even a fraction of the profession act entirely by stimulating in some way the resisting powers of the tissues and not by preventing the development of the invading germ."

Is it not curious that as our old school friends are perceiving the futility, and even danger of attacking the hostile bacteria within the system by germicides, and recognizing the wisdom of strengthening the resisting power of the tissues themselves, some of our own most thoughtful therapists are advocating the measures which they are abandoning? But it must be acknowledged that germicides have a place in therapeutics as well as in prevention, and it remains to discover the place and to use them with wise discrimination. May it not be that no general rule can be laid down, and that each tissue and fluid must be studied by itself, and its susceptibility and resistance determined? And does not the same observation apply to the various bacteria in relation to the different tissues? For instance, in tuberculosis of the lungs the accompanying streptococcus infection is the cause of a large part of the destruction which we seek to arrest, but we cannot successfully combat it by germicides. On the other hand, a destructive process in the skin of the lower extremity, for example, caused by streptococcus infection, can be speedily overcome by the local use of a solution of ichthyol, absolutely without harm to the tissues involved.

Theoretically there is no reason why the tissues of the eye should not be so reinforced by well chosen internal remedies that their resistance to germ infection will be strengthened, and they will be able to overcome an attack of conjunctivitis. Practically, this is the case in some kinds of infection of the milder sort, but who would dare, or have the right, to treat ophthalmia in the new born without local use of germicides? The gonococcus must here be attacked by a combination of internal and local treatment. In recent years the newer forms of the salts of silver have proved wonderfully effective, without producing the irritation of the nitrate, formerly the

main reliance. Argyrol I believe to be almost wholly without harmful effect upon the conjunctiva, even in very strong solution, while it is beyond question very destructive to the gonococcus.

Other illustrations might be given to emphasize the fact that I have tried to bring out—that no general rules as to infection and germicides can be laid down. Every germ and its relation to every tissue must be studied, and then we must employ the measures, whether general, local, or both, best fitted to the individual case. This means discrimination, individualization, which is the foundation of successful homœopathic and all other treatment.

We cannot all be surgeons—that is, devote ourselves exclusively to surgery—and it is a mighty good thing for humanity that we cannot. But we should let our clinical experience give us the clear vision, and cultivate the ripe judgment, which enables us to decide when an operation is and when it is not necessary. Accuracy in diagnosis is absolutely essential here, and a knowledge of the course of disease—in other words, diagnosis, pathology, and prognosis. It may be that we can prescribe successfully without these, but we can prescribe better with them and we are far short of performing our full duty if we let them slip into the background.

Our bedside experience, therefore, is not acquired wholly for the purpose of enabling us to make more accurate prescriptions, though that is perhaps the largest and most important use to which we put it.

In the light of what has thus been imperfectly shed upon the matters under consideration, what can we do to make these meetings more profitable to ourselves and to further the advance of the principles for which we stand?

The work of the bureau can be made more continuous and effective under the present organization chiefly by the chairman taking the pains to review the report of the previous year and to continue some of its lines.

The discussions should partake less of the nature of a

glorification, because of wonderful cures which have been wrought, but show more exactness of observation and evince more of the true scientific spirit which seeks the truth above all things.

We should not claim too much for our methods. As I have said, we have enough of eternal verity without claiming that which cannot really be proved.

On the other hand we should not be ashamed of homœopathy. At the bedside, in the consultation room, in the open meeting, we should manfully stand up for that which we believe to be true.

It is my firm belief, which grows stronger year by year, that if we cultivate the clear vision and the open mind our clinical experience will demonstrate that, whatever changes and advances there may be in the healing art, the homœopathic method will always have a place in therapeutics, which nothing else can fill. It may have more definite limitations than we can now give to it, and we may gain a clearer conception of its sphere of action. There will doubtless be other methods and measures of great usefulness, as there are now, and we shall have to exercise discrimination in our choice of weapons in the warfare of disease, yet it is my conviction that the place which homœopathic therapeutics occupies will, as time goes on, be wider rather than narrower, and that its position will become more and more honorable in the great world of medicine. But this depends upon ourselves. Are we complacently satisfied with our methods and our application of them? This state of mind is fatal to progress.

President Hadley of Yale University in his baccalaureate address to the seniors, day before yesterday, gave utterance to these forceful words:

“The sleep of conventionality is of all slumbers the most fatal. Life is progress—perpetual adaptation to new conditions. The self-satisfaction which leads a man to be content with the old is the beginning of death. The apparent excellence of a result actually attained, the mistakes and errors

involved in imperfect efforts to advance to better results, must not be allowed to obscure our view of this truth. No man, however far and however well he has managed the voyage of life, can afford to rest complacent in what he has achieved."

The signs are not wanting that we are not complacently satisfied, that we desire higher achievement, that we have already entered upon a new era, that we are combining something of the enthusiasm of the fathers of homœopathy with the scientific spirit which the present day demands. Animated with such spirit there will ensue true progress which will uplift homœopathy and enrich the whole medical profession.

IDEALISM IN THERAPEUTICS.

BY WM. A. GEOHEGAN, M.D., CINCINNATI, O.

[Sectional address before the Bureau of Materia Medica and Therapeutics, American Institute of Homœopathy.]

The quest of the ideal is a dominant factor in the intellectual life of man. To conceive of that which is perfect and strive for its attainment is elevating and ennobling. Ideals have been and ever will be the impelling powers in the history of human achievements. Idealism is only to be condemned when its conceptions are practically or absolutely unattainable and disturb one's harmonious relationship with his environment.

Homœopathy has two ideals, pre-eminently useful as guiding principles, but both are beyond the possibility of practical attainment. The first contemplates a *science* of therapeutics based upon the law *Similia Similibus Curentur*. The second demands the *totality of the symptoms* as the basis of a prescription in accordance with the law of similars. Both are of incalculable value *as ideals*, but their pursuit, without adequate understanding of their inherent limitations, has been

productive of undue discouragement and unwarranted skepticism.

The discovery of a law of therapeutics and the remarkable successes which followed even its imperfect application awakened great hope for the speedy consummation of these ideals of homœopathy. A reactionary era of complacency and non-progression was the inevitable result, but a renaissance is now apparent to the most casual observer. On every hand there is a demand for the reproofing of our materia medica on a strictly scientific basis. Of equal importance, though less generally recognized as requisite, is the evolutionary development of the art of its application. The two must come hand in hand. Scientific reproofing will necessarily be the work of a comparatively few and requires much time. The art of therapeutics must be acquired by every true physician and ought to be improved daily by comparison of results and the conservative criticism of the pathogenesis of drugs in the light of experience. The demand for new data thus created and their assimilation as soon as established will furnish the greatest incentive for the reproofing of drugs. Then, too, it will awaken the profession, and perhaps the public, to the practical necessity for the financial support of such work.

Much of the therapeutic nihilism and mongrelism that have tainted many members of our school is due to a prevalent misconception of the relationship between the law of similars and the art of therapeutics. The constant depreciation of our materia medica has led many astray and caused them to employ remedies of really less value but for which more was claimed.

The frequent criticisms of our materia medica and the earnest pleas for its extension and improvement serve to emphasize the honest and consistent belief in *Similia Similibus Curentur* as a guiding principle which characterizes our school. We know it to be the only possible law based upon the relationships of symptomatology. We recognize its capacity for infinite extension or progress. We have had ample proof in

our own experiences that it often grants the power of prevision. Given one series of phenomena, the symptoms of the diseased individual, and a drug capable of producing similar manifestations in the healthy, a cure may always be predicted if the disease be curable; all this, of course, within certain limits not yet fully defined. Laws are assumed to be those of Nature so long as no exception to them is found. There are times, however, within the wide limits of the application of the law of similars when we are unable thus to predict a cure. One such exception with both premises fully established would controvert the law. The question of absolute proof or disproof is far from an easy one, for the complexity and boundless variety of human peculiarities furnish elements unknown to us and thus limit our power of prevision. If then, our accepted law and its limitations can not be fully established, occasional failures or apparent exceptions furnish no just cause for disbelief or discouragement. In favor of the law is to be urged many thousands of verifications and the essential consistency of theory and practice of its followers for more than a century, with results far more favorable than can be claimed by any other system of therapeutics in the history of medicine.

The mental trend of the age is toward an almost universal skepticism or absolute materialism. Let us not yield to it too readily, but ever bear in mind that "unlimited doubt like unconditioned credulity is the child of mental weakness." The therapeutic nihilism of to-day is indicative of no greater intellectual vigor than was the boundless faith in the curative powers of drugs. The wonderful progress of Science has dazzled the majority of physicians, who, in the mad rush to pay homage at her shrine have sadly neglected her older and often wiser sister, Art. This over-exaltation of science has retarded the progress of therapeutics—having led to undue division of labor, narrowed the fields of research, favored the too great specialization of practice and tended to the production of artisans rather than true physicians.

The *art* of therapeutics must not be unduly disparaged.

The application of facts and the deductions of broad generalizations require higher intellectual attainments than the mere acquisition of data. Professional skill is knowledge tested and perfected by practical experience. Science is knowledge, art its application. Science furnishes facts upon which art bases its procedures. Knowledge is of value only when it can be and is applied. Science revels in details, while art reveals generalizations and fixes relative proportions. Science demands means and instruments of precision and despises all others. Art studies both the facts and the shortcomings of science, draws deductions therefrom, and uses them with its own failures to increase the probabilities of future success. "The merely scientific physician is apt to be blind to useful maneuvers which rest rather upon the accidental than upon the more permanent qualities of things; indeed, the practical man often sees more of the surface of things than does the analytical man, and thus keeps more of the sense of proportion, more of the sense called 'common'" (Albutt).

In the study of *materia medica* the distinction is ever to be borne in mind between its scientifically established facts and the data applicable in therapeutics. The difference has been so clearly stated by Dunham that his words, bearing as they do the weight of authority, are worthy of repetition: "The recorded facts of our *materia medica* are the same to every reader. Where one mind may see only confusion and a maze of unconnected words, another may discern order and light, and the outline of a definite and consecutive chain of pathological processes, and consequently a clear indication for the use of drugs in the treatment of the sick. For while the *materia medica* in the books is a simple record of observed facts, in the mind of the practitioner it becomes the subject of reflection, of comparison and of hypothetical reasoning, which will be more or less just and valuable, according to the measure of the practitioner's natural ability and of his intellectual culture. For, as has already been said, 'the significance of a fact is measured by the capacity of the observer.'

“It follows from this that each practitioner sees in every drug of the materia medica some properties and capabilities different in degree and perhaps even in kind from those which his neighbors see in it, inasmuch as his natural endowments and his acquirements differ from theirs. . . . By the interchange of ideas on these subjects physicians may be mutually benefited and their capacities for usefulness greatly enlarged. It would appear that while the text of our materia medica should be sedulously kept pure, we may with profit interchange our deductions from what we read therein, our views of its practical application, and the results of our clinical experience.

“And there would seem to be not only room but a legitimate demand for essays, or still more for systematic works on the drugs studied from a therapeutical and clinical point of view, just as a sort of compliment to our materia medica which very properly regards the remedies strictly from a pathogenetic standpoint. Such works would necessarily be of a transient nature, and have only an ephemeral value, since they would group symptoms and necessarily interpret them in accordance with the physiological and pathological notions of the day. But they might be none the less service to the physicians of the generation in which they appear, since it is by the light of such notions, transitory as they are, that he gropes his way among the difficulties and obstacles of his professional path.”

Our materia medica, then, is open to criticism from various standpoints. Criticism of the works of others implies the application of intelligence to their appreciation and interpretation. While the critical faculty and the creative faculty rarely reach the highest perfection in the same individual, it does not necessarily follow that the one is essentially opposed to the other. True criticism is not destructive, but conservative, and strikes only at the false, thus emphasizing realities. It never despises an honest effort, and its results point the way to something better. The ideal mind is one in which there is a perfect balance between the initial forces and the restraints of judgment. As perfect mental poise is the gift of

no one, criticism of the works of an individual implies no disparagement.

So much has been said regarding the development of our materia medica upon a scientific basis, that more than casual references to it seem unnecessary at this time, it being the chief aim of this paper to plead for the painstaking use of material now at hand, or as rapidly as produced in the future. The care of the patient of to-day is obviously our first duty. The establishment of scientific data is always a slow process, and especially is this true when the phenomena to be observed are of a very complex character. The influences upon men of heredity environment and education are so manifold that the disturbances of the equilibrium we call health can rarely be traced to a single cause. Minor disturbances of this equilibrium are constantly occurring, and their number, as revealed by introspection, is very great. In our *Materia Medica Pura* are very properly recorded, all of the symptoms occurring during the administration of the drug being tested, hence it contains, and ever will contain, many symptoms of questionable value. This of itself does not warrant undue discouragement. Fortunately the desired relationship between the drug disease and the natural one sought to be cured is one of similarity and not of identity. "Straws show which way the wind blows," and many cures have resulted when the selection of the drug was guided by very superficial resemblances. If there is any truth in our therapeutic law the proportion of cures ought to increase in direct ratio to the depth or degree of similarity.

The complexity and boundless variety of human peculiarities, and differing modes of reaction to extraneous influences, are manifested alike in the so-called natural diseases and in the provings of drugs. The resulting symptoms are beyond the comprehension of the mind without classification of some kind. This can rarely be of a purely scientific character, hence we must have recourse to art, which is the skilful and systematic arrangement or adaption of means for the attainment of a

desired end. The successful comparison of morbid processes for purposes of diagnosis or with a view to treatment in accordance with the law of similars demands, as of first importance, the ability to form a clear conception of their general character and the relation of their various phenomena. The investigation of individual symptoms, though important, must rank second to the broader view of the whole affection. Just as laboratory physicians are not the best diagnosticians, so those learned in the individual symptoms of drugs without adequate idea as to their relationship, can never attain great success in the practice of homœopathy.

A clear understanding as to what constitutes natural and drug diseases is absolutely necessary in the study of *materia medica* and in the application of drugs in accordance with the law of *similia*. Our conception of health is that of an ever-shifting equilibrium between the constructive forces of life upon one hand, and the destructive processes of molecular death upon the other. Disease is the disturbance of this equilibrium, and not an entity introduced from without. Health is of itself impossible of definition, so infinite are the variations of function under the influences of heredity, environment, and nutrition. Tenfold more difficult to define is disease manifesting in its earlier stages no demonstrable changes in function and structure from those normal to the organism. Disease is an effort to combat antagonistic influences or organisms or to eliminate effete or ill-assimilated material from the body. This attempt and the consequent symptoms vary as do individuals. The manifestations of disease may be classified or grouped as a matter of convenience, and this we term diagnosis. In this process we deal "not with all facts, but with crucial facts." The types thus established are but means or averages, and are purely artificial. The extremes, though divergent from the type, are just as real products of the exciting cause upon one hand and the reacting organism upon the other. Thus given an uniform exciting cause acting upon several healthy organisms, a widely

differing series of symptoms can always be predicted. This has been recognized in homœopathic therapeutics which demands the totality of the symptoms as the basis of the prescription—in other words the individualization of the case.

In the attempt to follow this principle in the application of drugs to diseased beings, in accordance with the demands of the law of similars, we are met with many difficulties which are the logical consequences of the facts stated.

To find a drug corresponding in its pathogenesis to the totality of the symptoms of the individual is the ideal prescription; in practice it is seldom if ever possible.

The variety of symptoms occurring in the provings of a drug is as great as those of a natural disease. Some of these occur with sufficient frequency to be considered fairly characteristic while others are rarely manifested. What is the relative value of these symptoms as the basis of a prescription? It is obvious that the effects of baptisia upon human beings vary as much in different individuals as does the action of Eberth's bacillus or its toxin. There are symptoms which are to a certain degree characteristic of the cases classed as typhoid fever. Diarrhea exists in about seventy per cent. (70%); a fairly typical temperature curve in perhaps eighty-five per cent. (85%); epistaxis occurs in at least thirty-five per cent. (35%); and the rose spots in more than eighty per cent. (80%). However characteristic of the disease these symptoms may be, none of them are pathognomonic. It is the selection and grouping of these symptoms and comparison with a fixed artificial type that enables the physician to make a diagnosis. In prescribing baptisia for a patient with typhoid fever we do not know what symptoms the drug would cause in that particular person if he were in health. Is it not evident that for purposes of primary comparison at least the only drug picture available is a composite one into which, as into the construction of a type of a disease, there enters "not all facts, but crucial facts?" This picture is unlike that in composite photography in which every feature of each individual leaves an

impress upon the sensitized plate. This disadvantage is offset by the selective action of the artistic sense of the human mind. The true portrait painter does not seek to depict his subject as he sees him at any one moment, for in that he could not hope to equal the work of the photographer. He endeavors to combine upon the canvas a composite of the varying moods and emotions characteristic of the man. So it is that we recognize in the painting a speaking likeness with an expression susceptible of many interpretations. In such a portrait peculiar facial markings of blemishes find a subordinate place.

Such must be the drug picture primarily of service for the purpose of comparison in accordance with the practical demands of our therapeutic law. If each drug is clearly portrayed in the mind of the physician a resemblance to the majority of cases is readily to be found. When two or more similar pictures present themselves the more unusual symptoms find their place in differentiation. This method of selecting a drug was aptly termed by Dr. T. F. Allen "the impressionist method," and he characterized it as "one only to be used by a master of the art and which, if used carelessly, leads to disaster and failure." To realize the practical value of this method we need only compare Dr. Allen's masterly essays on Mercury and the Potassium Salts presented to the American Institute of Homœopathy in 1894, and the vast symptomatology of these drugs as given in his Encyclopedia or even in his Handbook. The same method applied in another way was shown in Hahnemann's classic prescriptions for cholera. To obtain the best results this method does require a "master of the art" but the same is true of all medical practice. Without it rapid prescribing so necessary in everyday practice is an impossibility.

This brings us to another point worthy of careful consideration. Dunham claimed for his essays on materia medica nothing more than "a transient nature and an ephemeral value." With his works are to be classed those of Farrington,

Nash, and Kent. They are artistic conceptions, that is, individual interpretations of recorded facts, and are to be criticised as such. They are of great value to this day and generation, and contain much that will endure forever. As every artist finds guidance and inspiration in the productions of others, so may the physician find invaluable help in the works cited. The artist, however, who is content to copy the delineations of others, never displays talents of a high order; he should make his final interpretations directly from nature. So the physician who blindly follows the lead of others must fail to attain true success and fall behind in the march of progress. He is then too prone to yield to the temptations of the routine prescriptions and combination remedies, and often degenerates into a therapeutic nihilist. He wrongly concludes that because of his own failures, the fault lies in the inefficacy of remedial measures. If, on the other hand, he carefully studies the conceptions of others and compares them with pure pathogenetic material, his art will be perfected and his confidence in the curative power of drugs increased. Then, too, he will fill the part of one individual in the evolutionary development of an art of therapeutics based upon a natural law.

Of the valuable results of such study but two illustrations will be given. We have already referred to the so-called characteristic symptoms of natural and drug diseases. It must be recognized that those of the latter rest upon no more secure foundation than the former; that both are determined more by the selective action of the human mind than by their invariable presence or by a numerical or statistical method. Being thus selected may not impair their value, but it does remove them from the realm of scientific certainties. Every physician knows that many atypical cases must be diagnosed in the absence of the more common symptoms. How many homœopaths realize that the selection of a drug should sometimes be made in the same way. Seventy per cent. of the cases of typhoid fever must be diagnosed in the absence of diarrhea; twenty per cent. when there is no eruption. How

often is byronia prescribed in the absence of pain or deep inspiration, amelioration by lying on the painful side or aggravation of pain by motion? These characteristic modalities are absent from the provings of bryonia far more frequently than the diarrhea and rose spots are wanting in typhoid fever. The failure to prescribe bryonia in the absence of these modalities limits the full realization of the sphere of its usefulness by more than thirty per cent. In his paper to be presented to this bureau, Dr. Boericke has directed attention to the congestive phenomena of camphor, the symptoms of which are too often ignored as therapeutic indications. Is not the lesson an obvious one? The composite pictures primarily of use either in diagnosis or as the basis of a homœopathic prescription may be inspired by others but are always subject, however, to the individual interpretation of diagnostician or the prescriber. With their guidance a diagnosis may be easily made or a similimum readily found in ordinary cases. Atypical cases are only too frequent, and they demand the highest judgment of the diagnostician or the therapist. The homœopath who does not delve into the *Materia Medica Pura* must fail in such cases as inevitably as the diagnostician who is unfamiliar with variations from established types. This conclusion must follow the recognition of the impressionistic picture of a drug's action as equivalent to that upon which a diagnosis is founded in natural diseases, though they are by no means necessarily based upon the same symptoms. If the views stated are correct it is the manifest duty of every homœopath to supplement the conceptions of drug action derived from others by comparative study of the provings as a necessary means of perfecting his art of therapeutics. That few do this is a matter of common knowledge. The consequent failures are the fault of individual physicians and not of the homœopathic system of therapeutics.

The facts partially presented in this paper seem to warrant several conclusions.

First. In the demand for the reprovings of drugs too little

is said regarding the positive value of the data already in our possession. Notwithstanding the faults of the existing materia medica, its painstaking use is productive of better results than the vaunted scientific methods of the dominant school. Yielding, then, to no one in the earnestness of our desire for the exact determination of the pathogenetic action of drugs we plead for the conscientious use of the material now at hand.

Second. The idealism which seeks to establish therapeutics as a science has led to the disappointment of all who hoped to find in the provings of drugs data upon which to make a prescription with the exactitude of other sciences. The resulting discouragement will measurably disappear with the just recognition of therapeutics as an art and of its true place in the evolution of the materia medica.

Third. As the conception of others or the impressionistic pictures of drug action correspond only to their more striking manifestations, students ought to be taught to compare them with the provings as an essential part of their education. Physicians should be encouraged to continue such studies by the example of our leaders in medical societies and in the journals. A lack of the just appreciation of the conceptions of others has led to much discouragement and many dissensions. Even the majority of those who profess ultra-Hahnemannianism accept as orthodox the "characteristics," especially the "modalities," selected by others; a choice involving the judgment of individuals rather than fixed facts.

Fourth. The practical value of the individual conceptions of the action of drugs must be established by clinical experience. A science of therapeutics demands nothing more than "indications" developed by provings. As the action of a drug in health is by no means uniform, but subject to innumerable variations, the art of therapeutics is not satisfied with apparent indications, but measures their value by the results of their use in disease. Hence more or less diverse conceptions of the drug action are to be studied by comparison with pure

pathogenetic effects, modified by the results of clinical use, and supplemented by partial or more complete provings as demanded for the elucidation of special points.

Fifth. Practical papers on *materia medica* should consider the pathogenesis of drugs as compared with certain groups of diseased individuals as well as variations from the more or less fixed types. The careful and critical study of cases treated may thus result in the improvement of the technic of the prescriptions for a given disease so that its mortality may be lowered. For instance, a careful investigation of the relation by the various drugs to pneumonia ought to so improve our knowledge that four per cent. of those dying of that disease could be saved. That would spare more than four thousand lives to our country every year, or more than the total loss from all causes during the late Spanish-American War. Is it not worth while?

Sixth. Studies of this kind ought to be the principle object of homœopathic medical societies. If this work cannot be or is not performed by existing bureaus of *materia medica* and clinical medicine, separate departments for such clinical research should be organized.

Seventh. The earnest and persistent pursuit of such studies and their exemplification in our practice, in our colleges, and in the public institutions under our control, will do more for the propagandism of homœopathy than any other measures that can be devised. It is not sufficient that we effect cures of cases under our care; the homœopathicity of the remedy prescribed must ever be manifested as the salient feature of our work.

Eighth. The recognition of therapeutics as an art under the guidance of law is compatible with diversity of conceptions, and hence of practice, without contravention of the underlying principles. Therefore, we should manifest toward each other a great degree of tolerance in the nonessentials so long as there is an honest effort to fulfil the one requirement of our law.

Ninth. The title of many physicians to fame rests upon

their additions to the knowledge of one disease. When individuals are content to devote the best efforts of a lifetime to the study of the pathogenetic and therapeutic relationships of our drug, they may hope to leave a rich legacy to homœopathy and an enviable reputation to posterity.

Tenth. It may be urged that the study of drugs along the lines here indicated involves a vast amount of hard work or drudgery. It has often been termed a hopeless task. The latter is true only if too much is expected; that is, if we dare to hope for a science of therapeutics. Nine tenths of the work that produces results is drudgery. Perseverance against weariness and discouragement is the price to be paid for the advancement of any art. To seek exemption from this duty is to repudiate a just obligation. The history of medicine records thousands of lives devoted to investigation and studies that came to naught. Thanks to the law under the guidance of which we study, investigate, and practice, every honest effort in the elucidation of drug action and relationships is destined to play a part in the evolution of the art and perhaps ultimately the science of therapeutics. Work is never to be shunned. "Nature has made occupation a necessity to us; society makes it a duty, but habit may make it a pleasure." What greater pleasure, what higher inspiration, can there be than the knowledge that one's labors are certain to lessen the ills of mankind, not only to-day but for all times. If altruism does not bring ample compensation for the toil involved, then we must perform it as a solemn duty, for "When one has to do with an art the end of which is the saving of human life, any neglect to make one's self thoroughly master of it is a crime."

 EDITORIAL.

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THE INSTITUTE OF DRUG PROVING.

The editorial report in the August number of the *New England Medical Gazette*, on the progress of the committee appointed by the American Institute of Homœopathy in the important work of establishing this Institute on a firm basis, is extremely interesting and encouraging.

It would seem, however, that the rank and file of the members of the profession can be aroused from their seeming lethargy only by the continued efforts of those who are considered leaders in those branches of medicine particularly homœopathic. Strangely enough, at the recent Institute meeting in Chicago, the society whose president founded the movement gave evidence of great indifference towards the subject.

Three papers were prepared for this meeting from the provings recently made of belladonna under the supervision of Dr. Bellows. One, on the effect of the drug on the ear, by Dr. Bellows himself. One by Dr. Moffat, of New York, on the eye, and one on the nose and throat by Dr. Rice of Boston. The reading of those papers was postponed from one session to another to assure good attendance. In the absence of Drs. Bellows and Moffat, the papers were read by the secretary, who, at the beginning of the first, stood before an audience

of about seventy-five. Subdued conversation was indulged in and the greatest indifference shown, only about twenty-five remaining to hear the last paper. These occurrences show that among many of the specialists the subject of *materia medica* is not considered vital, and that interest in the new method of proving is by no means universal. It would seem that the success or failure of this new Institute of Drug Proving portends a great deal to the homœopathic profession. Failure means increasing indifference and a gradual abandonment of the methods of curing disease by distinctly homœopathic methods. Success means the establishment of our *materia medica* on a firm basis, and with this establishment, renewed confidence, fresh enthusiasm, greater attendance at our medical schools, and the recognition of our claims by the members of the dominant school. A recognition of these facts should arouse us to every possible effort towards furthering the work.

The forthcoming book on the results of the initial proving which Dr. Bellows has nearly completed should be owned and read by all who are on the side of homœopathy. Dr. Bellows has sacrificed time, money, and strength in completing this difficult task, and he should be supported in every possible way.

THE ARTIFICIAL CREATION OF LIFE.

In the August *Cosmopolitan* appears an article under this title, written by Garrett P. Serviss, who is supposedly familiar with the biological work of Professor Loeb of this country, and Dr. Burke of England. Those who have read the books of Dr. Loeb on General Physiology know that he has produced animal life, having but one line of heredity; but the announcement now comes that Dr. Burke may have produced life from inanimate matter by the use of radium as a vitalizing element.

The popular mind is much excited by statements of this character, and the physician is catechised by his patients

concerning the outcome of these discoveries. He must have a ready and logical answer for questions such as "If a man can create life, will it not be possible to arrest the natural disintegration of the body and prolong life indefinitely?" "If disease is a disturbance of vital force, will it not be possible to surely and quickly restore the normal balance?" "If the vital essence can be created by man and it is only a matter of chemistry, where is the Divine Creative power?" "Does not life cease to be a mystery?" The questioner may say: "Why does not this theory, combined with the known law of evolution, entirely explain our present state of existence?" At one time the earth, our earth, and all the other worlds, "were without form and void," gases finally became solids, positive and negative, ions were given off from radium and perhaps other sources, dead matter became vital, and the process of segmentation and development began, ending in "man the king of nature all."

To say that these questions are difficult to answer would be stating the fact mildly, but there is one answer that can be given to all, which although not a satisfying one, yet starts the mind in a channel less material, and more in accord with a belief in a Divine Essence, and the Divine order of the universe. Granted that life is a matter of chemistry and electricity, who created the chemical elements and the ions of electricity, and who arranged the process of segmentation so that the life and development of the cell is almost identical with the life and the development of the body?

We are told by biologists that the process of evolution is illustrated over and over again in the successive stages of growth from the vitalized ovum to the perfect human being. "What does this signify?" When the subject is considered in that broad way, when we realize how much there is in the law, and the order, of the universe, which is entirely beyond the comprehension of the most learned mind, so much that is absolutely unexplainable, then we must look upon the discovery of Professor Burke, if it be a discovery, as insignificant,

indeed, compared with the unknown. A step in advance, perhaps an important one, but not of sufficient importance to even faintly illumine the pathway leading to the maternal discovery of the origin of life, soul, and mind.

OBITUARY.

DR. JAMES HEDENBERG.

Dr. James Hedenberg, the oldest practising physician in Medford, and a resident of that city for over fifty years, died July 16 at the family residence, 14 Salem Street, that city. He was in his seventy-fifth year. Death was due to a heart trouble which he had been suffering from for the past two years. Dr. Hedenberg was widely known throughout the city and adjacent towns, where he had built up an enormous practice. He was one of the pioneers in homœopathic treatment, which he finally discarded about ten years ago for allopathy.

Dr. James Hedenberg was born in Troy, N. Y., June 20, 1831, and was the son of David J. and Katherine N. (Ritchie) Hedenberg. He was educated in the schools of that city and studied medicine in the old Castleton (Vt.) medical school, now no longer in existence. He graduated from that institution June 16, 1852, and returned at once to his native city, where he practised for two years.

He came to Medford July 4, 1854. Dr. Hedenberg early embraced the doctrines of homœopathy. For many years he was instructor in the diseases of children at the Boston University Medical School, and served as vice-president and president of the Massachusetts Homœopathic Society. About ten years ago he changed his opinion of methods of practice and joined the Massachusetts Medical Society, and at the time of his death was a member of the Middlesex south district section of that society.

For eleven years Dr. Hedenberg served as a member of the school board of this city. He was also a member of the Medford Historical Society.

The writer deems it a privilege to add his word of appreciation and praise to the character and professional attainments of Dr. Hedenberg. Of a retiring and sensitive disposition, he was punctilious in the observance of professional etiquette towards all physicians with whom he associated.

Unfortunately he did not always receive the same consideration in return, and to this fact, more than to any other, was his change of school, late in life, due.

He was an indefatigable student of medicine, always abreast of the times, thoroughly informed in current medicine literature, broad and liberal in thought and judgment. As a consultant, his advice was invaluable.

It was the privilege of but few to know the man intimately, but those few appreciated his character and intrinsic worth as the majority of those among whom his lot was cast did not.

J. L. C.

COLLABORATORS' DEPARTMENT.

There is a very interesting article in the *Journal of the American Medical Association* on "The Status of Medical Affairs in the Philippines," by Dr. John R. McGill.

He speaks particularly of the climatic conditions of the country. The surgeons and physicians sent there on military service were so much impressed with the beauty and resources of the country that after their two years' governmental experiences they wished to remain longer.

Their professional experience has proven that, excepting some intestinal disorders which are preventable and readily cured, and a limited amount of epidemic infectious diseases, there is nothing unusual about the kind or amount of disease encountered there or special difficulty in successful treatment when hospital care is obtainable. The surgeon's work, also, has fully demonstrated that ideal wound healing and convalescence after operation is as much the rule here as anywhere. Children's diseases, so prevalent in other places, are rare here, while the majority of all ills, especially among women, from real bodily ailments to a poor complexion, are found to be due to heredity or acquired by unhygienic living, and not attributable to the climate.

The healthful conditions of Manila and the surrounding country have been much improved by the efficient Board of Health on the island, for the members have taken a decided interest in introducing the most scientific and improved conditions of living. It is through their efforts that Manila has become a healthful and safe city, and promises to be a very handsome one.

The governmental laboratories and its scientific libraries whose cost was much criticised, have proved to be most useful, and are considered from a scientific point to be inferior only to those of Europe, America, and Japan. The laboratory facilities are freely at the disposal of research workers from all parts of the world. Much has been done already in dem-

onstrating the resources of the country, and in saving the crops from ravages of pests.

Among the hospitals established, there is an infectious disease hospital of permanent construction for one hundred beds. Temporary arrangements have been made for the care of seventy-five male and fifteen female insane. A venereal detention hospital has been in operation under the government care for four years, and there is a special hospital for civil employees. As yet there is no general hospital where the medical profession and laboratory scientists can properly treat and investigate disease among the natives. It is hoped that a government general hospital will be established soon, with careful management, for the country is overrun with untreated chronic diseases. The report of the Board of Health shows that the mortality of infants in the first year is sixty per cent., and that even in Manila fifty-two per cent. of all the deaths occur without medical treatment.

The chief medical association was formed in 1902 as the Manila Medical Society, and was organized by ten American and English physicians. Its organization was according to the basis laid down for local societies by the American Medical Association. Monthly meetings are held, and the admirable character of the papers is shown by the interest taken in their discussions, and by the excellent attendance.

The Filipino medical men are courteous and charming in manner, devoted to the interest of their patients, and apparently enthusiastic in medical affairs. They all have a very good knowledge of French and Spanish. Their two chief characteristics are a large capacity for absorbing and expounding theory, and their unique social position in that the abler men of the profession are foremost in political affairs of the country. Notwithstanding the good feeling between the alien members of the profession and the native doctors, all attempts to interest them in medical society work have proved unsuccessful.

Almost all the medical education is acquired in the medical

school of St. Thomas. The fees for the entire course of seven years are one hundred and twenty-one dollars.

Statistics show that at the present time there is one physician to 1,013 inhabitants, or one physician to each 430 square miles. This fact, with the results already obtained by the physicians and research workers, shows that medical science demands and requires the establishment of a university medical college course similar to that in the United States, and it is hoped that money will be given in large sums by the government, or by private individuals who are interested in the medical and sanitary conditions of the Filipinos. J. L. C.

TREATMENT OF ACUTE OTITIS MEDIA IN CHILDREN.—To sum up, the essentials of treatment in acute otitis media in children are:

Rest in bed and good nursing; mild catharsis and nasal sprays; free paracentesis under surgical cleanliness, good light, and general anesthesia, as soon as the diagnosis of an active inflammatory process in the tympanic cavity is reasonably sure.

Frequent and copious irrigation with hot antiseptic solutions. Mechanical cleansing of the canal and inspection of the fundus of both ears, daily, until the temperature remains normal, and at intervals of two or three days thereafter, until all discharge has ceased.

Evacuation of the middle ear by aspiration immediately after paracentesis, and in case of retention due to thickened secretion or a tendency to closure of the paracentesis wound.

Abortive measures, particularly leeching and the use of the ice-coil, are to be recommended only at the very beginning of mastoid involvement, and then for not more than a day or two.

Drugs for the relief of pain should be used only in case of unusual urgency, and then only with great care. Repeated administration of narcotics cannot be too strongly condemned.

In case of progressive involvement of the mastoid prompt surgical intervention is indicated.

To conclude with one or two negative suggestions: Don't wait for spontaneous perforation. Don't blow powders into a running ear. Don't pack the canal with gauze. Don't set a time limit for surgical intervention, but treat each case on its merits. Don't catheterize or politzerize in acute otitis media. Don't imagine that this affection is "self-limited," and don't forget that its possibilities for mischief are endless. Above all, don't temporize and dignify your inactivity with the name of conservatism.—*Dr. Percy Fridenberg, in American Journal of Surgery.*

ABSTRACTS FROM BOOKS AND JOURNALS.

EARLY HISTORY OF THE MICROSCOPE.—The early history of the microscope is obscure; but, as it is quite evident the property of magnifying possessed by the lens must have been noticed as soon as it was made, we are safe in attributing its existence in its simplest form to a period considerably anterior to the time of Christ. It is generally believed that the first compound microscope was made by Zacharias Jansen, a Dutchman, in the year 1590, and was exhibited to James I in 1619, by Cornelius Brebbel. It was then a very imperfect instrument of research, and it was only after the invention of the achromatic lens by Hall and Dollond and its application to the microscope by Lister and others, that the microscope reached the advanced position it now occupies among the scientific instruments of precision.

American Medicine.

PARAFFIN INJECTIONS IN GYNECOLOGY.—Stolz (*Monatschr. f. Geburtsh. u. Gynaek.*, Berlin, Bd. xx. Heft 6) refers to Gersung's cases of incontinence of urine and prolapse of the uterus so treated. In his first case, the patient aged twenty-five, had lost control of the sphincter vesicæ, which was unrelieved by seven repeated plastic operations. Gersung injected paraffin into folds of prolapsed vesical mucous membrane, with the result that complete power over the bladder was regained. Stolz reports a similar case cured by the injection of paraffin melting at forty-two degrees C. round the neck of the bladder. Haeban has tried the same method in cases of cystocele, injecting 20–25 cm. of paraffin between the bladder and vagina, and then directing it into the paravaginal tissues.

The results have been encouraging, and the method deserves further trial in cases where pessary and operative treatment fail.

ACONITE IN APOPLEXY.—In simple apoplexy, especially when occurring in stout and plethoric persons in whom the vessels of the brain are congested, but not ruptured, accompanied by a full, strong pulse, a hot, dry skin, a flushed and turgid face, and a tendency more or less to coma, aconite is decidedly the best remedy that can be employed. But in cases of apoplexy where

there is a tendency to syncope, a pale face, a feeble and perhaps an intermittent pulse, and a cold clammy skin, aconite should as decidedly be avoided, since the effect of this medicine upon the heart is certainly most depressing, and in some instances almost paralyzing. Should a marked reaction take place, and we find it necessary to reduce the action of the heart, and to diminish the force of the circulation through the brain, we may wisely resort to aconite as a medicine pretty certain to render the most speedy and effective aid.

Dr. M. E. Douglass, in The Medical Visitor.

PATHOLOGY OF SCIATICA.—J. Ramsay Hunt (New York City) records a typical case of sciatica with careful histologic study of the affected nerve. To the naked eye the nerve trunk below the sciatic notch and in the popliteal space was swollen and distinctly enlarged, the swelling due to an accumulation in the alveolar tissues of the translucent substance having the consistency of gelatine. A careful histologic examination of the nerve by modern laboratory methods failed to reveal any structural changes of an inflammatory or degenerative nature. Hunt concludes that the so-called sciatica or, more properly speaking, sciatic perineuritis, is not an inflammatory condition in the usual acceptation of the term. That the underlying change consists of a structureless transudate into the lymph spaces of the nerve sheath of obscure nature and origin, but probably dependent upon or closely allied to the gouty and rheumatic diathesis.—*American Medicine.*

GASTRIC ULCER.—At the May meeting of the British Homœopathic Society, Mr. C. J. Wilkinson, of Windsor, read a paper entitled "A Note Upon the Therapeutics of Gastric Ulcer." Mr. Wilkinson's note turned upon the sequence of causation in gastric ulcer as a guide to the therapeutics of the disease. He did not venture a complete theory of causation, but cited two varieties of autotoxemia as illustrative of the fact that absorption of toxins puts more stress on glands, and sets up inflammation in a distant, though connected, organ. The two factors in question are oral sepsis (in a fully developed form), and colonic constipation. In the bearing of the sequence of toxemia on the selection of the remedy, the question of pain has to be borne in

mind, this being probably a late symptom, owing to the fact that the stomach itself has no sensory nerves, and that pain is to be referred to the abdominal wall, the intercostal nerves, and the subserous tissue. Taking these facts into consideration, the pathogeneses of kali bichromicum, silver salts, uranium salts, cadmium salts, arsenicum, and atropine, are unmistakably pointed to as remedies for the disease.

Monthly Homœopathic Review (London).

DENTITION: UNUSUAL CASES.—Dentition is believed by some writers on pediatrics to be a simple normal condition, requiring but little consideration from the physician. But within the past two years I have had at least three cases in which the symptoms were alarming.

Ruth E., six months old, a splendidly developed child, of good parentage; artificially fed, with perfect agreement, as evidenced by normal growth and weight, quite undisturbed sleep, normal action of the bowels, both as regards frequency and color; developed fretfulness and an alarming pyrexia. In connection with the symptoms just narrated I found her with tense, swollen gums and constipated bowels. There had been no convulsions, but she would awaken from sleep with a start and cry that indicated a condition not far removed from convulsions. Her fever at the time of my first visit was 105° , and with the graduated bath which I ordered, together with enema, the temperature was reduced satisfactorily, but by night it was 106° . The baths were continued sufficiently often to control the fever, and as many as five were given in twenty-four hours. The gums were scarified on the second day, but the fever and restlessness continued more or less for eight days. The food was reduced to one fourth the amount ordinarily given, and an abundance of fresh pure water was given instead.

The other two cases presented were like the one just reported in being artificially fed—tense swollen gums, fretfulness and high fever—and differed in the following points: One of the two cases was twelve months old, and had vomiting and convulsions. The other child was twenty months old and had vomiting, no convulsions.

The treatment of the cases was practically the same—scarify-

ing gums, reduction of food, graduated baths. The one having convulsions was given in connection with treatment outlined, ice-cap to head, and hot mustard foot baths. All made satisfactory recoveries.—*Dr. J. M. Howell, in the Journal of Surgery, Gynecology, and Obstetrics.*

WOOD ALCOHOL POISONING.—The most conspicuous and characteristic feature of wood alcohol poisoning is complete bilateral blindness, appearing sometimes suddenly, but in most cases gradually after a period of failing vision. The disturbance of vision will sometimes come after a few hours; in most cases it lasts from one to several days, until a dimness of the sight is noticed. (In the case above reported it took about forty hours.) This progresses until the blindness is absolute. The interval between the ingestion of the poison and the onset of the eye symptoms is very characteristic, and may in some cases, as for instance in ours, hide the real cause of the blindness from the patient. The blindness lasts for a period of several days or even weeks, after which sight returns gradually. The improvement is frequently very considerable, sometimes full restoration takes place; but the improvement is not lasting. After several weeks the vision begins to fail again, and in the great majority of cases this progresses to final and irreparable blindness. Very few cases preserve useful vision; early treatment seems to be favorable to this termination.

With regard to the course of therapy to be followed in a case of wood alcohol poisoning, sweating by hot bath or pilocarpine, potassium iodide internally, and sufficient diuresis (perhaps by means of a milk diet), suggest themselves as rational, and have been successful in some cases.

The utmost importance belongs to prophylaxis. The public in general must be enlightened as to the poisonous nature of this substance, and laws should be enacted forbidding its use in the manufacture of "essences" and proprietary remedies which may be the means of poisoning persons not addicted to the use of intoxicating drinks, and who are entirely ignorant of the danger to which they are exposed.

Dr. Carl Koller, in Medical Record.

PYOGENIC INFECTIOUS ENDOMETRITIS.—These cases are due to direct infection of the uterine cavity by germs which are carried there by the hands of the physician or his instruments. These germs may have pre-existed in the vagina. There is not necessarily any residual material in the uterus; it is an infection *de novo*. In some instances the starting point is a wound in the perineum which becomes infected, and so by continuity of tissue, or by means of the lymphatics, not only the endometrium but the lymphatic and connective tissues become involved. Any one of the various forms of pyogenic micro-organisms may cause this form of endometritis; living tissues are attacked, in contradistinction to that of the putrid form when the inflammation is produced by the irritating influence of ptomains and leucomains, bacterial secretions, and decomposition products of dead tissue. As a result of these corrosive poisons, a grayish diphtheretic-like exudate layer forms over the affected surfaces. The course of this variety of endometritis depends entirely upon the intensity of the infection as compared with the resisting power of the organism. Anemia from hemorrhage, or any condition of lowered vitality, predisposes to intense infection. There are all grades, therefore, from the simple form with slight fever, purulent lochia, tender uterus, to the more intense forms, resulting in septic phlebitis, septic metritis and septic lymphangitis, depending upon which variety of structure received the brunt of the onslaught. In the mild forms there may be but little constitutional disturbance, merely a slight fever and no marked local symptoms. In the more intense forms of the disease the constitutional symptoms predominate, and include all those symptoms which depend upon pus formation, resorption, evidence of localized peritonitis, etc.

In the treatment of this more malignant variety of endometritis, as well as that of the mixed form (which simply means the first or putrid infection with an unevacuated uterus) little or no good comes from intra-uterine injections; indeed, harm more often results than good, except it be in a case which originates unmistakably in putrefaction and retained products, with subsequent deeper infection. If an attempt be made to examine the interior of the uterus, it will be found to be small

and to contain no débris. The uterine discharge is not offensive though pyogenic cocci exist in it, in large numbers.

In the mild cases, the use of cold locally, and the indicated homœopathic remedy, such as belladonna, bryonia, mercurius corrosivus and solubilis, lachesis, hepar, the symptoms will gradually subside.

In the severe types I am positively in favor of the operation suggested by the late lamented Dr. R. W. Pryor, viz.: a posterior colpotomy, whereby an opening is made through which a finger is introduced, the opening enlarged, the connective tissue and lymphatics in the lateral spaces is opened up, and through which drainage of infected tissues takes place. The cavity thus made is lightly packed with ten per cent. iodoform gauze. Profuse discharge of dark colored liquid takes place, in which great numbers of pyogenic cocci are found by microscopical examination. Pryor advocates enteroclysis or intravenous infusion or both to aid the kidneys in eliminating the toxins.

In order to be effective, this operation must be done early, that is, before pus formations have taken place. This is a consistent surgical procedure, and I believe in it thoroughly. When done at the right time it will save the patient from those dreadful complications of pelvic abscess, suppurative metritis and phlebitis and for the relief of which entire removal of the organs becomes necessary.

The treatment of a parametritis is that of connective tissue inflammations in general. Absolute rest in bed, ice-bag or the cold coil, and hot water douches, coupled with the internal use of the indicated homœopathic remedy, will, if adopted early and followed up diligently, give a good prognosis.

If suppuration becomes inevitable, hot poultices, with hepar internally, will hasten the process. Pus should be evacuated by the posterior incision.

In pelvic peritonitis, the ice-bag if it be tolerated, if not, hot applications will be useful.

If an affusion of serum alone is suspected, the treatment consists in preventing further extension of the process by removing the causative form of infection. The serum will then be absorbed.

If lymph is affused, the *cul-de-sac* should be opened, and all

attachments between the viscera should be removed, after the form of infection (usually the uterus) has been cleansed.

Suppurative pelvic peritonitis demands the most energetic means. The operation to be done is purely an evacuative one. Open the *cul-de-sac*, let out the pus, and fill the pelvis with iodoform gauze.—*Journal of Surgery, Gynecology, and Obstetrics.*

PERSONAL AND GENERAL ITEMS.

WASHINGTON, D. C., has suffered more from typhoid fever during the past month than at any time previously for several years.

DR. BERTRAM KRANZ, a leading homœopathic physician in Germany, has requested us to make mention of his present address, Luisenstrasse 92, Bad Homburg, v. d. Höhe.

By the will of the late Emily Caroline Harris, the Portsmouth (N. H.) Cottage Hospital will receive \$5,000 for the endowment of a bed, to be known as "The Robert Harris Bed, in Memorial."

DR. EZEKIEL MORRILL of Concord, N. H. is desirous of disposing of his homestead and personal property, that he may remove to a warmer climate. This is an excellent chance for a good homœopathic physician.

DOCTOR'S OFFICE TO RENT.—In a private homœopathic hospital on Newbury Street. Rates reasonable. Address A. B. C., 98 Dana Avenue, Hyde Park.

WANTED.—Two second-hand operating chairs in fairly good condition—Harvard, Yale, or similar make. Price must be low. Address, giving terms, etc., C. A. B., 98 Dana Avenue, Hyde Park.

THE daily press records the construction by a Dr. Hartman of Toledo, O., of a pair of rubber ears to take the place of natural ears lost in a laundry accident. The substitutes are flesh colored, and held in place by a steel band and silver tubes.

NEW YORK'S plans for a municipal hospital for tuberculosis cases are fast maturing. The building is to cost \$150,000, the exact sum authorized to be obtained as a loan for the same purpose by the city of Boston in 1901, but never issued. The New York hospital will be a permanent fireproof structure, three stories high, with four double-decked porches and two large solariums.

QUESTIONS ARISING IN APPENDICITIS WORK.

The question of operating upon moribund patients has always seemed to me to be one of morals rather than one of policy, and I have operated upon every patient who was still breathing when we got to the house or to the hospital. The pulse could not be counted in some of the cases, but it is surprising to note the effect of an intravenous saline infusion of fifteen hundred cubic centimeters given in advance of operation, and the effect of letting out a flood of toxins by a five or ten minute operation in many of these cases. One might as well not operate at all in such cases if he contemplates spending thirty minutes at the work, or of proceeding before the intravenous saline infusion has been given, and he must count upon having his chief death rate in this class of cases, at best.

The question of removing normal appendices when they are at hand in the course of other operative work is one that I have never favored, on the ground that removal of the normal appendix delayed the operation and added a trifle of danger. Leave the appendix alone until it is infected, and then lose no time in having it inspected. This has always been my ground, and the idea that I ever favored removal of normal appendices must have been a *reductio ad absurdum* from statistics.

In 1902, acting from experience, and upheld by the statistics of Dr. John G. Clark in pyosalpinx work, I began to close the abdomen without drainage in appendicitis cases in which considerable pus and other débris had been left in the peritoneal cavity. The object in closing completely was to get a stronger abdominal wall and to get the patients out of bed sooner. The practice was based upon belief in the power of the natural resistance factors of the patient to dispose of such material by way of the peritoneal lymphatics.

As a result of the practice it was noted that primary union would occur in about half of the cases, but the patients would carry a temperature ranging up to 100° F., for days or even weeks after they were up and about. In some of the cases secondary abscess would form, but it always pointed at the incision, so no harm was done. In several cases in which primary union of the muscles of the abdomen was obtained, the adipose layer became infected and showed remarkable tardiness in granulating after the skin wound had been reopened. As a result of this experience I have gone back to the method of using a cigarette drain in all cases in which pus or septic débris have been left in the peritoneal cavity, but the wound is closed without drainage in cases in which gangrene and pus occur within the peritoneal coat of the appendix.

The question about the time for operating in cases of appen-

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ANTITOXIN FROM A HOMŒOPATHIC STANDPOINT.

BY F. M. PADELFOED, M.D., FALL RIVER, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

It is claimed that statistics demonstrate the absolute superiority of the antitoxic over that of any other known method of treating diphtheria; a death rate even as low as two per cent. being claimed in the cases in which the antitoxin is injected in suitable doses early in the attack. A mortality of from ten to twelve per cent. is that most generally accepted by the leading authorities on the subject.

A series of tables compiled by Dr. Strickler of Denver, published in the Transactions of the American Institute for 1898, show that of 16,088 cases reported by allopaths, 5,228 died mortality 32.5 per cent. Of 1,992 cases reported by homœopaths 550 were fatal; death rate 27.9 per cent. A death rate of from 27 to 32 per cent., compared with that of from ten to twelve, rather strongly suggests the responsibility which he who neglects to administer the antitoxin, in diphtheria, must assume.

If the statistics are reliable they could hardly be expected to speak more emphatically in favor of any practice than do the above in favor of the serum treatment of diphtheria. Yet the statement so repeatedly made by competent observers that of all the cases admitted to hospitals, bacteriologically diag-

nosed "diphtheria," a large number are not such as would have been so diagnosed, clinically, a few years ago, must be considered; and because of this an accurate comparison of statistics can be made only with great difficulty, if indeed it can be made at all.

The enthusiastic believer in antitoxin will naturally attach but little weight to this doubt, yet the doubt must and does exist. And as long as it exists many will refuse to accept the statistics alone, as furnishing positive evidence of the superiority of the antitoxic over other methods, which are beyond question, more consistent with scientific principles.

The observation of retrograde changes in the pseudo membrane present in the throat or larynx, or better, in a case of diphtheritic conjunctivitis within a comparatively few hours of the injection of antitoxin—the results being fairly constant—furnishes far more conclusive evidence of the value of the remedy than statistics alone are likely to do. When we add to this the knowledge that before the serum is offered for distribution, laboratory experiment has shown that each unit of the antitoxin will prevent death when one hundred times the usual fatal dose of the diphtheria toxin is administered to a guinea-pig, I fail to see how we can deny the specific action of the remedy. Still, mere dilution of poison, or the stimulation naturally resulting from the injection of appreciable quantities of a vital fluid may, in some measure at least, be responsible for the favorable results observed.

Schussler's theories, while they may be to a considerable extent founded upon imagination, yet led him to believe and enabled both himself and his disciples to demonstrate that in the so-called tissue salts we possess a mine of remedial wealth.

It should not be forgotten that, in the solution in which the anti-body is presumably suspended, we have most, if not all, of the remedies included in Schussler's list, and this, too, in amounts not at all inconsistent with the doses which homœopaths successfully prescribe. The fact, that in some of the

serums no preservative is used, precludes our attributing the results to any antiseptic. It is upon the truth or falsity of the theories advanced in support of this system of therapeutics that our ultimate attitude in the matter must depend; and the theories at first sight seem attractive.

At a recent meeting of the British Medical Association, a Dr. Bullock stated that "the serum treatment of disease was practicable, and a comparatively simple matter in the case of toxemic diseases such as diphtheria and tetanus where only the toxin entered the blood, and all that was required was an antitoxin to neutralize the toxin. But the case was entirely different and infinitely more complex when the germs themselves entered the blood, as in streptococcal infection, tubercle, typhoid, and in most microbic diseases; and something was required which would dissolve the bacteria—a bacteriolytic serum."

In such conditions, on the authority of Ehrlich, he stated that intermediary factors were required,—the immune body and the complement. The (immune) body obtained from the serum of the animal had to combine with the complement manufactured by the cells of man, and that the process was very complex as anti-immune bodies might be injected into man, and it was impossible to say beforehand whether in giving such a serum as a remedy one was not actually lessening the patient's power of resistance and aggravating his disease. Anti-microbic serum he concluded should not be employed; at present the only hopeful outlook for such diseases lying in treatment by vaccines.

Then as a preliminary discouragement, we may understand that the cases which we can legitimately treat by methods in keeping with the antitoxin hypotheses are limited in number. The law, if we shall so term it, is decidedly limited in its application. According to Ehrlich the toxin molecule contains two independent atom complexes. The toxic element, by him termed "toxophorus," is incapable of producing its specific effects in the absence of the non-toxic "haptophorus"

element, which serves to bind the toxic principle to the cell. This actual combination between cell and poison must take place before any injury to the cell can occur. The mere presence of the toxic matter in the body, or in the fluids with which the cell is bathed does not, seemingly, have any effect on the cell. In the serum of the immune animal there is, it is assumed, some body or chemical which combines with the haptophorus element of the toxin molecule, thus depriving the poison of the agent which must be present to anchor it to the cell, and thus the affinity existing between the animal cell or tissue being destroyed no deleterious effects are observed.

This hypothesis may or may not be correct, but it is true phenomenally that the immune serum does possess some ingredient which seems to prevent the action of a most virulent poison. Although but little is known of the chemical character of antitoxin, serums taken from immune animals do have in solution some substance which seems to form chemical compounds with toxins; or, to express it differently, it is known that a mixture of two solutions, one known to contain a toxin, the other being the serum of an immune animal, is much less poisonous, if it is at all so, than is the toxin solution alone.

Buchner and Melchnikoff, with others, assert that the antibodies are but substances resulting from the action of the body cells upon either the toxins or products which are injected with it; not then being produced from any normal constituent of the body, but from something entirely foreign to it. Ehrlich contends that the antibodies are but the normal cell receptors produced in excess, and discharged into the blood stream. The chemical entity which he terms a receptor being, as I understand it, the agent to which the natural resistance possessed, in a varying degree, by all animals, is due. The injection of gradually increasing doses of the poison—*toxin*—serves but to stimulate the production of the normal constituents of the healthy body.

In the elaboration of any system of science or philosophy if the premises are not sound the conclusions adopted are

bound to be in error. Sir Isaac Newton long delayed the publication of his *Principia* because of one series of phenomena which he could not harmonize with the theories that he would advance. He recognized the fact that if it is possible to find one positive exception to any supposed law, the law as such then ceases to exist.

Nature alone is able to effect a cure in many cases of infectious disease, and from the fact that after a certain period germs no longer thrive upon the tissues of a diseased animal it was assumed that there was produced within the body of the animal, some substance which was detrimental to their growth. It would, then, seem but natural to question if the blood serum of this animal if administered to another similarly afflicted would not assist in or hasten its recovery. In diphtheria, clinical experience as well as laboratory experiment has seemingly given us a positive answer to this question. Tetanus is a toxemic disease. Tetanus antitoxin is used with doubtful success. It is, it is true, a remedy possessing a considerable prophylactic power, yet when administered for curative purposes the results are not encouraging. Pneumonia, if we may accept the statements made by the manufacturers of antitoxin, is most successfully treated with the anti-pneumonic serum yet at a recent meeting of the American Medical Association it was asserted that no serum or synthetic was known which was at all satisfactory in the treatment of pneumonia. Then, again, we read that equally as good results have been observed from the use of the diphtheria antitoxin in pneumonia as from the antipneumonic serum.

Of three diseases where brilliant success should be anticipated from the administration of a specific remedy, favorable results are obtained in the case of but one only. The cases of diphtheria most feared are those of a mixed infection, and in such cases if streptococci are present we are told to inject the antitoxin of diphtheria together with the antistreptococcal serum. Ehrlich would have us believe that this is dangerous, and competent observers state that their results from such measures have not been pleasing.

Our discouragement still grows when we read that meningitis is cured by the antitoxin of diphtheria; that whooping cough, asthma, and scarlet fever are to be treated in the same manner; that pernicious anemia may be cured by injecting antistreptococcic serum; and that vaccination will promptly cure whooping cough.

While it is yet too early for us to form any final opinion as to the actual value of serum therapy, we are, I think, justified in concluding that the practice, as it is to-day, rests upon a basis of empiricism rather than law. We now know that the serum of an animal immune against a specific disease does not suffice to cure this disease in another animal. It does sometimes cure, but in many instances it fails utterly. New cultures and new culture media, and experimental injections into many animals may at last result in the production of a curative serum for each and every infectious disease, yet the outlook is but little more promising than is the search for a vegetable or mineral specific.

If the prompt improvement occurring after the injection of antitoxin is rightly held to prove the value of this agent, an equally prompt and marked change for the better after the administration of the homœopathic remedy must to the same extent demonstrate the value of this. In the *Journal of Homœopathics* Dr. Cutting has reported the following case:

“On the afternoon of Feb. 5 a child, aged four years, was admitted to the hospital. Grayish membrane covering both tonsils. Breath very offensive. Tongue heavily coated. Glands on both sides of neck enlarged. Much salivation. Temperature, 104°. Pulse, 120. Respiration, 36.

“At 9 A.M. on the sixth. Patient had a restless night. Seemed worse after waking. Great difficulty in swallowing. Took cold drinks greedily, refused all warm drinks. Membrane greenish yellow, larger and thicker on right, rather less on left tonsil. Nurse thinks that when case was admitted there was more membrane on the left than on the right side. Fluids escape through the nose. Patient twitches during sleep.

Temperature, 104°. Pulse, 144. Respiration, 49. At this time lachesis was prescribed. At noon the temperature had dropped to 96°. Pulse to 80. Respiration to 24. No symptoms of collapse. Child quietly sleeping.

“At 9 P.M. Temperature, 99°. Pulse, 100. Respiration, 24. Child had slept most of afternoon. Skin warm and moist. Membrane gone from left tonsil, and less on right. Odor not so bad. Still calls for cold drinks.

“Feb. 7. Temperature, normal. Membrane all gone. Child made an uninterrupted recovery, and was discharged on the eleventh, having had a negative culture on the tenth and eleventh.”

One such case might be but a coincidence. Of five more treated by the same physician—with the single homœopathic remedy—the clinical records of which I have, the membrane in two had disappeared on the third, in two on the fourth, and in one on the fifth day.

In the *Lancet* of April 24, 1888, fourteen hundred cases of diphtheria were reported in which the cyanide of mercury had been administered, and the death rate was but 4.9 per cent. In another old school publication of 1896, eighty-one cases were reported treated with the same remedy, and of these but one died.

Dr. Villers using the potentized mercury cyanide treated one hundred cases without a death. To continue further with such testimony seems wholly unnecessary.

When the homœopathic remedy, properly selected, has been given, the results seem to be as prompt and marked, and the death rate seems to be as low as in the cases in which antitoxin has been administered. From a purely scientific viewpoint, the fact that failures are more frequent under the homœopathic method of treatment is a matter of no very great importance, if it can be shown that such failures are due, not to any lack of curative power on the part of the drug, but rather to an error in its selection.

If the results following the administration of the homœo-

pathic remedy, and those occurring after the injection of antitoxin are apparently the same—that is, they occur after about the same length of time and are similar in character, the natural inference would seem to be that the actual principle involved in was the same. This is not necessarily true, but similia may well be held to imply that similar results may be due to one of two or more remedial agents, either one similar enough in its effects to assist nature in establishing a cure in a given disease. In both methods of treating diphtheria we find that a dose (or more) of medicine possessing but slight toxic qualities does manifest very active curative properties. When it is stated that antitoxin is inert, or practically so, in so far as its effect on the healthy is concerned, we will do well to bear in mind that by antitoxin a complex substance consisting of a presumed anti-body, and horse serum, which according to Landois is itself injurious, together with, in most instances, an appreciable amount of some antiseptic, is meant; and not as might be inferred, an anti-body suspended in some inert vehicle.

In the Feb. 17, 1898 issue of the *Boston Medical and Surgical Journal*, a case is reported which should go far toward proving that the antitoxin will cause symptoms similar, indeed, to those of true diphtheria. The dose injected (5c.c.) should have rendered the person immune against the disease; for several weeks at least, yet within five days such a train of symptoms appeared that as yet no one has been able to decide, positively, whether the man did or did not have diphtheria itself.

It matters not what the practice may be named, the administration to a person already ill of a poison or of a substance which if given to one in health would result in injury—would disturb the healthy action of any tissue or aggregate of tissues is the very cornerstone of all drug therapeutics. As far as we know there is no exception to this rule; and antitoxin, if it is a medicine, in all probability will ultimately be found to be such exactly as others are so, injurious when given to the healthy, curative when administered in disease.

If, logically, we may expect that the antitoxic serum will produce pathogenetic effects when a proving is made, and on investigation we find reports of repeated instances where symptoms similar to those of diphtheria have been observed after the injection of antitoxin, it may be contended that nothing remains but to prescribe it, and do so with the belief that it is but a further addition to our homœopathic armamentarium.

The objections are too great. As homœopaths we postulate the single remedy, and the minimum dose. The single remedy is to be attenuated in a non-medicinal medium. As long as serious claims are made that the serum of a healthy animal is a patent medicine, animal serum can hardly be held to fulfil our requirements. Furthermore, as little is known of the chemical character of the substance which the anti-body is assumed to be, we are apparently dependent upon clinical experience for our knowledge as to the size of the dose.

If the quantity of medicine is to be measured by its curative power, what shall we say of this in cases in which marked improvement has followed the administration of a few doses of a remedy in potencies between the third and two-hundredth?

The object of the physician is not to theorize, but to cure disease, and the question before us is, can we, holding ourselves before the world as exponents of a scientific system of therapeutics, by methods unquestionably in harmony with our law, cure the percentage of our cases of toxemic disease—of diphtheria, which the users of antitoxin seem able to do? Can we do this in the families of the poor and unfortunate where but few symptoms other than those which enable us to make a diagnosis can be elicited?

Tetanus antitoxin is a valuable prophylactic but is of little use as a curative agent. The injection of from 250 to 1500 units of diphtheria antitoxin renders the individual immune from diphtheria infection. Susceptible animals may be made immune from diphtheritic infection by injecting weakened cultures of the bacillus, or what is better, suitable doses of the diphtheria toxin. (Osler).

Dr. Goodno after reviewing at some length the results observed in lupus after the injection of Koch's tuberculin, and the conditions found by Virchow in post-mortem examinations of twenty-one cases of tuberculosis where this agent had been used, states that this report of Virchow's was the beginning of the reaction against the method which has been supposed by most persons to have overwhelmed it; but that the use of a smaller dose of a purified tuberculin has given better results, and that the agent may yet be demonstrated to possess great therapeutic value.

Dr. Arnulphy asserts that he has rescued some cases of acute tuberculosis with tuberculin 6x and 8x.

Tuberculin is a fifty per cent. glycerine extract of cultures of the bacillus tuberculosis. The injection of a small dose of the toxin produced by the growth of the Klebs Loeffler bacilli upon an artificial culture medium, gives to the animal immunity against diphtheria. Diphtheria antitoxin does the same. The antitoxin of tetanus does little but furnish immunity. If the toxin produced by the tubercle bacilli when artificially cultivated has cured tuberculosis, as it seems to have done, logically the toxin of the diphtheria bacilli similarly produced should, when properly attenuated, suffice to cure this last disease. If such preparations, diluted or triturated, are used, their action is as homœopathic as would be the case if the cure resulted from the administration of lachesis, lycopodium or the cyanide of mercury.

Isopathy has been held (and rightly, I think) to consist in the giving of attenuated doses of the identical material which is known to be the essential cause of the disease.

The toxin elaborated by a specific microorganism grown upon bouillon or gelatin should not be regarded as identical with that present in the human body, produced by the germs acting upon human tissue.

Pasteur stated that the microbe of an infectious disease cultivated under certain detrimental conditions is attenuated in its pathogenic activity, and from a virus has become a vaccine.

Virchow is said to have asserted that serum therapy rested upon a homœopathic basis. Buchner and Melchnikoff seem to be but reiterating theories advanced by Hering as early as 1830. If, as they assert, antitoxin is a modified toxin, the only essential difference between the practice advised by Hering, and that of to-day is in the method of administering the remedy.

According to Ehrlich no effect is produced by a toxin unless it becomes anchored to the organic cell—in other words in order that the specific action of the toxin may be manifested there must be an actual combination between the cell and the the toxin. Then when the diseased organism has acted, or reacted, in such a manner that a pathological lesion has resulted, be it vesicle or pustule, or be it the diseased spleen from which anthracinum was obtained; the toxin, it may be assumed, has been modified by the cell. If Ehrlich be correct, the nosode, if we may so call it, is either the cell-toxin compound or some derivative of it. It is not the simple poison to which the diseased condition owes its origin. The principle involved where this product is given in disease is homœopathic and not isopathic.

Accepting as a probable truth the idea, that within reasonable limits an ill nourished cell will assimilate pabulum from the solution in which it is most diluted, we can understand that, by presenting to such a cell a substance for which it possesses a strong affinity, in less concentrated solutions than is the toxin of the disease, we can assist it in its struggle toward health. The substance, or drug, used as a medicine, then acts as a substitute for the food which for the time being it is unable to assimilate.

I believe that the specific curative action of all remedies used in disease, can be better explained by the now generally recognized principles of nutrition alone, than by any chemical or physical theory advanced by the authorities of the present day. Exact knowledge of bacteriology has thus far added but little to the therapeutics of any system of practice, yet it

would seem to offer to those of us who accept similia as a guide, a most fertile field for cultivation.

Psorinum, anthracinum and diphtherinum are justly objected to because of their doubtful origin, and perhaps because of their more doubtful pathogenetic properties. They are not available except in the dilutions, which, with the rank and file, are not popular. The toxins developed by the germs of diphtheria, tetanus and pneumonia, as well as by all other microorganisms of disease, which can be artificially cultivated, should be available to all who care to experiment in this field. It should be possible to obtain the same in all potencies from the lowest to the highest. The lowest, be it a tincture or triturate, should be of known toxic strength.

Many object to the pathological basis for the homœopathic prescription, yet how else shall we eliminate the too frequent almost, if not quite, insurmountable difficulties encountered in the search for the similimum?

None of us are infallible. Most of us must practice among the uneducated, where in many instances little or nothing can be obtained in the way of symptoms other than what we can personally see during the brief visit which we are able to make.

A simple Klebs Loeffler infection ingrafted upon a psoric, sycotic or syphilitic base, will naturally differ in its manifestation from that occurring in an individual otherwise in good health. The highest degree of success in practice will undoubtedly follow the administration of a remedy selected with a full knowledge of all the conditions which can have any bearing upon the disease in question. Diphtherinum, nevertheless, may cure, less promptly perhaps, but may cure many cases which without it we would fail to cure; not necessarily because the symptomatic similimum did not exist, but rather because in the limited time during which the disease was in a stage when a cure was possible, we were unable to find it.

If clinical testimony is needed to justify our experimenting

with homœopathic preparations of what are inexactly termed "the nosodes," Goodno's report as to the value of vaccininum; that of Raul and others as to variolinum; that of Burnett as to bacillinum, and of many as to anthracinum and diphtherinum should suffice. If we as homœopaths desire to enjoy the continued respect of the public at large, so dearly purchased by the *old guard*, I fear that we must show that the results following the administration of the single remedy in a minimum dose are not less pleasing than are those obtained from the empirical use of an animal serum hypodermically injected.

DIFFICULTIES IN EARLY DIAGNOSIS OF PHTHISIS.

BY PERCY G. BROWNE, M.D., EAST BOSTON, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

Tubercular disease of the lung is now so widely discussed both in medical circles and in the lay journals that at first glance there appears little to be added. Like everything else we all have different view points and methods of approach in the early diagnosis, so that in a way it is constantly presenting a new phase for examination.

It is the early diagnosis that the public at large demand. They have been properly educated up to the knowledge that such an early recognition is possible, and, consequently, consider it an essential of good practice that these early cases be recognized, both for the help of the individual attacked and for the protection of those exposed to the infection. It is in the early stage that the greatest good can be done. Practically in all sanatoria that attempt the cure or arrest of the disease, only those are admitted in the initial stage.

Along with this refinement in detection of the early stage, comes the important fact that the old classical symptoms hold good no longer. If we only investigated the cases that have a racking cough, emaciation, night sweats, with marked sec-

ondary anemia, few cases would recover. It is when there is a very slight cough or a constant state of catching cold, lassitude, and trifling disturbances of digestion that we must expect trouble. Fortunate is the patient who early in his illness has a small hemorrhage. Blood frightens the average person, and he is pretty apt to seek help.

The physical signs of the early stage are described in all text books. Usually it is said there is found at the apex an area of slight dullness, over which upon auscultation there is harsh respiration and occasional rales with increased vocal resonance and fremitus. Limitation of movement is also present, what is designated as lagging, i.e., the chest at the diseased apex dilates upon inspiration to a less degree, and after the well one has begun to expand. Such is the condition after a certain amount of infiltration has occurred. With such a series of physical signs, upon examination of the area involved we would probably find a small part of the lung partially consolidated, with free passage of the air through the enclosed bronchioles. In cases like the above the early detection is most frequent; but there is another group in which the physical signs differ widely, and yet the pathological condition is the same. It is in this second group of cases that error is most likely to occur. Although the disease is limited, yet such is the position of the products of inflammation that free circulation of the air in the small bronchioles is prevented. It is true that we get dullness as we do in the first case, but upon auscultation, instead of vesiculo-bronchial respiration with increased vocal resonance and fremitus, there is found diminished or suppressed breathing and absent resonance and fremitus.

This enfeebled respiration does not attract the attention as forcibly as does the higher pitched respiration of the vesiculo-bronchial type, since in many patients, particularly women of the anemic class, the whole respiratory act is decidedly feeble. So apt is this enfeebled respiration to mislead, we often have cases in the clinics far advanced in their course that have never been recognized. Comparison with the neighboring

pulmonary tissue would show the changes, but it is easy to put the diminished breathing down to generalized feeble respiration. For this reason the determination of dullness means a long step towards the diagnosis, and a few variations in percussion will often show a raised pitch where a hurried examination would omit it.

In the early stage of the disease the area of deposit is small, and may be found situated deeply in the substance of the apex or superficially immediately under the pleura. If anteriorly placed near the surface, auscultation will reveal it if practised in front, but upon listening behind, the much larger amount of healthy lung tissue would completely hide it,—or if the diseased area is on the posterior aspect the same difficulty will occur in front. The recognition of slight degrees of dullness is difficult enough for all of us, but this variation in the location of the deposit makes it very much more trying.

With a small amount of consolidation immediately under the pleural surface, great care is necessary lest the percussion waves extend beyond the deposit, and give an erroneous pitch to the percussion note. If the lesion is situated deep within the lung then light percussion will not bring it out, while heavier blows will show it easily. This care, if always exercised when making percussion, will not infrequently reveal difficulty where otherwise it might escape notice.

To assist in defining these trying cases an examination of the sputum is always to be tried, but one examination unless positive is absolutely worthless. The earlier the stage of the disease the less likely are we to find the bacilli, for until there is some breaking down of tissue they are not liberated, and therefore do not appear in the sputum. Repeated microscopical examinations are necessary, and even then one cannot be sure.

As to family history there is no question of the importance if it is looked at as an opportunity for infection. Careful investigation has shown that the children of consumptive patients are only to a limited degree more likely to contract

the disease than those of healthy ones. I believe one observer after due consideration, has declared it almost possible of proof that such children possess a certain immunity. But the fact that a patient has had members of his immediate family become tubercular, gives such excellent opportunity for infection that it becomes of great importance in making a diagnosis in doubtful cases. In the clinic at the dispensary, we always make particular inquiries regarding any possible source by which the patient might have been infected, and it is curious to see the widely varying sources of apparent infection. Sometimes it is the place of employment, a close associate being badly infected and freely expectorating without due care. It may be a relative visiting for a prolonged space of time, or possibly the patient may be one of that large number of people rooming with an associate who has the disease. At other times we have found the probable origin of the infection in a sweetheart. A very few cases have shown what was apparently a house infection—that is, after removal of a family of which one or two members had died from the disease, a new family entering, some members had developed a well marked case. It is difficult to state a fact of this kind positively, since the case might have been in the early stage before the patient had entered upon residence in the suspected quarters.

There is one other condition that is more than suggestive of a previous infection. A patient appearing for examination, but who claims freedom from tubercular infection, will state that some time in the past he suffered from a sharp attack of pleurisy. Within the past few years a more careful investigation has been made concerning pleurisy and its relationship to tuberculosis, and it can be stated very strongly that, as far as can be determined practically, all cases of pleurisy are secondary to the invasion of the lung by the bacillus of tuberculosis. If such a patient appears with such a history, it is better to consider him as at least a case that has been infected, and which may be again developing trouble.

Of course, the cases of which I am speaking are those that

are so difficult to diagnose with certainty, cases where the lesion is small, and situated so that heavy and light percussion are necessary to detect it; and cases where the bronchioles are obstructed and free circulation of air prevented, thus giving rise to diminished respiration instead of the vesiculo-bronchial usually expected in like conditions. It is for this reason that these points are of benefit: a hemorrhage, the blood not being coughed up but apparently welling up into the throat, all other points than the lungs being excluded; a prolonged opportunity for infection by close association with one exhibiting the disease, and a past history of what was probably a pleurisy. By pleurisy I mean a genuine attack, and not fugitive pains plainly of a rheumatic nature.

To tell a patient that he has tuberculosis when to all appearances he is in fairly good health, demands certainty in one's own mind, at least as to diagnosis. Certainly it is well to treat all doubtful cases as positive until any suspicion that may have arisen has been removed.

EARLY SYMPTOMS OF TUBERCULAR LESIONS OF THE BONES.

BY GEORGE H. EARL, M.D., BOSTON, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

The earliest symptoms of tubercular lesions of the bones are local pain, limitation of motion of the neighboring joint, a limp if a lower extremity is affected, and tenderness over the affected area. Swelling and heat appear a little later, and are not accompanied by redness. The general health suffers late, as compared with pulmonary tuberculosis. The local symptoms are few in number, rather constant, and not difficult of recognition.

The usual seat of a tubercular lesion in the bone, is at the epiphiseal line, where nutrition and growth are most active.

This close proximity to a joint, gives rise to the characteristic symptoms by which the disease may be recognized early.

Tubercular bone disease rarely, if ever, *begins* in the joint; but on the other hand, it seldom fails to invade the joint, so that for all practical purposes, the symptoms and treatment are those of joint disease.

Pain is nature's notice of disease, and rest is her method of cure. This is most emphatically true in joint disease, and it is by a recognition of these facts, and a proper interpretation of them, that we make an early diagnosis in tubercular disease of the bones.

An important point is the fact that only one joint is affected. It is rare for a patient to present tubercular lesions of more than a single joint. The onset is usually insidious, and presents frequent remissions. A careful record of temperature is apt to show a slight evening exacerbation.

In the lower extremity, a slight, occasional limp is one of the earliest symptoms. If the knee or ankle is the joint affected, there is apt to be slight swelling, and motion is somewhat limited. An attempt at full flexion or extension gives pain, there is also tenderness on firm pressure. If at the knee, the tender point is oftenest over the inner condyle. The favorite position for the part, involuntarily assumed by the patient is one of slight flexion.

If the hip is affected, the limp is more marked, and there is a tendency to drag the leg. Pressure over the acetabulum gives pain, as does also a blow on the bottom of the heel. The limitation of motion is most evident by turning the child on the face and attempting to make by preextension. This is sure to be limited, as compared with the sound side. A common early symptom in disease of the hip-joint is pain on the inner side of the knee; but this is not attended with pain on pressure at this point. This symptom is explained by the fact that the obturator nerve sends branches both to the acetabulum and to the knee.

When the spine is affected the earliest symptom is a pecul-

ilarity of the gait; a stiffness, the result of an attempt on the part of the child to guard the affected part against motion. This involuntary muscular splinting of the part furnishes the key to diagnosis by objective symptoms. Nature attempts to give the affected part rest, and her efforts bring about the limitation of motion, and the painful motion so characteristic.

Very early the symptom known as "night cries" appears, and furnishes strong confirmation of the diagnosis. While awake the child successfully guards the joint against motion or pressure, and so may play all day long, with only an occasional twinge, which easily escapes the parents' notice. But once sound asleep, the muscles relax, with the result that motion takes place to a painful degree, and the child cries out sharply. Once awake, or partially so, the muscles resume their office, and the mother finds the child asleep, or nothing the matter.

These "night cries," occurring in just this way, and repeated at intervals, furnish strong evidence of joint disease.

Tubercular disease of the spine presents, besides the usual signs spoken of, some which are peculiar. "Stomach-ache" is a common symptom. It is caused by irritation of the spinal nerves at the affected point, the pain being referred to their termination on the anterior surface of the body. Disease of the cervical or upper dorsal vertebrae may cause a form of "wry-neck."

In the dorsal region, chest symptoms only. In the lumbar or sacral region, the early symptoms may closely resemble hip disease. The spine in a real case is always stiff, in the neighborhood of the affected vertebrae. This stiffness, or muscular splinting, is seen in hyperextension. The child is placed face downward on a table or couch, and the spine extended by raising the feet, until only the chest and shoulders remain on the table.

A healthy spine, or one one affected only with rickets, will curve evenly the entire length. A spine in which there is

beginning caries will remain stiff and unbending near the seat of trouble. The history of a fall, unless it has clearly caused direct injury to the joint, is of little value in diagnosis. Hardly a child with tubercular joint disease but what has had a fall; and just as truly, hardly a child without, but what has had just as many.

Clinically, a case often presents itself with all the symptoms of beginning hip disease, for instance: limp, dragging of the foot, tenderness of the joint, history of fall, night cries, etc. The case has gone along for two weeks or two months. The absence of marked thickening over the joint, together with the fact that the case is not progressing, lead to doubt as to its being tubercular, and it clears up in a few weeks under calcarea phos.

This is a case of slight traumatism not followed by tubercular infection. Calcarea phos. is of value often in helping out a diagnosis in early suspicious cases, and is the sheet anchor in the storm which accompanies the real case.

DRAINAGE IN DIFFUSE, SEPTIC PERITONITIS.—Operations for diffuse septic peritonitis should be made as quickly and with as little manipulation as is compatible with thoroughness. Evisceration, partial or complete, greatly increases shock and the prospects of a fatal result. The generous use of clean, hot water will most thoroughly cleanse the infected cavity with the least traumatism. Drainage is simplified by collecting the peritoneal fluid at one point where drains may be easily placed. The elevated head and trunk posture followed by the gravitation of fluid to the lower pelvis best accomplishes this. Results following the surgical treatment of diffuse septic peritonitis will be improved should each individual operator adopt some definite form of procedure in such cases, which, being well understood by operator and assistants, may be methodically, speedily, and thoroughly carried out.

Dr. Van Buren Knott in Annals of Surgery.

 EDITORIAL.

Books, exchanges and contributions—the latter to be contributed to the GAZETTE only, and preferably to be typewritten—should be sent to the Gazette Associates, 279 Dartmouth Street, Boston; personal and other news items to Dr. A. T. Lovering, 10A Park Square, Boston; subscriptions and all communications relating to advertising, etc., to the business manager, Mr. Chas. A. Boynton, Hyde Park, Mass.

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 AFTER VACATION.

The holidays are over, the vacation period has passed for a season, and we are now face to face with the work of the year. Few, if any, of us can have followed the example of Sir Henry Holland, whose habit of taking two months from his professional duties was largely responsible for his wonderful health and a brain as clear and active at eighty-four as that or most men of fifty. None of us should have returned unrefreshed, still less with those words of a well-known author on his heart: "The day returns and brings with it the petty round of irritating concerns and duties." Rest is a much abused and little understood word. It is never to be used synonymously with illness as is so often done, but better, as an old professor once said. Mental rest is only gained by change of mental work, not by its cessation, and physical rest is often gained in the same way. Above all, the physician should find when the days of rest are over but that he has profited by them and those with whom he has been thrown. Far be it from us to urge that the doctor should not absolve himself from everything pertaining to medicine, but as an expert upon matters of sanitation he should do constant missionary work. One of the most brilliant men in the Baptist Church said at a missionary meeting: "The ripest field for religious work in the world lies in the country towns of

New England;" and equally true is that for the intelligent physican who would interest himself in the question of food, water, and waste disposal, as well as the greater question of moral sanitation, the field is equally ready. This kind of work is done in the daily tasks, through the friendly interest in their lives, and above all by the example of right living and thinking, which we all can and must give. It has been well said that the present crusade against tuberculosis has done quite as much for the well as the sick, to the education of the people to right living. Such work as has been suggested can be done by all, and while the harvest at first may not be great, it will pay. Looking at this from a purely selfish standpoint it should be undertaken, for we are too much given over to studying drug influences and anything which will incite us to the investigation and mastery of such problems as these, will inspire one to scientific investigation in other fields. Said a brave officer who was about to leave his family for three years of service in a tropical clime: "Everyone should strive to do his work a little better than anyone else has done. It is the greatest comfort in life under such trying circumstances as these in that I am placed where I must try." If, as Osha says, the master word is Work, let us try to emulate this gallant soldier and the year will end with victory.

BOOKS AND READING.

Medical, literary and scientific publications will be reviewed in this department. Books and journals should be marked NEW ENGLAND MEDICAL GAZETTE, and sent to the Gazette Associates, 279 Dartmouth Street, Boston.

A TEXT-BOOK OF PHYSIOLOGY, NORMAL AND PATHOLOGICAL. By Winfield S. Hall, Ph.D. (Leipzig), M.D., (Leipzig) Professor of Physiology, Northwestern University Medical School, Chicago, etc. Second edition. Illustrated. Philadelphia, and New York: Lea Brothers & Co. 1905. pp. 795. Price, cloth, \$4.00, *net*.

A good, scholarly, and extremely interesting treatise which will give students or practitioners a thorough knowledge of modern physiology, pathologic and normal. The author says: "The most notable additions to this work are the sub-chapters on pathologic physiology. It is becoming apparent to medical educators that to master normal physiology alone without applying its laws to the symptomatology of disease is to miss a large part of the service which physiology should render, just as the mastery of structural or morphologic pathology without an understanding of the modification which structural changes induce in the functions implies the loss of a large part of the advantage which the study of pathology should give."

This important field the author has covered, and covered well, and we do not doubt but that his text-book will be widely used.

THE DIAGNOSIS OF DISEASES OF WOMEN. A Treatise for Students and Practitioners. By Palmer Findley, B.S., M.D., Assistant Professor of Gynecology and Obstetrics, Rush Medical College in Affiliation with the University of Chicago, etc. Second edition. Illustrated. Philadelphia and New York: Lea Brothers & Co. 1905. pp. 588. Price, cloth, \$4.75, *net*.

There can hardly be any other department of medical practice where accurate and early diagnosis is of more importance than in diseases of women. In Dr. Findley's book will be found a careful survey of all diagnostic methods available to the twentieth century physician, including chapters on micro-

scopic examination of scrapings and excised pieces, examination of the blood, bacteriological examinations, etc. The plates, most of them full-page and in colors, illustrating these chapters are very satisfactory.

The body of the book is given up to special diagnosis, abnormal forms of pregnancy receiving mention, and, as a necessary starting point the distinctive features of normal pregnancy being noted. There is a final section on diseases of the urinary system. Engravings have been lavishly employed, and there are three score plates in colors and monochrome. This book might be universally and advantageously used by instructors and students in connection with clinical work, which is the *sine qua non* of the study of gynecology to-day.

MANUAL OF THE DISEASES OF THE EYE FOR STUDENTS AND GENERAL PRACTITIONERS. By Charles H. May, M.D., Chief of Clinic and Instructor in Ophthalmology, College of Physicians and Surgeons, Medical Department, Columbia University, New York—1890 to 1903, etc. Fourth edition. Illustrated. New York: William Wood & Co. 1905. pp. 400. Price, \$2.00 *net*.

There has been a considerable demand for this manual in Italy, Germany and England, as well as in America. It is very well gotten up, and contains an immense amount of information in comparatively small space. Original illustrations and colored plates are freely used. It gives a clear and direct summary of a department of medical practice too often insufficiently taught, and contains valuable instruction concerning topical applications, surgical treatment, and other approved methods. There is an exceptionally good index.

HOMŒOPATHY EXPLAINED. By John Henry Clarke, M.D. London: Homœopathic Publishing Co. 1905. pp. 212. Price, cloth, 2s. *net*; paper, 1s. 6d. *net*.

Dr. Clarke's book will be welcomed by all who are familiar with his able expositions of the tenets and application of homœopathy, and by many who have not heretofore had the opportunity of profiting by his familiarity with the subject. The present volume includes the gist of his previous monograph.

“Homœopathy: All about It,” and much of that matter has been expanded.

Students will find this brief treatise contains the answer to many questions naturally arising when beginning the study of our drug methods, and will learn much from it concerning Hahnemann's processes and patient verifications of therapeutic laws now taken for granted, but too seldom, unfortunately, clearly comprehended in their minutiae.

A PRACTICAL TREATISE ON SEXUAL DISORDERS OF THE MALE AND FEMALE. By Robert W. Taylor, A.M., M.D., formerly clinical Professor of Genitourinary Diseases at the College of Physicians and Surgeons (Columbia University), New York, etc. Third edition. Illustrated. New York and Philadelphia: Lea Brothers & Co. 1905. pp. 525. Price, cloth, \$3.50.

New chapters added to this work are: Pruritus of the Vulva, Herpes Progenitalis in Women, Gangrene of the Vulva, and Injuries to the Female Genitals in Coitus. These offer nothing not hitherto presented as to treatment, but contain valuable data, and comparisons of causes and cases. In other parts of the book a considerable number of new sections have been introduced, all excellent and practical. A careful perusal of the early chapters on the physiology of the male sexual function and the nature and composition of the seminal fluid will repay the reader, and render him more competent to trace the development of pathological conditions, and distinguish departures from the normal. The chapter on Azoöspermatism is an important one, and well written. Attention is also called to that portion of the book which takes up affections of the urethra and prostate.

HANDBOOK OF ANATOMY. Being a complete Compend of Anatomy, including the Anatomy of the Viscera, and Numerous Tables. By James K. Young, M.D., Professor of Orthopedic Surgery, Philadelphia Polyclinic, etc. Second edition. Illustrated. Philadelphia: F. A. Davis Co. 1905. pp. 402. Price. \$1.00.

We do not think there is anything to be gained by introducing to students a condensation of the large works on anatomy,

always excepting the very brief epitome or quiz book designed solely to assist in reviewing. Too much time can hardly be given to anatomy *as now taught* in the leading colleges, the mere memorizing of a compilation of dry facts being superseded by a thorough presentation of the relational aspects of this fundamental branch, also by laboratory work and demonstrations, all requiring close application on the part of the student to the most modern and comprehensive text-books. Those who wish merely brief statements, will find such a handbook as the above serviceable.

PATHOLOGY AND MORBID ANATOMY. By T. Henry Green, M.D., F.R.C.P. Tenth American revised from the tenth English edition. Revised and enlarged by W. Cecil Bosanquet, M.A., M.D Oxon., F.R.C.P. London, Assistant Physician (Late Pathologist) to Charing Cross Hospital, London, etc. Illustrated. Philadelphia and New York: Lea Brothers & Co. 1905. pp. 610.

Following the introduction, thirteen chapters take up in detail the subjects that would naturally be grouped under the following principal headings: Malformations; Nutrition Arrested; Nutrition Impaired; Hypertrophy; Tumors; Irritation and Repair; Local Disturbances of Circulation; Fever; Parasites Certain Infective Diseases; Diseases of Special Tissues and Organs; Intoxications, Auto-Intoxications and Nutritional Diseases; Pathology of the Nervous System. Much of the matter in the next to the last chapter is new. Frequent revision has made it possible for the authors to incorporate the latest discoveries in the realm of pathology. The most notable progress has been made along the lines of animal parasitology and of immunity to infectious diseases, and these subjects are here adequately treated.

THE CRAFTSMAN. Gustav Stickley, editor and publisher. Syracuse, N. Y. Price, 25 cents per copy; \$3.00 a year.

Now is the time to subscribe for *The Craftsman*, as the October issue is the first number of a new volume. It is full of good things for lovers of art and of applied art in the various crafts. House builders and home makers will gain many ideas

from the plans for buildings and from the color schemes, etc., for interior decorating and furnishing. The sociologist will rejoice in "The Gospel of Simplicity as applied to Tenement Homes," a well written article. There are many others: "Memorials of McKinley," "Civic Art in Cleveland, Ohio," "Evolution of the Chinese Carpenter," "Modern Concrete Construction," "The Living Room," "Home Training in Cabinet Work," etc. The illustrations are numerous and praiseworthy.

EDUCATION: A monthly magazine devoted to the Science, Art, Philosophy and Literature of Education. Editors: Richard G. Boone, Frank H. Palmer, Boston. The Palmer Company, 50 Bromfield Street. Price, 35 cents per copy; \$3.00 a year.

With the September issue the twenty-sixth volume of this standard journal on education was commenced. It contained, among other timely contributions, a review of secondary education during the past twenty-five years. A very interesting article in the October number is on "Education of Country Children for the Farm." Other good papers are "Some Points on the Teaching of Physics and Chemistry," "A Day at Tuskegee," and "How the Library is the Center of the School." All interested in improved educational methods, and who is not, will find *Education* informative and suggestive.

ABSTRACTS FROM BOOKS AND JOURNALS.

SIMPLICITY IN PEDIATRIC THERAPEUSIS.—On general principles, the fewer drugs that are sent rasping through a baby's intestinal canal, the better for the baby. A few remedies, however, are of priceless value in intestinal infections, and prominent among these are arsenic, the arsenite of copper, and the two mercuries, *solubilis* and *corrosivus*. This does not exhaust the list by any means, but possibly the ones mentioned are more often indicated than any of the others. Given according to their well-known indications, these remedies frequently produce results that are surprisingly prompt and satisfactory. Nor is it necessary, as a rule, to worry over their supposed re-

enforcement by presumably proper intestinal antiseptics. Many of these so-called antiseptics are nauseating and hard to administer to an infant, and, more than that, their real effect is always largely problematical. A baby's intestinal canal is not a test tube, and its behavior cannot be predicated in the laboratory.—*Dr. Harvey B. Dale, in The Medical Visitor.*

MEDICAL EDUCATION IN THE UNITED STATES.—The *Journal of the American Medical Association*, August 19, reports that during the year ended June 30, 1905, 26,147 persons, including 1,073 women, studied medicine at 157 colleges in 36 States and Territories, and 5,606 of these graduated. The students numbered 1,995 less than the number in 1904; graduates, 141 less. The attendance at regular schools, 24,119, was an increase of 457 over 1904, but a decrease of 801 below 1903 and 759 below 1902. Attendance at homœopathic schools has been decreasing steadily since 1900, when it was 1909; this year it was 1,104. At eclectic schools, attendance increased yearly from 1900, when it was 552, to 1904, when it was 1,014, but this year it dropped to 578—a falling off of nearly half. All graduates number 141 less than last year, 92 less than 1903. Homœopathic graduates in 1903 were 420; 1904, 371; 1905, 1,276; but eclectic graduates (153) numbered more in 1905 than in any year since 1900. Three of the 157 colleges are exclusively for women, 63 for men, and 91 co-educational.

GASTRIC INTOLERANCE IN YOUNG CHILDREN.—*Dr. M. E. Terrien in Le Bulletin Medical*, remarks the occurrence of marked gastric disturbances in children without intestinal manifestations. Three causes are distinguished: dyspepsia, acetone-mia pyloric stenosis. The therapeutic indications are nearly the same in all. To arrest the emesis only water should be allowed at first—ice-water—a teaspoonful every half-hour, and hot applications to the epigastrium. Lavage may sometimes be necessary, and injections of artificial serum may be employed. When vomiting has become frequent, vegetable broths, salted, are allowed. When emesis has ceased, a bouillon, containing a coffeespoonful of farina to each three ounces, is given, to which after a few days, a little milk may be added, and if well borne it may be gradually substituted for bouillon. The quantity of

sugar in the milk must be carefully regulated. If the milk is not tolerated, the vegetable broth must be returned to, and after a few days buttermilk tried. If these means fail and pyloric stenosis is suspected, the case becomes one for the surgeon.

The Monthly Cyclopedica.

LEAD POISONING.—Joseph Sailer and John M. Speese, Philadelphia, examined the gastric contents, after test meals, in twelve cases of lead poisoning, and report the findings. The stomach contents were tested for lactic acid, free HCl and amount of pepsin present. In all cases a microscopic examination was made for the Oppler-Boas bacillus. Their conclusions are as follows: 1. In a series of twelve cases of lead poisoning or of suspected lead poisoning, deficiency in the secretion of HCl was noted in ten of the chronic cases, and was not observed in two, one of which was doubtful and the other acute. 2. This deficiency in the secretion of free HCl, in the majority of cases, is associated with an extreme reduction in the percentage of peptic digestion, and with the presence of lactic acid. 3. It is not justifiable at present to regard it as an indication for treatment, at least not until the effects of the ordinary treatment for achylia gastrica in cases of lead poisoning have been tested. The authors have found no similar studies in the literature, which they consider rather remarkable in view of the pronounced gastric disturbances produced by lead poisoning.

Journal of the American Medical Association.

THE ETHICS OF CONSULTATION.—The physician who is asked to respond to the call of a brother physician cannot possibly know anything of the willingness or ability of the patient to pay for special service, and he is therefore placed in a position of decided disadvantage, financially, and since he has had no previous claim upon the patient and will probably have no future professional relation with him, it is the duty and ethical obligation of the doctor who seeks the consultation to provide for the prompt settlement of the consultation fee at prevailing rates. His failure to do so, unless special arrangements to the contrary are agreed to at the time, renders him obnoxious to a professional brotherhood and susceptible of the suspicion of using the knowledge and experience of a brother physician un-

fairly for advancing his personal interests with his patrons. Could anything be more utterly repugnant to the ethics of professional decorum and moral certitude?

The struggles of a consultant with the patient of a brother physician for the collection of a consultation fee is not only a delicate and unpleasant expedient, but passes the bounds of reason and justice. It should never occur in the lives of reputable physicians.—*Progress.*

ACIDUM PHOSPHORICUM IN DIABETES MELLITUS.—Several cases of diabetes mellitus have come under my notice, all the patients being of the male sex, who have been permanently cured by the administration of the above remedy, 5 minims of the 1x dilution three times a day. The symptoms indicating the remedy were: A frequent urging to urinate, accompanied with pain in the loins. There was also great prostration and emaciation present. The beneficial effect of the medicine was apparent during the first week's treatment, and the patients had perfectly recovered by the end of from four to five months. Attention, of course, was directed to the dyspeptic symptoms which intervened, and which were met by an occasional 2-minim dose of nux vomica 1x. The patients were debarred from indulging in all articles of food containing sugar, bran bread being used as a substitute for ordinary bread. The action of acidum phosphoricum in such cases is very prompt, as it speedily improves the constitutional condition of the patient, and acts in striking contrast to the drugs made use of by the allopathic profession, who appear to possess no means, amongst all their conglomerations, of arresting the formation of sugar, and the consequent progress of the disease.

Dr. Kopp in Homœopathic World (London.).

MUCO-MEMBRANOUS COLITIS AND FATAL SYNCOPE.—Mucos-membranous colitis gives rise to various crises of reflex character. Dyspnea, vertigo, tremor, and temporary cardiac dilatation have been described by Potain, and Mathieu has observed attacks of general prostration with tendency to syncope. Journeault records the following cases in support of these observations: The first case was a woman, aged seventy-

two, who suffered from slight mucous colitis. One morning she took a saline purge, which had no result. She was found dead in her bed eighteen hours after taking the medicine. There had been no symptoms of angina pectoris. The second case was a woman, aged fifty-three, dyspeptic and constipated. She also suffered from mucous colitis of medium severity. Following the severe fatigue of a sea journey, an acute exacerbation of colitis appeared. An enema brought away some scybalous masses and casts. About twelve hours after the beginning of the symptoms, the pulse, hitherto normal, became feeble and irregular. There were cold sweats. The patient died of syncope within thirty-six hours of the beginning of the attack. He points out the importance of being acquainted with such an event, otherwise the prognosis of membranous colitis may be regarded as too uniformly favorable.

British Medical Journal.

SURGICAL SCARLATINA.—From Eschersch's clinic in Vienna Rossiwall (*Jahrbuch für Kinderheilkunde*) describes in detail twelve cases of scarlatina in which the infection, he believes, entered through a wound and not through the throat. Some doubt as to the correctness of his diagnosis in two of the cases must be expressed, as there was no desquamation subsequently. In another case the disease was possibly septicemia. But in the remaining cases there is no doubt the disease was scarlatina, showing the typical rash, strawberry tongue, desquamation, and the usual course of febrile reaction. Nephritis also occurred in some cases. No swelling of the tonsils or submaxillary lymph glands was present, showing that the throat was not the portal of infection. On the other hand, various skin lesions, either accidental wounds, surgical incisions, or large suppurating skin vesicles, showed marked local reaction, being covered with a deposit of yellowish gray lymph with redness and edema of the surrounding skin and enlargement of the corresponding lymph glands. Local antiseptic treatment was always employed. He believes that the reason scarlatina is so prone to attack surgical cases is that a wound is an exceptionally favorable soil and fosters the development of the most minute particle of scarlatinal infective material. This view is opposed to that

which attributes the susceptibility in question to a lowered vital resistance of the constitution.

Pacific Coast Journal of Homœopathy.

POWDER BURNS OF THE CORNEA.—I cannot resist the temptation to warn you in powder burns not to pick off the grains of powder from the cornea with a spud; the trouble is aggravated by irritating the already damaged cornea in this way. The face should be freely washed with hot water or with dioxide of hydrogen diluted one-half. The solution will find its way into the wounds and by chemical reaction with the tissues dissect out much of the powder grain. If we find the cornea very much involved and the boracic solution fails to remove the powder then the dioxide may be applied, after diluting it two-thirds or three-fourths. The water that enters the lids will dissolve the grains of powder and cleanse the parts thoroughly. When examining the cornea, the lids should be kept open by the eye speculum and the eyeballs should be gently irrigated by the eye douche. While the eye is rotating, gently try to remove the powder grains with a small pledget of cotton; this is the best means of removing foreign bodies of any kind from the cornea. After the removal of all foreign bodies, the eyeballs and conjunctival *cul-de-sac* should be again irrigated with a sterile boric acid solution. Rest of the eye is best obtained by the instillation of 1 drop of atropine solution (1 grain to 3 drachms). Both eyes should be dressed with sterilized vaseline and eye-pads. This treatment should be repeated at the end of twenty-four hours. When the cornea is hazy, instillation of eserin ($\frac{1}{4}$ grain to 3 drachms) will aid in its preservation.

Dr. L. Webster Fox in The Medical Bulletin.

MUMPS AND METASTASIS.—Three-fifths of all prescriptions for the relief of that unique inflammation of the parotid glands known as "mumps" consist of mercurius (vivus or solubilis), belladonna, pulsatilla, mercurius iodatus (ruber or flavus), rhus toxicodendron, phytolacca or aconite. No accessory treatment is employed by 26 per cent. of homœopathic physicians and possibly not by 8 per cent. more. Heat, it is vaguely declared, is applied by 9 per cent. cotton batting, or an equivalent, by 8 per cent., and hot fomentations by 6 per cent. A

change of temperature is avoided by 7 per cent., while an equal number see their patients are kept warm and 6 per cent. put them to bed. Metastasis to the breast is not a common occurrence. A decent homœopathist need not expect to meet a case oftener than once in fifty years or be called in consultation therefor by a fellow practitioner once in a century, though that once may be to-morrow. In that emergency *pulsatilla*, *phytolacca*, *bryonia*, or *aconite* are most thought of. Some have applied *belladonna*, *phytolacca*, or *hamamelis* (hot or cold as desired and in varied form), while a few others have contented themselves with cotton tightly bandaged. Orchitis following mumps obtains more frequently, possibly because boys are more restive than girls. We may be obliged to treat that once in six years and be consulted in relation thereto once in thirty-five years. *Pulsatilla*, *belladonna*, *clematis*, *mercurius* (*vivus* or *solubilis*), *aconite*, *phytolacca*, *mercurius iodatus*, *bryonia* or *gelsemium* are generally administered. Our mortality from mumps, direct or indirect, is practically nil.—*Dr. Geo. B. Peck in Progress.*

NEW YORK EXAMINATION QUESTIONS IN THERAPEUTICS, PRACTICE AND MATERIA MEDICA.—Questions prepared by the board of examiners representing the Homœopathic Medical Society of the State of New York.

1. Differentiate *alumina* and *opium* in constipation.
2. Give the homœopathic indications for *digitalis* in heart diseases.
3. Differentiate *cimicifuga* and *rhus toxicodendron* in rheumatism.
4. Differentiate *carbo vegetabilis* and *argentum nitricum* in diseases of the stomach.
5. When is *viburnum opulus* indicated in dysmenorrhœa?
6. Give the symptoms and treatment of acute pleurisy.
7. Differentiate *belladonna* and *glonoin* in headache.
8. Differentiate *esculus hippocastanum* and *aloe socotrina* in hemorrhoids.
9. Give the characteristic respiratory symptoms of *ipêcac.*
10. How should a case of renal colic be treated?
11. Differentiate *carbo vegetabilis* and *muriatic acid* in typhoid fever.

12. Give the general characteristics and the therapeutic uses of picric acid.

13. Describe the cough of (a) belladonna, (b) hyoscyamus, (c) rumex crispus.

14. Give the urinary symptoms of cantharis.

15. Describe the treatment of acute gout.

Ten out of the fifteen questions to be answered by the candidates taking the examination.

ETIOLOGY AND PATHOGENESIS OF PERNICIOUS ANEMIA.—In hemorrhage there is created a deficiency in circulating red cells, which is met by the marrow with the mature red cells lying close to the capillaries at the periphery of the erythro-genetic groups. In large hemorrhages with exhaustion of the supply of mature red cells a certain number of normoblasts are called out to supply the deficiency.

On the other hand, with a circulating toxin, there is destruction not only of red cells in the circulation, but also of some, at least, in the marrow, even of normoblasts as suggested by the large number of naked nuclei found later in the circulation. The marrow responds in this emergency, with nucleated red cells of normoblastic or megaloblastic type, depending upon the extent of the destruction. The experiment of the repeated dose of ricin where megaloblasts appeared only after the second dose would seem to confirm this idea, as well as the observation as to the arrangement of the cells in the erythro-genetic groups in the marrow.

Applying these conclusions to pernicious anemia, it seems possible that an analagous toxin may be present, destroying red cells both in the circulation and in the marrow, so that in the reaction nucleated red cells are used to supply the deficiency—that further action of the toxin reduces the erythro-genetic groups more or less to the megaloblastic centers, diminishing greatly the regenerating power of the marrow and resulting in a discharge of megaloblastic cells in the hasty effort to supply the needs of the circulation. Thus, the regular orderly development of the groups of the marrow cells is interfered with and a short cut is taken from the megaloblast to the macrocyte, an imperfect, immature cell, as shown by its polychromatophilia

and granular basophilia. In this light it is not difficult to see why cases of pernicious anemia with few normoblasts and more megaloblasts in the circulation are of graver prognosis than those with a large number of normoblasts and few megaloblasts. And again, if the presence of nucleated cells in the circulation is regarded as evidence of injury to the bone marrow, the "nucleated red cells crises" of pernicious anemia and leukemia in which the blood picture resembles much that shown in ricin intoxication is explained.

Bulletin of the Johns Hopkins Hospital.

ACUTE DIABETES MELLITUS IN CHILDREN: GENERAL TREATMENT.— Dietetic: A strict carbohydrate-free diet should be advised, and is usually well borne by children, though the individual capacity for assimilating sugar should be tested from time to time and the case dieted accordingly, but carbohydrates must be allowed with greater caution than to adults.

Opinions differ as to the permissibility of more than a small quantity of milk, but a pint slowly sipped morning and evening may generally be allowed. If sugar-free milk can be obtained, it is of great service to the patient. An excess of meat in the dietary is said to cause an increase in the amount of sugar excreted, and a German authority gives it as his opinion that in children the withdrawal of carbohydrate food is useless and harmful, in that the excreted sugar is taken from the body proteids and the quantity in the urine remains the same. He would reduce the amount of bread taken to a minimum and allow a diet of meat, vegetables and potatoes.

Hygienic: Gentle exercise or massage is of service, for muscular exercise frequently reduces the glycosuria, especially in recent cases and when the nutrition is well maintained; in older cases and greatly emaciated individuals it may, however, increase the amount of sugar excreted. When coma threatens, large quantities of milk and other fluids should be given, and a little carbohydrate food may be allowed as a temporary measure. In actual coma, the intravenous injection of a 3 per cent. solution of sodium bicarbonate is advised, but von Noorden states that he has never seen more than temporary benefit from

its use, and, as in the case detailed above, it may not produce any amelioration.

Prophylactic: In the case of marked hereditary predisposition to diabetes, a quiet and regular life, with outdoor exercise in moderation, and the early and permanent withholding of carbohydrate food, especially sugar, may prevent the incidence of the disease.

Great care should be taken to prevent the young patient taking cold, or any zymotic disease, as the supervention of bronchitis, whooping cough, or scarlet fever, would have most serious consequences.

Medicinal treatment of diabetes mellitus occurring in children is, of course, similar to that of the disease in adults.

Journal of the British Homœopathic Medical Society.

FRONTAL SINUS DISEASE.—The evidences of frontal sinus disease are:

1. A unilateral headache which does not involve the supra-orbital nerve and is located over the region of the frontal sinus.

2. Tenderness on pressure at the upper inner angle of the orbit.

3. Presence of pus at the eye side of the middle turbinate body on the same side as the headache. The flow of pus may be checked by packing it up between the middle turbinate body and the external nasal wall.

4. If the pus does not flow from the usual opening but is retained within the sinus under pressure, the pain is characteristic and more severe, and the floor of the sinus at the upper and inner angle of the eye may bulge or rupture, thus forming a fistula.

All of the above characteristic symptoms may be present, followed by a pachymeningitis, if the posterior wall of the sinus is involved.

The evidences of ethmoiditis are usually:

1. Headache, pain over the bridge of the nose, extending to the inner wall of the orbit.

2. A slight degree of photophobia.

3. Diffuse and general headache, though not very severe. There is also usually some interference with mentality.

4. The presence of a constant discharge within the nostril, either in the middle or superior meatus.

Involvement of the sphenoidal sinus is indicated by:

1. A characteristic occipital headache, or a feeling of intense pain located midway between the ears at the base of the brain.

2. The presence of pus in the superior meatus. This will increase in quantity when the head is tipped well forward.

The indications of antrum disease are:

1. Pain and swelling over the region of the upper jaw, with neuralgia of the teeth and occasional involvement of the inferior orbital nerve.

2. The discharge of pus into the middle meatus of the nose which is increased by bending the head forward between the patient's knees.

3. The presence of a disagreeable odor within one nostril.

4. It is positively diagnosed by washing out the sinus.

By observing these simple symptoms the practitioner can be guided to a fairly accurate diagnosis of the situation of the sinus lesion.—*The Post-Graduate*.

EPIDEMIC CEREBROSPINAL MENINGITIS.—Berlin medical circles have recently been much interested in the subject of epidemic meningitis. Three authorities, Kirchner, Westenhoeffer (both of whom were sent by the government to Silesia), and Grawitz, have spoken before the Medical Society on this subject, in which they have all had considerable experience. I have already discussed Kirchner's paper, which was read also before the Prussian Parliament. Westenhoeffer discussed this disease in relation to its pathological anatomy and its manner of infection. He has performed twenty-nine autopsies, and in every case has found an edematous swelling of the tonsils, which also involved the posterior wall of the pharynx. The Eustachian tubes were also red and swollen. The nose was affected in only three cases, but there was middle ear inflammation in 70 per cent. of the cases. This authority believes that the disease always starts in the lymphatic tissue of the pharynx, from which it extends to the meninges, involving a region behind the chiasm over the sella turcica. The infection travels through the sphenoidal bone, or perhaps along the carotid. As to the

involvement of the internal organs, the speaker noted swelling of the spleen, nephritis, swelling of the glands of the neck, enteritis, and swelling of the thymus gland. Bacteriological researches showed several cocci. On account of the predisposition of the tonsillar tissue to be affected by this disease is explained the fact that scrofulous children are especially susceptible to this disease. Thorough disinfection of the nose is the best prophylactic remedy.

Grawitz, in his paper, said that he had not noticed any alterations in the pharynx in his cases. In the cerebrospinal liquid he found chiefly the diplococcus of Fraenkel-Weichselbaum. The differential diagnosis between epidemic and tuberculous meningitis is very difficult. However, in general, the mononuclear lymphocytes are the most frequent cells found in the cerebrospinal liquid in the cases of tubercular meningitis. In epidemic meningitis, more polymorphonuclear leucocytes are found. In the line of treatment he recommended lumbar puncture and frequent rectal injections of salt solution. In the discussion following these papers, Heubner disagreed with the theory that the lymphatic constitution predisposed the child to this disease. According to him, a frequent symptom of epidemic meningitis is marked anorexia. Senator recommended hot baths, and if these were impossible, he advocated the use of hot air. Michaelis has always found in cases of tuberculous meningitis Koch's bacilli in the cerebrospinal liquid. V. Hausemann has not always had the same experience. In one of his cases the pharynx had undergone no changes whatever.—*Medical Record.*

MUSCULAR RHEUMATISM.—Muscular rheumatism is common enough, but ought to be less so. It is entirely preventable; it is amenable to cure, but it is seldom possible to command all the conditions of life necessary to achieve either. It is relievable by simpler means than are usually employed, and to a far more perfect degree than is often obtained. When once established it is liable to remain with one till death. Eternal vigilance is the price of relative emancipation. However, their fate is not so pitiful when it is reflected that by following the rules whereby these discomforts are alleviated or eliminated, many

other desirable effects are also attained; among them passports to longevity. As Oliver Wendell Holmes said: "Nothing so conduces to a long life as an incurable malady." This is eminently true of the acidoses, notwithstanding the incidental annoyances and dolors, and the actual perils of possible consequences if suffered to go on unchecked.

Contributory causes are many, but we may focus our attention upon that which underlies our conditions most, if not all, viz., errors in diet. If the digestive functions be wisely conserved from earliest infancy, it is scarcely conceivable that the "diathesis" habit of body, katabolic status can become established. The problem presenting is usually to overcome the effects of reprehensible abuse, especially pernicious habits and vitiated tastes. The deranged walls of the stomach or bowel become permeable for germs to pass into the general circulation. Bilioussness shows that the normal guardianship of the liver, its function as poison filter, is impaired.

As the subject of digestive derangements is so vast, it will be sufficient here to outline briefly the principles upon which I have been able to secure the most conspicuous results. The choice of foods is of less significance than the manner of eating. The thorough mastication of food, whether it be dense or fluid, is the *sine qua non*; permitting no mass to be swallowed until completely comminuted. Even milk and raw eggs should be held in the mouth till insalivated. Fluids, water, decoctions of tea or coffee, should never be taken into the mouth unless then empty. Soups, broths, purées, should be taken alone and slowly, held in the mouth for an appreciable time. As to choice of foods, it will be found that, as Fletcher has so wisely pointed out, once the sanity of taste is restored by careful mastication, the impulse to select a suitable dietary will soon be restored by a return of normal wholesome instincts.

It is obvious that if the intake of foods be above reproach, not only will digestion proceed normally, but the great elaborating agencies will not be overtaxed, fewer and simpler poisons will be formed and more perfectly disposed of, eliminated, or destroyed. The dejecta must, of course, be extruded from bowels, skin, kidneys, and lungs. It may be necessary occasionally to specify the articles of diet permissible, but as a general

rule the safeguards outlined above are of vastly greater efficacy than the most thorough chemical adaptation. In any event they must also be enforced.

My experience leads me to advise limiting the amount of food in most cases, although where exhaustion be recognized, hyperalimentation is required. For this purpose the use of raw eggs, especially yolks, as pointed out by Heinrich Stern, serves admirably.—*Dr. J. M. Taylor, in The Monthly Cyclopedic.*

ELECTRICITY IN DISEASES OF CHILDREN.—In this paper reference will be made more especially to electrical currents of high potential and high frequency, the therapeutics of which have developed so rapidly in the past few years. The fields of usefulness of galvanism and faradism are well established and their value none will gainsay; yet they bid fair to be supplanted in the treatment of many conditions by some of the newer modalities.

First, let us consider briefly the action of these currents of high potential and high frequency. The current from our static machines is a high potential, unidirectional current, that from our solenoids and resonators is a high potential, alternating current of many million oscillations per second—so rapid that nerves do not recognize them as abnormal vibrations, therefore transmit them without sensation of pain. When applied therapeutically to the human organism, these currents may, according to the mode of application, act either as a local or constitutional stimulant, tonic, sedative or alterative, if we may be allowed to use the adjectives of drugs. Their dosage is flexible and readily adjusted to the needs of the individual case.

These currents are essentially regulators of function, increasing local and general nutritional activity, exciting metabolic changes and developing the potential energy of cell life, affecting profoundly every particle of protoplasm, seeming indeed to supply "life more abundantly" and put the organism again in harmony with its environment.

Relative to the diseases of children we find the same applicability and indications therefor as in diseased conditions in adults, with the added recommendation that efficient applica-

tion can be made without pain or distress or even annoyance to the little ones; and that the good results are more quickly obtained, owing to the greater activity of vital processes in youth, and the ready response to electrical stimulus.

Chorea is one of the diseases of childhood in which is well illustrated the beneficent effect of these currents. This disease usually manifests itself in one of nervous temperament whose general nutrition is below par, with more or less anemia, especially of the brain, where an exciting cause, such as some peripheral irritation, or mental or emotional excitement, suffices to throw off the governor of the nervous engine, and irregular uncertain discharge of nerve force is the result. The static and high frequency currents promote general nutrition, and that of the nerve cells, soothe and regulate their action, and consequently reduce the violence and frequency of the muscular movements, promote sleep, nature's great restorer, and materially shorten the usual duration of this affection under other forms of treatment. It is superfluous to say that the exciting and contributing causes of the trouble should always be searched out and removed when possible.

Likewise with *epilepsy*. Here again electricity is a valuable adjunct to other treatment, materially modifying and lessening the frequency of attacks, and, when bromides are being given, rendering efficient much smaller doses than ordinary, and shortening the duration of such treatment. In children, where metabolic processes are so much more rapid than in adults, and the spasm habit has not become so firmly fixed, the prognosis is much better.

Favorable results have also been recorded when the X-ray was used in conjunction with electricity, and the demonstration seems to be complete that these agents are of great value as aids in bringing about a stable equilibrium in these unfortunates who are the bugbear of the medical profession.

Paralysis, spinal or peripheral, finds a special remedy in electricity. Galvanism and faradism have won their laurels in this field, but the newer modalities are vigorous rivals. Anterior poliomyelitis may be treated much more effectually by static applications than by either of the former, more quickly establishing normal conditions within the spinal canal, and

restoring the functions of the musculature. The treatment must be instituted early, however. After two or three months have elapsed the results are not so satisfactory, though hopeful, and after a year the chances for improvement are poor. Peripheral nerve lesions, traumatic or toxic, are likewise much benefited by high potential modalities.

Skin diseases—acne, chronic eczemas, psoriasis, etc.—evidence of both local and general faulty nutrition, are cured by local and general applications of high frequency currents. The X-ray has been used with good result in this class of cases, but we believe the high frequency currents to be more lastingly beneficial, owing to their greater systemic tonic effects.

Pacific Coast Journal of Homœopathy.

SEA AIR TREATMENT OF SURGICAL TUBERCULOSIS. The work is carried on at Sea Breeze, Coney Island, an experimental hospital for the sea-air treatment of surgical tuberculosis. . . . There are four factors in our treatment, namely: (1) Sea air night and day. (2) Cheerful, normal surroundings. (3) Ample, nourishing food. (4) Orthopedic treatment.

The greatest and most successful European hospitals of this class, for we have no American example for comparison, are upon the seashore, for European authorities have experimented and found that there is some curative quality in the sea air which is wonderfully efficacious in the treatment of surgical tuberculosis. . . . We give our children all of the sea air possible; rain or shine they are out of doors the entire day except for two hours in a tent school on the beach, and at night they sleep in wards where all the windows are open during even the coldest weather, 12° F. being not an uncommon temperature here in winter. They are, of course, amply protected against the cold by many blankets, and wear warm hoods and jackets over flannel night-gowns, also mittens and woolen bed slippers. The same rule about open windows prevails in the dining hall. The patients in the non-ambulatory class spend their days in bed upon the second floor veranda. Under all this radical treatment the children are happy and comfortable. After a few days of gradual acclimatization they become accustomed to the outdoor life and do not mind the cold. There has been only one slight case of bronchitis, and coughs and colds are unknown.

The children owe their cheerful, normal surroundings in part to the informal, homelike atmosphere of the hospital, and in part to their free and natural life out-of-doors upon the beach. The nurses are chosen not alone for their professional ability, but for their interest in the children, and they try to give the individual attention that a child needs. They see to the perfect fulfilment of physical needs, encourage him to do his part toward the harmony of the whole, try to cultivate a cheerful, hopeful outlook by the aid of games and songs and other simple amusement that shall take his thoughts away from himself and his suffering or his deformity. On the beach, they constantly lead the normal child's life. . . . The dietary is abundant and of the best. There are five meals a day—breakfast, dinner, supper, and two luncheons. A half hour before arising the windows are closed and the wards warmed for dressing. At half after six the children arise, and breakfast at seven on a cereal, bread and butter, and milk, and a choice from either broiled minced beef, or eggs, or baked potatoes and bacon, or stewed fruit. After breakfast they are out of doors until nine o'clock, when they go to school in a tent on the beach for two hours, with a recess at ten, during which a luncheon of milk and crackers is served. Then they play and have short calisthenic exercises, all out of doors. At twelve they have dinner, consisting of a choice from either roast beef or lamb, or stewed beef or lamb, or chicken and rice, or broiled fresh fish, or minced fresh beef, with two vegetables chosen from the following: Peas, beans, potatoes, rice, spinach, carrots, and macaroni. They always have an unlimited quantity of bread and butter and milk with cream. For dessert there is either some milk pudding, or ice cream, or baked apples and cream. After dinner the children play out of doors until supper time, with a luncheon of milk and crackers and fruit at three. At five they have a very light supper of bread and butter and toast and milk, with either stewed fruit, or eggs, or a cereal. Directly after supper, the babies from three to seven years of age are put to bed, the older children going at seven, the windows being closed in the ward for undressing. . . .

We have, during one year's experiment, taken cases regarded as hopeless by the best city surgeons and within a remarkably

short time have obtained results beyond all anticipations. Sinuses of long standing have healed, acute pain has rapidly subsided, and, as the summary shows, all but one of the patients have gained in weight in amount varying from thirteen ounces to twenty-four pounds, eleven ounces.—*The Medical Record.*

HOMŒOPATHY IN OBSTETRICS.—In rather over thirty-seven years of practice I have attended 1089 cases. I find some cases of extreme depression, in which *ignatia 3x* proved most valuable. One case of strange dread as to “power to bear” the time of trial and effort, was wonderfully helped by *anacardium orientale 3x* (which often afterwards cured rapidly cases of “mistrust,” preceding examination by students). *Aconite 30* was markedly helpful in cases where “physical depression and dread of a fatal issue” were prominent symptoms. The mammary disturbances (often the earliest reliable sign of pregnancy) assumed troublesome importance in several instances, and excellent results came from *phytolacca 3x*, and where the ovaries showed sympathetic tenderness, *apis mel. 3*. Here let me advise invariable preparative care of the breasts and nipples during the later months of pregnancy.

Toothache, often severe, and ending frequently in the decay and loss of a tooth or teeth, met with successful treatment from *kreosote 3* and *staphisagria 1*, and in some cases of very sore gums and even salivation, *merc. sol. 6* proved very helpful. In some patients with weak teeth, *calc. phos. 3x* was very valuable in preventing pain and decay.

The vomiting of pregnancy proved singularly amenable to treatment by *nux vomica*. A few cases more serious and persistent found help from *kreosote 3*, *pulsatilla 3x*. Rest in bed entirely for a few days was often a valuable help, and in one case rectal feeding had to be resorted to for many days, giving the tired stomach absolute rest.

Heartburn and flatulence found appropriate remedies in *carbo. veg. 6*, *pulsatilla 3*, and *capsicum 3*.

Constipation caused much trouble, but usually yielded readily to *nux vomica 1x*, with regulated diet and regular exercise.

Where piles threatened, *collinsonia 3x* gave good results, preventing one of the most troublesome hindrances and complications of labor.

Dyspnea gave trouble in several cases, and as clearly nervous, yielded remarkably to *ignatia* 3x. Cramp was often present, often severely, but found an excellent remedy in *cuprum metal.* 3.

Bladder troubles found in *cantharis* 3 (*tenesmus*), and *belladonna* 3x (*irritability*), efficient remedies, while in cases accompanied by dragging downward, *pulsatilla* 1x was effective. In some cases where the kidneys seemed to feel strain and pressure, *arsenicum alb.* 3 gave substantial assistance. Where head fullness was an additional trouble *belladonna* 3x was very helpful.

Pruritus was often relieved by *plantago* 3x, with careful ablution with borax and tepid water, and in some persistent cases *resinol* ointment proved an effective adjunct. Excessive fetal movement at night was met by *bell.* 3. False pains yielded to *actea* 3x, or where "worry" was prominent *cham.* 3; while in some exceptionally severe pains, almost like labor itself, *gelsemium* 1x gave great relief. Where these pains recurred time and again at more or less regular intervals, *caulophyllum* 3x was an effective remedy.

Miscarriage, threatened or actual, will often be a more or less serious trouble. Rest at once, especially where any slip or fall or other injury has been experienced, will be of great advantage. *Arnica* 3x has often proved its value as an internal remedy, accompanied by external use if required. *Sabina* 3 in the earlier months, and *secale* 6 later, have often been promptly effective. In a few cases of exceptional severity, *china* 3x, as a restorative, was of great service.

The last month of pregnancy I always advise, as a preparation, a morning and evening dose of *actea* 3x, and the last few days one or two doses daily in addition of *arnica* 3. With *rigid os uteri*, I have found *belladonna* 3 supremely helpful every hour, with, in extreme cases, persistent hot hip baths.

Deficient pains from general inertia yield readily to *gelsemium* 3x, or if with restlessness *aconite* 6, and if fretful *chamomilla* 3; while in some extreme cases of almost absent pains I got excellent results from *pulsatilla* 30, or where good pains at first had ended in none, *secale* 30 was effective. Delay in extrusion of the placenta, due to *rigid os uteri*, yielded readily to *belladonna*, or if fatigue seemed the cause, *arnica* 3x proved its power.

After pains, often so very troublesome and even intolerable to patients, were best relieved by gelsemium 1x in frequent doses until well controlled. I always give arnica 3x after labour, and I believe it often prevents this trying complication.

Dr. Wm. Roche, in Monthly Homœopathic Review (London).

INJECTIONS OF GAS FOR THE PAIN IN NEURALGIA.—Desplats has found that the injection of gas is very efficacious in cases of neuralgic pain. The object of this treatment is to distend the subcutaneous cellular or the deep interstitial tissue. This action is successfully attained by the use of air, Desplats' experience with irritating or sedative vapors having yielded only negative results. The bulb of a thermocautery and a Pravaz needle are the only apparatus required. The bulb is worked rapidly until the reservoir is filled with air, which is then gradually injected into the cellular tissue. A little massage of the injected part will displace the air. Any region seems to be amenable to this treatment. The course of the air through the tissues can be watched when the injection is subcutaneous. In some cases the diffusion is vascular, the air spreading with great rapidity along the length of the vessels. Relief quickly follows the injection, which is always painless, though sometimes several hours elapse before the pain ceases, but relief is sure to come. Generally, one injection is sufficient, but in severe cases sometimes two or three injections at different points are necessary. These air injections, although first employed in cases of neuralgia have given the best results in cases of sciatica, intercostal neuralgia, lumbago, certain arthralgias, and acute affections of the lungs and pleuræ.—*Revue Francaise de Medecine et de Chirurgie.*

THE MANAGEMENT OF GENITAL SORES.—E. Wood Ruggles says that there is no other class of cases so frequently neglected and mismanaged as that of venereal diseases, and states that the only safe course to pursue in the management of genital sores is to regard them with all suspicion and, in fact, to hold them all as syphilitic until proven otherwise. Again he believes it to be equally important to refrain from instituting general specific treatment until the diagnosis of syphilis is confirmed by the secondary symptoms. The venereal trinity, an indurated ulcer,

multiple, shotty, enlarged glands in the groins, and a roseola ensuing in from five to ten weeks after the first appearance of the ulcer are the three requisites to the earliest possible certain diagnosis of syphilis. The most reliable single sign of syphilis is the roseola. The simpler the treatment of genital sores the better. One cardinal principle is to cauterize no such sore with silver nitrate or other caustic that produces induration, until all doubt about the diagnosis is removed. A soft chancre is cauterized thoroughly with carbolic acid and then some antiseptic drying powder is applied. In the treatment of herpes, cleanliness and dryness are the most important factors. Frequent washings with some mild antiseptic and the application of salicylic acid in starch, 1 to 100, on a thin layer of cotton, will quickly cure. In the treatment of the hard chancre it matters little what line of local treatment is used, tepid water being as good a dressing as anything.—*New York Medical Journal.*

PERSONAL AND GENERAL ITEMS.

DR. ALICE H. BASSETT has removed to 803 Boylston Street, Boston. Dr. Bassett's office hours are from 3 to 5 P. M.

DR. NATHANIEL W. EMERSON, of Boston, was married to Miss C. A. Bond, also of Boston, September 20.

ANDREW CARNEGIE has donated \$125,000 to Smith College for a biological laboratory, provided the alumni will raise an equal amount.

THE erection and endowment of a State Tuberculosis Hospital for Vermont, by United States Senator Redfield Proctor was announced September 26 by Dr. W. M. Bryant of Burlington, Vt., the secretary of the State tuberculosis commission. In his letter to Dr. Bryant, Senator Proctor stated he would furnish the site, erect the building at a cost of not less than \$50,000 and more if necessary, and endow the institution by a fund of \$100,000, the interest to be used in its maintenance.

The offer of Senator Proctor is made, as he says in his letter, at the request of his children. He desires that it shall be managed by a State commission, and that the governor shall be a member of the board. The hospital will accommodate twenty-five or thirty patients.

DR. JOHN L. COFFIN has removed to 220 Clarendon Street, Boston.

DOCTOR'S OFFICE TO RENT.—In a private homœopathic hospital on Newbury Street. Rates reasonable. Address, A. B. C., 98 Dana Avenue, Hyde Park.

DR. ANNA T. LOVERING, 10a Park Square, Boston, will assist members of the profession and others, as in former years, in the preparation of books, or of papers for societies; research work, revision, proofreading, etc.

FINE OPENING FOR DOCTOR IN JAMAICA PLAIN.—Rooms in nice quiet family; been occupied by a Homœopath last 9 years; terms reasonable, including intelligent door and telephone service; references exchanged. Address C. A. Leach, 50 Seaverns Ave., Jamaica Plain.

DR. NATHANIEL W. EMERSON will be away until November 15th, 1905. His hospital will be open as usual and during his absence will be under the direction of Dr. Winfield Smith, who, in the absence of Dr. Emerson, will be pleased to operate and care for any patients who would otherwise be referred to Dr. Emerson.

DR. ORVILLE R. CHADWELL has changed his residence from 50 Seaverns Ave., Jamaica Plain, to 28 Eliot St., Jamaica Plain, assuming the office and practice of the late Dr. Robert E. Jameson. Office hours: mornings until 9 a.m.; afternoons, 1.30 to 3 p.m., except Tuesday and Friday; evenings until 8.30 p.m. Telephone, Jamaica 252.

DR. BENJAMIN T. LORING has removed his office to Hotel Guildford, 220 Clarendon Street, Boston, where he will be pleased to receive cases for diagnosis or treatment by Roentgen-rays, electrolysis, galvanism, faradism, and static and high frequency electricity. Hours, 2.30 to 4.30 p. m., and by appointment.

DR. JOHN P. SUTHERLAND announces that on and after October 1, 1905, his residence and office will be at 302 Beacon Street (between Exeter and Fairfield Streets). Hours for office consultation until 10 a.m. and 4 to 6 p.m. Other hours by appointment.

While continuing general and consultation practice, Dr. Sutherland is prepared to use X-Rays and high frequency electricity in cases suitable for such treatment.

Telephone, 2059 Back Bay.

REMOVAL.—Dr. Alonzo Gale Howard announces the removal of his Boston office to 67, 68, and 69 Newbury Building, cor-

ner of Newbury Street and Massachusetts Avenue, where his practice will be limited to Orthopedics and Mechanical Therapeutics.

Diseases of Locomotion will be treated by surgery, mechanical supports, electricity, vibratory stimulation, massage, gymnastic exercises, electric light and hot air baths, and other mechano-therapeutic measures. Office hours, 12 to 1 P. M., Tuesdays excepted, and by appointment.

DR. FRANK C. RICHARDSON, specialist in diseases of the nervous system, has removed to "The Windemere," 1069 Boylston Street, corner of Massachusetts Avenue, Boston. Consultation by appointment.

MR. JOHN D. ROCKEFELLER is to erect a home for foundlings in Cleveland, Ohio, to be conducted under the auspices of the Cleveland Humane Society. The home will be provided with incubators for infants born prematurely.

NOTES ON DIAGNOSIS OF AFFECTIONS OF THE EYE.—With the exception of severe injuries that require immediate surgical attention, the first thing to demand investigation in affections of the eye and its appendages is the cause of the trouble. The signs or symptoms, or both, are often indicative of the cause sought, so that it is possible to determine promptly and accurately what it is that has produced the disturbance.

Removing the cause in many instances will of itself, soon or late, also remove the effects; but in many injuries of the eye the cause is not active longer than the agent producing the mischief is at work. A blow upon the eye, a cut, or a laceration is each an example in point. If, however, a particle of steel or other foreign body penetrates the eyeball there is not only the wound but the cause is also persisting by the chip remaining within the globe. Burns by lime or hot metal are also injuries in which the cause is likely to persist by more or less of the substance remaining on the site of the burned surface.

Palpable physical causes like the above are recognized at once and their relation to the results produced is readily appreciated.

There is another class of cases not due to the causes mentioned which are not always so apparent, and are sometimes so obscure as to baffle the general physician, if not the oculist, as well. These are causes producing inflammatory or painful conditions having their initial symptoms due to taking cold, to poison, to

germ infection, to want of muscular co-ordination, over-use of the eyes, and to the influence of illumination not suited to the occupation of the patient.

One or more of these causes may operate at the same time and may combine in a way to constitute a riddle of no mean obscurity.

In addition to these, there is a class of symptoms due to reflex action, the real cause having its seat in some other part of the system suffering from the presence of some malady or the other. Such, for instance, are injuries or disease of the spine, cerebral tumors or exudations, uterine disease, especially displacements, and various constitutional affections, as Bright's disease, diabetes, syphilis, functional diseases of the nervous economy, and a score of other troubles that are sometimes convicted of being the prime mover in this or that grave ocular disturbance.

But long-continued and sagacious observation on the part of oculists the world over has shown that purely reflex affections of the eye are comparatively rare; in fact, excluding syphilis, they may be said to be extremely rare, considering the thousands upon thousands of cases of various diseases that are daily treated in public and private practice.

There are in the aggregate a large number of people, old and young, who have a moderate degree of optical defect, as hyperopia, myopia, astigmatia, or imbalance of the ocular muscles, but who, with the strength of good health, have little or no trouble in the use of their eyes; but when weakened by disease of any sort, the ocular defect manifests itself. On the restoration of the general health, there is not always a return of the strength of the eyes for a considerable time, and perhaps not at all.

An expert examination will show that one or more of the defects named is the real cause of the inability of the patient to use the eyes with ease. In cases of this character it appears that the ocular muscles do not fully regain their normal tone, and hence an optical correction with lenses is demanded.

If, however, the tone is promptly restored in any case, with or without defect, the physician often congratulates himself on his skill in effecting a cure of the eye symptoms, when as a matter

(Continued on last page.)

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ORIGINAL COMMUNICATIONS.

THE CARE OF THE EYE BY THE GENERAL PRACTITIONER.

BY JOHN H. SHAW, M.D., PLYMOUTH, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

I remember very distinctly the shock to my New England soul when, as a child, I heard the perhaps intentionally irreverent remark, that the optician who could not make a more perfect instrument than the human eye would be a poor workman. Since then I have learned the truth of that statement, and the utter futility of it.

Viewed as a mathematically exact instrument, the human eye may be subject to criticism; but as an organ of vision, conveying an intimate and accurate knowledge of the external world to a sentient brain under ever varying and often adverse conditions, it is beyond criticism, commanding reverent admiration for a facility of operation in the fulfillment of its delicate processes which leaves its possessor all but ignorant of its presence, working on tirelessly and uncomplainingly until, perhaps, driven by ill-treatment and abuse, it sends in a warning complaint to its careless master.

I shall not attempt to launch any new theories, or even advocate any revolutionary methods, but simply call your attention to a few plain facts about the human eye, and the common sense way to take care of it.

The adjustment of the eye of normal shape is such that rays of light coming from a distance of twenty feet or more, are focused directly on the back of the eyeball or retina. Now if the eyeball be too short in its antero-posterior diameter, the rays of light falling on the retina fail to focus, as it is too far forward, meeting the rays too soon and giving a blurred image.

The majority of children at birth have eyes that are too flat to give a perfect image on the retina. In some the degree of flattening is much greater than others, but in all for the first six or seven years of life, perhaps more, the tendency is to outgrow this condition, that is to say, the eyeball gradually becomes longer antero-posteriorly until, in the case of those having only a moderate flattening, there is at length a perfect adjustment of the distance for the proper focusing of the light.

In those cases of greater degree this happy result is never reached. The eye still remains flat or far-sighted, but a clear image is obtained in another way, and at the expense of the focusing apparatus of the eye. The delicate ciliary muscle contracts, releasing the tension on the suspensory ligament, and the lens assumes a more rounded form, thus bending the rays of light so that they focus directly upon the back of the flattened eyeball.

Of course this focusing process should only be used to see near objects, so that as a result of the over use of it, the far-sighted child when he goes to school and places new burdens on the already overtaxed muscle, begins to complain of pain in and about the eyes. Frequent blurring of the print when attempting to read (the tired muscle giving up), headaches, often very severe, pain down the spine and even nausea, and sometimes the strain under which the eyes are placed shows itself in severe attacks of conjunctival inflammation.

The unpleasant results of this deformity of the eyeball, may be readily obviated by placing before the eye a lens having a sufficient curvature to bend the rays to a focus on the retina, without the aid of the focusing muscle.

I quote from a paper by Dr. Elmer E. Keeler on "Modern

School Work from the Standpoint of the Oculist:" "Our teachers are learning, and the public must soon be made to understand that an error in refraction means a difference in the actual shape of the eyeball, and that glasses are as necessary to correct that deformity, as the wearing of a thick cork sole is necessary to correct the deformity resulting from a shortened limb."

Unfortunately this tendency of the eyeball to become longer does not always stop at the proper point, but goes on until it is too long, and rays of light coming from a distance come to a focus before reaching the retina. This condition is known as myopia, and the focusing apparatus of the eye is powerless to overcome it, as any effort on its part will only result in bringing the rays of light to a focus still sooner, and thus aggravate the condition. It is a most unfortunate deformity, which should be thoroughly understood in order that every possible means may be used to prevent its occurrence.

The nearsighted child is obliged to hold his book very near his eyes in order to see clearly, and this aggravates the condition, thus forming a vicious circle, nearsight causing over-convergence, over-convergence in turn causing nearsight, and so on *ad infinitum*. Looking at near objects tends to produce nearsight for this reason: when we look at objects at a distance the lines of vision of the two eyes are parallel, and the recti and oblique muscles are at rest. If now we look at a very near object all the muscles are called into play more or less, but particularly the inner ones, and the eyeball is subjected to a considerable amount of pressure, which is harmful in direct proportion to the length of time it is continued. The condition is often aggravated by stooping over the book or paper, a position which favors an increase of the *congestion* of the eyeball already produced by pressure.

Still another in the group of baneful influences which militate against the nearsighted eye is poor light, which not only causes the sufferer to hold the book still nearer, but increases the congestion by making vision difficult. Bad air and poor

food play their part in lessening the powers of resistance until, in some cases, the thinning coats of the distended eyeball are unable to withstand the strain and rupture, setting up inflammatory troubles which result in more or less impairment of sight.

Nearsight is a rare condition among the illiterate or those who are for the most part out-of-doors, for they are seldom looking at objects very near them, and have the benefit of the nearly perfect hygienic conditions which exist in the open air.

Out of two hundred refractive cases taken from my office records, thirty-six, or eighteen per cent., were more or less nearsighted in both eyes. For comparison with these, I took thirty-six consecutive cases of farsight, and noted the occupation of the individuals of each list with regard to the use of the eyes for near work. Of the thirty-six cases of myopia, I found twenty-one engaged in occupations requiring continued and exacting use of the eyes, while only three of the cases of hyperopia were engaged in such occupations.

The contrast between the number of nearsighted individuals who follow occupations which require continuous and exacting use of the eyes for near work (twenty-one), and the number of farsighted persons who follow similar occupations (three) is sufficiently striking.

How shall we prevent the occurrence of this unfortunate condition?

First, by refraining from causing the very young children to use their eyes for near work for long at a time, or for exacting work. On this ground the present kindergarten methods have been severely criticized, and perhaps with some justice. At the early kindergarten age the eyeball is plastic, and the coatings comparatively weak, while the natural tendency to elongation of the eyeball is at its height, so that any prolonged or excessive use of the focusing apparatus, together with the pressure produced upon the eyeball by the associated convergence, is extremely likely to produce a permanent lengthening of the eyeball or nearsight.

Second, care should be taken that all through the school life the position of the desk and chair is such that the pupil will not be obliged to stoop over his work, thus favoring congestion of the eyeball, and perhaps get too near the book or paper, which is, of course, very harmful for reasons already explained.

Third, good light for near work is imperative. A few hours close application to near work, with insufficient illumination, will cause the eye to become visibly reddened or "bloodshot," as we say, showing a congestion which in an eyeball already lengthened, or with a tendency to it cannot fail to do harm. The unfortunate habit so many young people have of picking up a book and throwing themselves carelessly down in some dimly lighted nook or corner to read, perhaps hours at a time, should be industriously opposed.

Fourth, the importance of outdoor life cannot be too strongly emphasized, as it allows the use of the eyes upon distant objects, with complete relaxation and rest for the tired out and overworked focusing apparatus, to say nothing of the general tonic effect of fresh air, sunshine and exercise.

The prevalence of nearsight among the German people who have devoted comparatively little attention to out-of-door sports is well known, while among the English and Americans who are great lovers of open-air recreation, the percentage of persons afflicted with nearsight is small. It may also be said that the hygienic conditions in the schools of Germany were undoubtedly very unsatisfactory in the past, poor light, impure air and prolonged application producing their inevitable results upon the susceptible growing eyeball, and developing nearsight as a national characteristic after generations of abuse.

We need more outdoor recesses in our schools. Our educators in their eagerness to reach higher standards of scholarship, have left too little time for this necessary corrective, and have placed restrictions upon it which have robbed it, in a measure, of its usefulness. In another particular they are,

however, moving in the right direction. The old sort of school examination occupying a week or more at the close of the school year cannot be too strongly condemned, and it is being generally discarded, not so much for hygienic reasons, as because it's uselessness as a test of scholarship is being recognized. The unhappy victim of these inquisitorial tortures studied through long days and sleepless nights without proper food or rest, to emerge after the last dread hour a pale and trembling wreck. The eyes naturally suffered most, and the damage done them in these periods of unremitting grind was often irreparable.

Helpful changes may still be made by substituting a larger number of oral for written exercises in school work, thus relieving the strain upon the eyes, and at the same time giving the personal equation the prominence it demands in teaching. (Any reference to astigmatism has been purposely omitted, as it is only a phase of hyperopia or myopia, or both.)

It is easy to see that a very delicate adjustment must exist for the extrinsic muscles of the eyes always to keep them at just the proper angle in relation to each other, and at the same time move them about freely in every direction. This nice adjustment is sometimes interfered with owing to a weakness of one or more muscles or, less frequently, to an overdevelopment. The inner muscles, because of the amount of work they are obliged to do in turning the eyes in toward each other in connection with the focusing of the eyes in looking at near objects, are the most frequent sufferers, but perhaps a greater amount of disturbance comes from a weakness of one of the upper or lower muscles. The excessive nerve stimulus necessary to whip the lagging muscles up to their work and maintain single vision, causes severe headaches and a long list of possible reflex disturbances.

A very simple, but valuable test of the efficiency of these muscles is performed by gazing at a spot or figure upon some plain background which gives a good contrast, then passing a card immediately before the eyes, covering first one and then

the other. If the muscle balance be normal there will be no apparent movement of the spot or figure, but if, for instance, the inner muscles are weak, the eye that is covered, lacking the stimulus of sight, is allowed to turn outward by the weakened muscle, then as it is exposed and its fellow quickly covered, the muscle is forced to its work and the eye turns back again, thus causing an apparent movement of the spot or figure. The apparent movement will always be toward the affected muscle.

There are three ways of alleviating this condition: (1) Prisms may be worn which bend the rays of light thus allowing the eye to turn slightly in whichever way is necessary in order to favor the weakened muscle; (2) the muscle may be systematically exercised by the use of prisms opposing its action in precisely the same way that the weak muscles in an arm may be exercised by opposing the weight of a dumb bell to them, or (3) the muscle balance may be adjusted by operative means.

It may perhaps seem superfluous to speak of cleanliness in connection with this subject, and yet I can assure you that a large number of the eye troubles which are to be met with in any large hospital clinic are more or less the result of lack of care in this respect.

The moist warm surfaces of the eye afford an excellent culture medium for various forms of germ life, and the opportunities offered in schools, work shops, factories, and other public places for the transmission of these germs from the hands of one individual to another through the means of books, pencils, soap, towels, etc., are obvious. The unclean germ infected finger is used to rub the eye, and mischief is done. Nature protects the small child, for you will notice that it always uses the back of its fist to rub its eyes, but older persons put themselves in danger of serious consequences by rubbing the eyes with the fingers.

However, not every case which presents a slight roughening of the palpebral conjunctiva is one of granular lids. If we are

to believe our patients, there must be a large number of physicians who are diagnosing simple catarrhal conditions of the conjunctiva as granular lids, which, in itself, *i.e.*, the diagnosis would not be a serious matter, but unfortunately they frequently follow up their diagnosis with a vigorous application of copper sulphate which destroys the delicate membrane and produces scar tissue in its place. A freer use of a sterilized solution of boracic acid, and less frequent resort to harsher methods unless the diagnosis is positive would result in fewer mistakes of this sort; in fact, in most diseases of the eye, there is more danger of doing too much than of doing too little. It is not uncommon to find a glaucoma which has been treated with instillations of cocaine or atropia, or both. The ability to estimate the tension of the eyeball accurately may only be acquired by constant practice, but once mastered it places its possessor in touch with a warning signal which may take the difference between darkness and light to more than one of his patients.

Among the popular errors which it is the province of the physician to correct is the use of the eye stone. It is the practice of some persons, whenever they believe that they have gotten a foreign body into the eye, to immediately borrow an eye stone from a neighbor and insert it. Nothing could be worse. The only way in which the stone could possibly do good would be by irritating the eye, and causing a flow of tears sufficient to wash out the offending substance, provided there was something in the eye. On the other hand the stone is seldom clean, and may transmit disease. It may be that the discomfort which the person attributed to a foreign body was not from that source at all, but the beginning of an inflammatory trouble which the use of a stone would seriously aggravate. In the same class we may put such picturesque remedies as tea leaves, curds, bread and milk and scraped potato. They are relics of that barbarous time in the dark ages when such savory prescriptions as the following called from a treatise on "Ancient Cymric Medicine," were used.

“To Clean the Eye: Obtain some fresh sprats (a sort of herring) and lay them in the sun, or at such a distance from the fire as will subject them to a like heat, till an oil exudes therefrom. Mix this oil with honey and anoint your head therewith.”

If it were not for the admirable irrigation and drainage continually going on over the surface of the eyeball, dust and germs would very soon destroy the eye as an efficient organ of sight. It is therefore rational to supplement and assist nature in this process whenever occasion requires it. This may be safely done by anyone by flushing the eye out freely with sterilized water, using an ordinary dropper, also sterilized. The water must go, of course, directly into the eye, and be used very freely, that it may thoroughly cleanse the folds of the conjunctiva. The public should be made familiar with this “toilet of the eye,” for by its use much discomfort and not a little disease may be avoided.

There are a number of drugs which have a decidedly harmful and specific action on the optic nerves, such as chloroform, arsenic, lead, tobacco, chloral, opium and alcohol, but owing to the general use of alcohol and tobacco, impairment of the sight from their use is much more commonly met with than from the use of other drugs. It has been a difficult problem to decide whether tobacco or alcohol is the more harmful, but at the present time tobacco is regarded as the more potent agent. (DeSweinitz.)

It really makes little difference to us as physicians, which does the greater harm, as they are usually associated. Such symptoms as poor appetite, irritability, sleeplessness, lack of concentration, failure of memory and disturbed heart action may put us on our guard against the insidious attack of these poisons upon the optic nerve. Often, however, there is nothing to indicate trouble but a fogginess in the center of the field of vision, not improved by glasses. This in a man of middle or approaching middle age, and a user of tobacco or alcohol, or both, should lead to further investigation, and if

the color sense be affected, particularly the appreciation of reds and greens, no time is to be lost in abandoning absolutely any further use of either tobacco or alcohol.

The very common abuse of these poisons, and their selective affinity for the special nerve of sight to destroy its functional activity, bring the unfortunate results constantly before the profession whose efforts are unavailing when once atrophic changes have taken place. It remains for us, however, to impress upon the lay mind this special danger in the use of tobacco and alcohol, that if necessary, they may seek advice before it is too late, and learn to exercise vigilance in detecting the early signs of poisoning.

In concluding this paper, I wish to emphasize the necessity of keeping the whole body well and strong in order to maintain the efficiency of so delicate a part as the eye. Whenever the bodily health becomes impaired, the eye and the ear are the first organs to suffer, and I have no hesitation in saying that the majority of persons who seek advice for eye troubles do so because of a general physical depression, whether physiological or from ill health.

Only he who gives his eyes the benefit of a bodily environment of glowing robust health induced by a temperate life, by good food regularly taken, by sufficient sleep and most of all by hours of exercise in the great out-of-doors, only such a one I say may reasonably expect the lifelong enjoyment of the priceless gift of perfect sight.

Summary of principal points:

1. The eye of the young child is in a state of transition and is easily injured by misuse.
2. The harmful results of the common deformities of the eyeball may be avoided by the use of proper lenses.
3. An improper position during the use of the eyes for near work tends to produce nearsight.
4. Poor light causes congestion of the eyeball.
5. Out-of-door life is a necessary corrective for those who use the eyes habitually for near work.

6. Cleanliness is an important aid to the health. And the toilet of the eye should be performed with sterilized water as often as necessary. Eye stones and the other popular remedies are harmful.

7. Tobacco and alcohol together with other drugs less commonly used may injure the eyesight.

8. Only a perfect physical development of the whole body will give a perfectly efficient eye.

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SEXUAL LIFE AND SEXUAL HYGIENE.

BY ORREN B. SANDERS, M.D., BOSTON, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

Were excuse needed for bringing before you such a subject, it might well be found not only in the complete ignorance of the laity as to any meaning whatever attaching to the phrase "sexual hygiene," but also, unfortunately, the very general ignoring of the matter by the profession at large.

It is true that in the numerous papers on gonorrhœa, syphilis, and kindred subjects, read before societies or appearing in our medical journals, not infrequent reference is made to the wide-spreading and disastrous effects of specific infection. And in

these papers authorities are quoted, and cases brought in as evidence to show how the introduction of the micro-organisms of these specific affections render women sterile, and their pelvic organs permanently diseased; and how innocent children bear through life, weakened and defective constitutions, bestowed on them through the vicious practices of their progenitors.

When functional diseases of the nervous system are under discussion, some passing comment will be made on the effects of that common habit known as masturbation, or to other disastrous forms of departure from the normal in the sexual life. But the men, who, however inadequately, touch on these subjects, constitute a small, a very small fraction of a profession having great weight and influence, and numerically well represented in every considerable community. A profession with unexcelled opportunities for knowing, and to an important extent determining, the personal, intimate life of the people. This is so obvious and so true, that it is reasonable to assume that, if unremitting and well-considered efforts were made by physicians as a whole, to thoroughly enlighten those with whom they are brought in contact as to the nature and use of the sexual functions, the inevitable results of abuse, and the perfect compatibility existing between the observance of sexual hygiene and the natural exercise of the sexual powers, that, if such instructions were given by the whole profession, another generation or two would show a marked decrease in the now appalling number of cases attributable to misdirected sexual activity.

I do not hesitate to affirm that the present state of affairs reflects seriously upon the way in which, in past years, the overwhelming majority of physicians have met this duty which naturally devolves upon them.

The existence of the sexual life, the problems it creates, the mere fact of sexuality itself are one and all actualities entitled to perfectly frank and unblushing recognition.

It has been well said by a noted German writer that: "Sexuality is the most powerful factor in individual and social ex-

istence; the strongest incentive to the exertion of strength and acquisition of property, to the foundation of a home, and to the awakening of altruistic feelings, first for a person of the opposite sex, then for the offspring, and in a wide sense for all humanity."

No other impulse of the human being is more instinctive, more in harmony with the laws of creation than the sexual impulse, more far-reaching in its consequences, more imperative, and, therefore, more imperatively demanding direction. If it leads to the highest virtues in its normal exhibition, it is undeniably capable of a degradation sounding the lowest depths.

Knowing these statements to be indisputable, it remains to emphasize the necessity for studying and watching over the sexual life in the individual from the earliest period, from birth itself. Too often no examination at all is made of the new born child, or an examination so perfunctory that the external genitals receive only a cursory glance. This on the face of it is wrong; the physician should fully inform himself if the parts are perfect and in a healthy condition, that immediate steps may be taken to correct any departure from the normal. Before the physician's attendance ceases, he should impress upon the mother and the nurse the necessity for frequent and careful cleansing of the parts, the removal of smegma, and the prevention of chafing; and, equally, the criminality of needless handling of these sensitive organs lest the habit of masturbation be established.

At the same time on behalf of the mother, he should make it his business to plainly instruct her husband in his duty to practice continence and self-restraint until his wife is physically, as well as mentally in condition to resume the marriage relation.

The child grows to boyhood, let us say, passing through many of the minor, at least, illnesses of childhood, affording the physician sufficient opportunity to confer with the father and mother, and assure himself that the child is being properly taught, so that his sexual organs may not be neglected, or be

regarded by him as a disgrace or secret shame, but rather as possessing honorable functions, and as entitled to as much care as the eye or ear. And that all his natural curiosity in regard to them may be honestly, if judiciously gratified by his parents, to the forestalling of ignorant, misleading and vulgar misinformation imparted by his mates, or by servants or chance acquaintances.

Such sensible and timely oversight, such refusal to unworthily make a mystery of what is honorable until dishonored by impurity, will aid the boy to come safely to puberty, and pass safely to manhood. To this end, every physician as he sees the children, whether girls or boys, in a family he attends, approaching this period, should certainly have an earnest talk with the father and mother. This will be of two-fold benefit, considering how very many adults are themselves ignorant of the phenomena of puberty and the physiology of procreation, and therefore unable to instruct their children. Frequently, also, parents will prefer to have this instruction given to the sons and daughters by the medical adviser.

It may well be the ambition of every physician to know his subject so thoroughly, as to be able to present it in perfectly simple, clear English, so that the truths imparted may be unmistakably comprehended.

No young man or young woman at puberty, is too young or too immature to have explained to him or her the development of the sexual organs, their functions, the nature of the sexual impulse, the high privileges and possibilities of marriage founded on mutual love and respect, the possible result of sexual intercourse in the perpetuation of life, the added manliness and womanliness that the complete development of the sexual consciousness should produce.

At the same time, it is equally the duty of the physician to explain to young men at puberty, the danger and the cowardliness of the abuse of the sexual powers, the moral and physical degradation of illicit intercourse, the result of the transmission of infection especially in marriage to wife and offspring, the

increase in mental and physical powers through continence in youth, and, by no means least, to impress upon them the reasonableness and desirability of consulting a reputable medical man whenever any question relating to the sphere of sexual activity arises. This cannot be considered unimportant, when we remember the immense amount of harm done by a certain class of advertisements, and the individual quacks and medical institutes that originate them, and so rapaciously follow them up.

Because of our comprehension of the situation, the part we have to undertake is evident. Ignorance of these matters, conjoined with bad influences and false ideas of making a test of manhood, or a curiosity as to what the sexual act really is, must be held responsible for many a young man's introduction to an impure life, and not, as the unscientific moralist would have us believe, to "original sin." Surely the physician is the one most competent to prevent such errors.

The instruction of young men, and indeed older men, must include the dissipation of the popular error that the contraction of gonorrhœa is of little more moment than an attack of influenza. I shall not enlarge upon this, before men and women well aware of the far-reaching baneful effects of this infection, especially when conveyed to the female.

Findley, of the University of Chicago, in the new edition of his excellent work on the *Diagnosis of the Diseases of Women*, just published, says: "Of the various exciting causes of salpingitis, we have the authority of Noeggerath and Wertheim for placing the gonococcus at the head of the list of micro-organisms. L. R. Guthrie collected statistics from operators in fifteen cities of Iowa, and concludes that 70 per cent. of inflammatory diseases of the tubes are of gonorrhœal origin. Neisser, in 143 cases, found the gonococcus in 80 after a latent period of from two months to two years."

The need of instructing parents, as well as children, as to the functions of the sexual organs, has already been referred to. In illustration of this, permit me to cite a bona fide case

that came under my own observation. While it may seem an extreme instance, it is by no means without parallel.

G. W. M., aged forty-two years. Graduate of Harvard College, with honors. When twelve years old had an erection at night, and in the morning told his father, a well-educated man, the principal of a Latin school. The father, a deacon of the church, said to his son, that it was a sin to think of such things; that he must not touch the parts in any way. This made such an impression on the boy's mind, that from that time on he never even dared to wash his sexual organs, and never urinated except by sitting on the toilet. Of course, finally an inflammation developed, causing balanoposthitis, with the accompanying mental or nervous condition, melancholia, a retiring from all society, fear of everyone, going about with the eyes cast down, a conviction that he was abnormal, and that every woman who looked at him thought so. Such was the disastrous result of want of knowledge on the father's part.

Young men not infrequently are alarmed by occasional involuntary emissions at night, and should be promptly reassured by the physician. Seminal losses for a well adult person are by no means abnormal, but normal. A seminal emission occurs physiologically in a healthy man from once in one, to once in four weeks, according to the temperament, condition of life and general occupation. To sanction illicit intercourse or approve of it in a young man because he has an occasional emission, is a grievous error scientifically, apart from the moral aspects of the case.

When seminal emissions are associated with general sexual irritability and excessive desire, we may alleviate these symptoms through the physical system, by giving the patient some occupation that will necessitate muscular exercise, preferably out of doors, diverting his superfluous nervous energy in this direction, by cold baths, and a non-stimulating diet. This last recommendation is of great importance, and should include to a considerable extent, the omission of meat as well as the disuse of tea, coffee, alcoholic beverages and tobacco.

He may also be benefited through the medium of the mind by being kept occupied with something that will serve to divert his thoughts from the sexual organs. Literature of an erotic or prurient nature, and female society of a doubtful character should be forbidden. In many instances, sedative and antiphrodisiac remedies are of great service.

A careful examination of the sexual organs will reveal any local condition provocative of nervous irritability. Indeed, in all cases marked by pronounced nervous symptoms, whether in the male or female, the condition of the sexual organs, and the state of the sexual functions should be invariably ascertained.

Incomplete and imperfect as this paper necessarily must be, it would be still more so if I omitted some reference to sexual life and sexual hygiene in the marriage state. Few men or women enter upon the marriage relation with a correct understanding of its significance; another evidence of past failure on the part of the profession to meet its responsibilities.

Time, unfortunately, does not permit of my referring to more than one or two of the misapprehensions existing among the laity, and which it seems to me it is our duty to correct, substituting therefore scientific truths, and inculcating the principles of sexual hygiene.

One of the most common and reprehensible practices of married life is that known as *coitus reservatus*, or withdrawal of the male organ before emission. To properly estimate the far-reaching effects of this frauding in what should be a normal and complete physiological act, it should be remembered that the human nervous system is formed by a mass of separate but contiguous nerve cells, and that dissection shows it to be continuous throughout its entire extent. By virtue of its continuity, the nervous system puts into connection all the other systems of the body; conforming to the framework of the body, its branches extend to all parts. It is, of course, well known to you that all incoming impulses must reach the central system, the brain and spinal cord, before those outgoing occur, and that by means of this central system reactions

are established in parts of the body not directly affected by the variation of the external conditions.*

Erection† is a complex reflex act, the centre of which lies in the lumbar spinal cord, and may be aroused to activity by nervous impulses coming from different directions. Impulses may originate in the walls of the ducts of the testis from the pressure of the contained semen, or in the penis from external stimulation of the nerve-endings in the skin, in both cases passing along the sensory nerves of the organs to the spinal centre, or they may originate in the brain, cerebrum, and pass downward through the cord, the impulses in this case corresponding to sexual emotions.

In the female, anatomists recognize the homologues of the male erectile parts, and, in general, it may be said that the mechanism of erection is similar to that in the male.

Ejaculation is a reflex act, and the centre lies in the lumbar spinal cord.

Taylor, in his excellent treatise on Sexual Disorders in the Male and Female, in his own words and in those of Eulenberg, clearly shows why the practice of *coitus reservatus* is so harmful, and enumerates the untoward results. I quote from the latest edition: "The excitation of both men and women is in a great measure under restraint. What should be absolutely spontaneous and untrammelled in the way of desire and sensation, becomes abnormal by reason of the mental process by which the act is interfered with at its most critical stage. On this point the words of Eulenberg are really graphic. He says: "The natural energetic sexual act experiences from the beginning an essentially artificial change. The attention directed toward the postponement and prevention of the natural intravaginal ejaculation, introduces an altogether heterogeneous arbitrary element in the process, which necessarily retards and harms the proper working of the automatic reflex mechanism. The slower and less energetic friction,

* American Text-book of Physiology, vol. 2, p. 171.

† American Text-book of Physiology, vol. 2, p. 464.

the weaker sexual feeling, and the less complete and sudden dissolution of the sexual tension, prevent the occurrence of such complete reaction as results from the natural ejaculation, by which, on account of the necessary energetic muscular action, a sudden emptying of the engorged blood vessels of the genital apparatus results. The centripetal stimulus is set at naught, and through the disappearance of the central innervation, the entire genital apparatus becomes suddenly and completely relaxed.'

When a man has not previously suffered from chronic gonorrhœa or from the effects of masturbation, this bad habit produces a low grade of inflammation in the bulb of the urethra, and in the posterior urethra, and in the prostatic follicles, and it may extend farther and involve the ejaculatory ducts, the deferential ampullations, and the seminal vesicles. In any case, an irritable, flabby and atonic condition is induced, which is unfavorable to the performance of coitus. When any of the above-mentioned parts has previously been the seat of chronic gonorrhœal inflammation an intensification of the process is naturally induced."

Peyer of Stuttgart (*Der Unvollständige Beischlaf*, etc., Stuttgart, 1890), reports a case of neuralgia of the testis from *coitus reservatus*, so severe that when it came on the man had to go to bed or lie down on the spot on which he stood when he was attacked. He had also deep circumscribed pains in the pelvis, groins, lumbar and sacral regions. In similar cases aching and burning pains in the perineum and anus have been observed, and even mild hematuria.

Other symptoms more commonly noted are spinal irritation, including painful spots along the spine, girdle pains, excessive sweating on slight exertion; also gastro-intestinal inertia, shortness of breath and palpitation of the heart. This latter symptom is an especially prominent one in women suffering from incomplete coitus, and may last from a few minutes to several hours, with increasing irritability of the heart, depression, headache, indigestion, constipation, weakness, vertigo, fainting spells, and great emotional sensibility.

It may be claimed that *coitus reservatus* is often long-continued without apparent ill effects. While this may be true in instances, the practice is diametrically opposed to the teachings of physiology, and is a distinct perversion of the normal act. The psychological aspects, which are not unimportant, I must necessarily leave untouched.

The only other point to which I will briefly refer is that of sexual excesses. The laity must be taught, and by physicians, that it is a prostitution of the sexual powers in marriage, as well as in illicit relations, to indulge unduly in sexual intercourse. Findley asserts that, in women, sexual excess conduces to sterility through the resulting congestion and inflammation of the parts. Goodno in his *Practice of Medicine*, vol. 1, p. 845, in his discussion of Neurasthenia, says: "Of the local causes, none is so prolific of this condition (exhaustion of nerve function) than is sexual excess."

With all the long train of nervous symptoms which result, you are familiar; and with the haggard, worn out men and women who have allowed the sexual appetite to sap their vitality. Instruction before marriage, and education in sexual matters at an early age, in fact at all ages, is the protection we are capable of giving. And it cannot be doubted, that the number of ill-considered and unhappy marriages will be greatly diminished by such action on our part.

It must be evident to you all that I have spoken very superficially and imperfectly of matters of grave importance. I could not, had I been capable of so doing, have given within the limits of this paper, an adēquate scientific summary. Such was not my expectation, but merely to call attention to some aspects of sexual life and sexual hygiene, with the hope that the renewed interest it may awaken may add to the services we have so many opportunities for rendering, and which contribute so materially to the betterment of the world through the betterment of the individual.

THE CARE OF THE NOSE AND THROAT BY THE GENERAL PRACTITIONER.

BY WINFRED N. EMERY, M.D., WALTHAM, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

There are constantly appearing in various medical journals, articles in regard to the duty of the general practitioner in the recognition and treatment of the initial stages of all the specialties applied to the human body. To my mind this is nothing more or less than the sphere which the general practitioner should legitimately occupy. An ideal family physician is one whom I met in Vienna in 1899, Dr. G. of Baltimore, who every summer devoted six weeks to study in some medical centre noted for the specialty in which he had decided to better himself.

I have consented to write a short paper on the care of the nose and throat in general practice, not because I expect to introduce any new thing in this line, but in hopes that it will stimulate more thorough examination by the general practitioner. When the patient comes into the office complaining of having caught cold, or having to breathe through the mouth, or of not being able to breathe through one or both nostrils, droppings in the throat with aches or pains located in the vicinity of the naso-pharyngeal cavities, pharynx or larynx, do not content yourself with simply a cursory glance into these ora, and following the same with a well indicated remedy, for by so doing many a case is allowed to progress from a simple, acute inflammatory state, to a chronic condition suffering much on account of loss of time from lack of definite knowledge of the disease.

To make the examination more thorough, have the patient sit on a stool facing you with a strong light on the level with, and a few inches to the rear of his ear, a circular, four inch in diameter, concave mirror containing an opening in its center, on your own head, the eye nearest the light, opposite the opening, and thus throw a concentrated illumination on the parts

before you. A tongue depressor, nasal speculum, rhinoscopic and laryngoscopic mirror, cotton carrier, and probe are indispensable. In order to examine the parts satisfactorily, the toilet of the nose and throat must first be attended to. So after introducing a nasal speculum, remove all crusts and secretions by means of cotton wound on the end of a cotton carrier. This having been accomplished, cocainize the parts with a two to four per cent. solution of cocaine hydrochlorate. This is done by moistening a pledget of cotton on the end of a cotton carrier, then introducing it along the nasal floor carrying it back to the pharynx, then upward and forward bathing all surfaces of the cavity; or a pledget of cotton saturated in the solution may be placed in the nose between the middle and inferior turbinals, and allowed to remain *in situ* five minutes, and then removed. This causes the intumescence to disappear, thus enlarging the nasal lumen, at the same time procuring an anesthesia which is absolutely necessary to a complete examination. A fresh solution of cocaine hydrochlorate is essential, and may be quickly made by keeping on hand a freely soluble tablet prepared by Otis Clapp & Son. One of these tablets dissolved in a fluid dram of water makes a four per cent. solution. Adrenalin chloride 1:1000, added to equal parts four to six per cent. cocaine, will aid in depleting the congested area and prolonging the anesthesia. This combination is generally used if any operation is contemplated, thus making it practically bloodless as well as painless.

We will begin with the septum, noticing its deviations, protuberances and deficiencies, then sweep the eye over the vault outward and downward noting the color of the mucus membrane, the size of the turbinate bodies, the kind, color and consistency of any discharge present, and particularly its origin, finishing with an examination of the floor of the cavity. Should you discover pus during the observation, be very persistent in tracing its origin, for the presence of pus within the nose is an important indication of sinus disease. If the sinuses are discharging, the pus will be seen flowing somewhere upon

the external nasal wall either in a small thread of a stream or possibly in drops. It may take the skill of the specialist to determine the origin of this pus, whether it is from the frontal sinus, ethmoidal cells, sphenoidal sinus, or antrum of Highmore; and it certainly belongs exclusively to the specialist to treat the same. Many a case of chronic headache or face ache has at last been cured by an examination of the nose bringing to light some sinus disease.

To examine the posterior nasal fossae, tip the patient's head slightly backward, the mouth being open, depress the tongue, introduce the small mirror, after slightly heating it and examine the vomer, the three turbinals, the meati, the eustachian opening, the fossa of Rosenmuller, the vault of the pharynx and posterior surface of the velum. Remove the mirror and sweep the eye over tonsils and pharynx, then take out the tongue depressor, and, with a napkin, envelop the point of the tongue, and drawing it out to its full extent, introduce a larger mirror and inspect the lingual gland, epiglottis, vocal bands and connecting mucus surfaces. Having made a careful examination and diagnosis we are in a position to know what *we* can do for the case, and what we can advise to have done by a specialist. Acute catarrhal rhinitis, simple chronic rhinitis, atrophic and purulent rhinitis, tonsillitis, pharyngitis, and laryngitis, are wholly within the scope of the general practitioner. Hypertrophied tonsils and adenoids might easily be operated upon by the family physician. The removal of turbinals, spurs, polypoid and bony growths, treatment of diseased sinuses, and like remote conditions belong strictly to the specialist. The general practitioner ought to be so familiar with nose and throat landscape that he quickly recognizes the course to pursue.

Some six years ago a man came to my office complaining of his inability to breathe through his nose, and saying he could not remember of ever breathing with his mouth shut. On examination I could see nothing specially abnormal, except that he had a general anemia, and his face and nose looked pinched,

the nasal mucous membrane was very pale, the turbinals normal in size. I was about to close the examination unsatisfactorily to myself, when it occurred to me to introduce a probe into the pharynx through the nose, and to my surprise found a hard and fast wall completely shutting off the nasal pharyngeal cavities. Dr. Rice was consulted, and relieved the condition by trephining openings through bony tissue on both sides, and allowing the patient for the first time in his remembrance to breathe through his nose, and incidentally to experience a little later the extreme pleasure of an acute rhinitis. I may add that he has enjoyed a more robust health since then, probably on account of being able to more thoroughly masticate his food.

Children are troubled principally with acute catarrhal or purulent rhinitis, enlarged adenoids, and hypertrophied tonsils. Do not allow your little patients to neglect these discharging nasal conditions, but insist strenuously upon absolute cleanliness, with the indicated remedy. A neglect of this condition is a very prolific cause of adenoids and enlarged tonsils. Mouth breathing children, with pinched noses, expressionless faces suggestive of idiocy, require immediate removal of adenoid growths or a Luska's tonsil as well as the faucial tonsils. Patients under eight years of age should be anesthetized with chloroform, others with ether. A mouth gag, Gottstein curette, a Cradle's adenoid forceps, or one of its modifications, a Mandeville's tonsillotome, tongue depressor, sponge holder and long curved dressing forceps, and a right and left Douglass tonsil knife, are all the instruments necessary in extirpation of adenoids and tonsils. In removing adenoids take care not to cut the eustachian tubes. If you would have little or no pain following your excision of the faucial tonsils, be careful not to injure the anterior and posterior muscular pillars. This operation is a bloody one, but bleeding generally subsides in a half minute or so. Occasionally a hemorrhage will follow, and must be controlled by pressure. A tonsil hemostat has recently been devised which easily controls such an emergency

I have seen operators who use no cleansing wash before, during, or after these operations; but generally a mild alkaline antiseptic solution is used before, to cleanse the parts of any mucoid secretion, and during and after to remove clots and any escaped shreds of tissue. The patient during the operation should be prone, with the face turned to one side sufficiently to admit of free use of instruments, and particularly in order that the blood and washes may drain easily out of the mouth, and not into the larynx. Ordinarily after such operations the patient is up and dressed twenty-four hours later, but should be kept quiet and in the house for four days, with care that the wounded surfaces are kept clean by the occasional use of alkaline antiseptic washes.

In adults the turbinals are more at fault, being often enlarged, and from neglect, chronically so; this latter is the stage where the specialist is a necessary adjunct. If on the application of cocaine we find that the turbinals contract, we know that they are in the acute or sub-acute stages, and are amenable to medicinal and local treatment. Fortunately we have a rich store of remedies from which to draw, that definitely aid us, but since this paper is a general one, I will simply mention a few that have been most useful to me in the order given without going into definition: Arsenicum, mercurius vivus, and mercurius dulcis, bryonia, nux vomica and gelsemium.

Locally, in acute rhinitic conditions, a campho-menthol nebulation will temporarily contract the swollen surfaces. In the sub-acute stages according to the condition present we are aided by simple antiseptic alkaline washes, stimulating lotions and astringent formulas. In using astringents care should be taken not to have them too powerful, and then to apply the portion only on the site where it is needed, whereas a general application may so injure the mucous membrane as to cause anosmia. As a cleansing wash I have used with much satisfaction Dr. Rice's formula, alkaline nose and throat tablet. One tablet in four to six tablespoonfuls of warm

water. When the turbinals are intumescent, so that they fill the nasal cavity reaching over onto the septum, I find an application of

Tr. Iodine dr. 1
Fl. ext. Ergot
Glycerine āā oz. 1

very beneficial in producing contraction. Should the turbinal tissue present a red, angry, slightly swollen condition, easily bleeding when touched, a lotion consisting of

Aristol gr. XLVIII.
Petroleum Oil oz. 1

will greatly benefit the case.

You will find that powders applied directly to the mucous surface of the nose are shortly thrown off, and the medication lost. In order to avoid this, nebulize an oil over the parts before using the dusting powder. This has the effect of making the parts more tolerant of the medicine applied, increasing its efficacy.

We might go on somewhat indefinitely in this line, but I think enough has been said to open up a discussion which, I trust, will be beneficial in some way to all present.

 EDITORIAL.

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 THE SUPERIORITY OF THE HOMŒOPATHIC TREATMENT OF DISEASES OF THE NERVOUS SYSTEM.

It is for the purpose of saving time and space that one system of diseases is selected for present consideration. It might, however, be claimed that remedies selected according to our formula, and administered in the smallest useful dose were peculiarly adapted to the treatment of the delicate and nicely balanced nervous system. If we divide all nervous diseases into two general classes, functional and organic, it aids the matter somewhat. Functional diseases show no lesions discoverable by any expedients or measures now at our command, and of this class neuralgia, neurasthenia and hysteria may be selected as fairly typical, to which may be added a few of the mental disorders. It can be assumed that there are but few who read this, who will not readily admit that, for such troubles, homœopathic remedies are most peculiarly applicable, as they introduce no irritating or symptom-producing agent, but act by the natural method of affinity upon the organs or functions at fault. Were all diseases in this realm of the above type, there would be but little need of argument to convince, unless there were a deep professed prejudice against all homœopathic treatment, not open to conviction. A true homœopathic prescription no more ignores causes than does one based upon the principles of the so-called physiological school. If the

disturbance is from heredity, from exhaustion, from auto-infection, or from the action of external intoxication, each and all should be taken into account in treating any case, and with our method of minutely interrogating every organ and function such observations are no more likely to escape us, than they are practitioners of the other school. Of still greater importance is also the fact that we are less likely to yield to the habit of routine practice — the bane of all true science.

Let us, without further discussion, look to the much more formidable class of organic nervous diseases. Here we have a class of cases where our more regular brethren, after years of trial of nearly all the remedies in their voluminous *materia medica*, can only say of the majority, that they are incurables. Not only are they so classed, but, as a rule, palliation is only to be hoped for from the use of sedatives and analgesics, given in such doses that ever and anon their use must be suspended, and measures resorted to to counteract their evil effects upon the whole body, and thus the pendulum is made to swing from the pangs of the disease at one end of the arc, to the perils of drug action at the other extremity. In our poorest efforts we can offer as much relief as this. Can we do more by still better procedure.

There is good reason to suppose that in all chronic lesions of the nervous system there is a prodromal period when the condition is one of disordered function. This prodrome may not be particularly noticed by the patient at the time, but a careful inquiry will show that there has been a period when there was some error but no evidence of a well-established lesion. If such is the condition, then just here is the time when the remedy can be expected to be the most useful. This remark applies as aptly in the older school as in ours, but it may justly be claimed that, with our method of carefully soliciting the total of the symptoms, we shall be more likely to detect the early errors in function, and, also, if guided by the strictness of our method we are not as likely to be led astray by nosological theory. It is not necessary to ignore

pathological findings, but there are cases when much valuable time is lost in treating the name of a disease, and trying to twist pathology to fit this name. It may be granted that there is a growing tendency toward this error in our own school, but it does not militate against the original sound principle of totality and congruence. Even where the nervous lesion has become well established, such is the natural healing power that the system is constantly striving to re-establish the normal condition, and as a result we are apt to find longer or shorter periods of rest — sometimes actual improvement in the course of the untoward symptoms. If by proper treatment these periods can be prolonged, or the improvement increased, it certainly makes for the comfort and the usefulness of the patient. Such being the fact it is our plain duty to forward such an event. By our methods this has been done heretofore, and can be again accomplished. Here, as in the functional cases previously mentioned, we have a certain degree of advantage over the more radical school, as our remedies are administered in the smallest and most beneficial doses. Not only does the patient miss the irritation of the more heroic remedy, but also, what is of still greater importance, the remedy is so selected as to meet *all* the demands. The errors in digestion, metabolism, excretion, and rest or sleep are as carefully studied and provided against as are those directly referred to the nervous lesion. By our methods we do not give a powerful sedative to relieve pain, as the one symptom to be met by the remedy, leaving other drugs to be necessary for the paresis, or other nervous symptoms. Nor are we called upon to mix some corrective drug with a sedative in the prescription to counteract its evil effects upon the whole system. In a correct prescription one remedy should, for the time being, cover the entire field of existing symptomatology, always bearing in mind that in relief or cure we are assisting, but not coercing the natural efforts of life. We should go farther than this and, in our study of any case, not ignore the original cause. A large percentage of organic

nervous disorders have their foundation in a syphilitic invasion. This outcome may be the direct result of this poison, or as in many instances, only very indirectly the syphilis may have so weakened the nervous structure as to leave it unable to protect itself against the stress and strain of civilized life.

Our elder brothers know of but two remedies with which to combat syphilitic manifestations, viz., mercury and iodine. While we recognize the adaptability of both drugs to the dyscrasia, still we do not feel constrained to rely upon them alone, for the late results of the disease, be they direct or indirect. Anyone studying our materia medica will notice that there is quite a noticeable group of drugs which include late syphilis among a large number of other symptoms.

Leaving now all comparison between schools of practice, it will not be out of place to devote a few words to inherited or congenital instability. In a large number of instances, future serious nervous disorder sounds its alarm in infancy. Frequent convulsions from trivial causes, children who have one or more fits with the "cutting" of each of the first teeth or with every attack of summer diarrhea, furnish a large percentage of future epileptics. Those who at a little later period develop chorea are quite certain to break down nervously from very ordinary strains in early adult life. The fractious, brooding child, not liking the companionship of others of its age, stands in danger of melancholia from misfortune or any extraordinary strain; and, if a girl, is in more than usual peril at the two great epochs of a woman's life. These are only examples which might be multiplied, where the physician may, in a great measure, foretell the future tale of nervous invalidism. Fortunately our materia medica is replete with indications for the relief of such incipient troubles. We do not all have an opportunity to guide the bringing up of families under our care, which care is more than formerly temporary. With the advance of the profession in exactitude, and modern methods of diagnosis, there has been something lost out of the physician's province, something which our

predecessors possessed. In their days the family physician had the care of one or two generations, and was on such intimate terms that he was the family adviser, and, as a natural consequence, had a lively interest in every member. Despite his nasty doses and homely way he was always a *persona grata*. Now when knowledge is greater, opportunity is less. Heads of families know much more than their ancestors, but they have yet to learn how little they do know, and how superficially they know that little. It is not a common occurrence now, for the same physician to remain in charge of a family through an entire generation, and watch the growth of individual members. Each one, however, can meet his duty at the time it presents itself. Seeing then that the homœopathic method of treatment offers a somewhat more sure promise of success in nervous diseases, at the same time safer and more mild, let us adhere closely to our principles, and not be lead astray by the importunities of our patients, or by the action of our own impatience. E. P. C.

MEDICAL TREATMENT OF INGROWING NAIL.—The writer has found that copious application of drie ' powdered alum is sufficient to cure every case of ingrowing nail in his experience in about five days. The applications were never painful in the least, and the destruction of the pathologic tissue resulted in the formation of a hard, resistant and non-sensitive bed for the nail, a perfect cure for the ingrowing tendency. The non-toxicity of the alum, its easy application, and the fine results render it the chosen treatment for cases in which surgical intervention is not contemplated. The writer applies a fomentation of soap and water for twenty-four hours beforehand and then pours the alum into the space between the nail and its bed, tamponing with cotton to keep the alum in place, and repeating the application daily. The suppuration rapidly dries up, and pain and discomfort are relieved almost at once.

A. Gasparini, *Gazetta Ospedali*.

BOOKS AND READING.

Medical, literary and scientific publications will be reviewed in this department. Books and journals should be marked *NEW ENGLAND MEDICAL GAZETTE*, and sent to the Business Manager.

NEUROTIC DISORDERS OF CHILDHOOD. By B. K. Rachford, M.D., Professor of Diseases of Children, Medical College of Ohio, University of Cincinnati, etc. New York: E. B. Treat & Co. 1905. pp. 440. Price, cloth, \$2.75.

Without contributing anything essentially new on this subject, Dr. Rachford has given us an exceedingly readable book, calling attention to many conditions in childhood too often lightly dismissed, and far too often occasioned by lack of knowledge on the part of the child's parents and attendants. Much of the information which should be imparted to them by the physician is emphasized in this treatise which, however, contains as well some excellent discussions of the purely scientific aspects of nervous disorders in the young, with well chosen illustrative cases.

A TEXT-BOOK OF OBSTETRICS. By Adam H. Wright, Professor of Obstetrics, University of Toronto, etc. Illustrated. New York and London: D. Appleton & Co. 1905. pp. 591. Price, cloth, \$4.50 *net*.

The author is to be congratulated on having compiled a work of such practical value. Especial credit is due him for the excellent arrangement of the subject matter and the directness with which he approaches his topic, for the reader is not confronted at once by one hundred or more pages devoted to anatomy and physiology of the female pelvis, as these subjects are amply dealt with in two brief and terse chapters.

It is in the hints and suggestions that mean so much to the physician engaged in active practice that Dr. Wright's book makes its strongest claim for popularity. The chapters on the Diseases of Pregnancy and Puerperal Infection are of great value and deserve special mention, for the author has freely illustrated his statements by the introduction of clinical reports which cannot fail to appeal to the practical reader.

We take pleasure in being able to extend Dr. Wright our heartiest approval of his efforts, and recommend his work to the attention of both students and physicians. C. S.

CLINICAL TREATISES ON THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Professor Dr. Carl von Noorden, Physician-in-Chief to the City Hospital, Frankfort, A. M. Part VII. DIABETES MELLITUS: ITS PATHOLOGICAL CHEMISTRY AND TREATMENT. New York: E. B. Treat & Co. 1905. pp. 211. Price, cloth, \$1.50.

Part VII will undoubtedly be as well received by the profession as the preceding volumes of this series. Between its covers will be found the substance of Professor Von Noorden's lectures on diabetes recently delivered in this country. After a brief introduction, the first sixty pages give an account of the pathogenesis of glycosuria, most minute and instructive. The following section on the acetone-bodies is full of interest. Other changes in metabolism in diabetes are taken up, also the course and progress of the disease. The treatment outlined presents not only the latest scientific deductions as to the value of restricted diets, but also as to the selection of drugs, and the relative merits of various health resorts.

SOCIETY REPORTS.

BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

At the meeting of the Boston Homœopathic Medical Society, held Thursday, Oct. 5, 1905, it was voted that the action of the Massachusetts Homœopathic Medical Society, endorsing the Pharmacopeia of the American Institute of Homœopathy and demanding that hereafter preparations be made according to the rules thereof, be approved by the Boston Homœopathic Medical Society.

Applications for membership were received from Arathena B. Drake, M.D., South Boston; Dana F. Downing, M.D., West Newton; Deborah Fawcett, M.D., Newton; Henry M. Emmons, M.D., Jamaica Plain; W. F. Phillips, M.D., Dorchester; Anna M. Skinner, M.D., Watertown.

The resignations of James Utley, M.D., and Alice M. Patterson, M.D., were accepted.

The following resolutions on the death of William L. Jackson, M.D., were unanimously adopted.

WHEREAS, It has pleased an all-wise Providence to remove from this earth our colleague, Dr. William L. Jackson of Roxbury, be it

Resolved, That in his death this Society, as well as the whole medical profession, loses one of its ablest and most skilful members, one who would be an ornament to any body of practitioners.

Resolved, That this Society, recognizing his lovable character and his kindly and sympathetic nature, feels sure that these qualities must have endeared him to a large circle of patients who must now sincerely mourn his loss.

Resolved, That this Society views with admiration the sweetness of his disposition and the Christian patience which enabled him to bear his tedious invalidism for many years.

Resolved, That we hereby extend to his family our sincerest sympathy.

(Signed) H. C. CLAPP.
F. P. PERCY.
N. E. PAINE.

SCIENTIFIC SESSION.

PROGRAM.

1. Congenital Deformity of the Shoulder. Waldo H. Stone, M.D.
2. A Clinical Study of Mercurius. George H. Wilkins, M.D.
Discussion opened by Herbert E. Maynard, M.D.
3. Diagnosis and Treatment of Flatfoot. Alonzo G. Howard, M.D. Illustrated by stereopticon.

DISCUSSION (DR. STONE'S PAPER).

Dr. Clapp: I should like to ask if the apparent hitherto rarity of this case is not due to the fact that we have not always had the X-ray.

Dr. Stone: I find no reference to that in the literature. The fact that the baby cannot bring his hand to his mouth would, it seems to me, attract the attention of the mother or nurse and they would immediately begin to inquire. For those muscles are certainly the ones that are defective, because there is no place to pull on when they are brought into activity. These are certainly the muscles which are first brought into play.

Dr. Wilkins: I should like to ask whether the arm itself has developed as the other arm in this case.

Dr. Stone: This motion (flexion of forearm) and the rotary motions of the lower arm are all right. It is only this one motion (putting hand to mouth: drawing up;) that is defective now.

Dr. Wilkins: I asked the question because I was making a call the other day, and the mother called my attention to her daughter, who is also a mother, and in speaking about her said that when she was born her left arm was put out of joint. Although I was in a hurry, and made no careful examination, yet I could see that the arm was at least an inch shorter than the other arm, and not more than half or two-thirds as large. She has some use of it, I do not know how much.

Dr. Klein: I think if we had had the X-rays formerly we should have recognized many such cases. I well remember the case of a young man who all his life was able to raise his arm only just that far. I think it was nothing else but just what Dr. Stone had here. Of course we could not look into it so well formerly, but if we could go back I think we should find that many cases where children were unable to raise the arm, which were formerly attributed to dislocation or some other trouble, were just like this case.

Dr. Howard: Recently a trained nurse came to me for deformity of the right shoulder. In getting the history of the case she said that when she was a very little girl she had an injury to that shoulder. Nothing was ever done for it, and she was never able to raise her right hand to the top of the head, or get it about to the back, and her clothing was all made to fasten in front. The arm was strong, well developed, apparently about the same size as the left arm. The distance from the spine to the shoulder was one and one-half inches less on the affected side than on the well side. She came to have a pad made so that her dresses would look right, and Dr. Loring has made an X-ray of the shoulder. I do not know yet whether the deformity was congenital or traumatic.

Dr. Loring: The humerus is smaller than the bone of the other arm, and the clavicle is shorter and smaller than on the other side. It seems to me that the condition is rather one caused by paralysis, and that the trouble is paralytic. We have under treatment at the dispensary a case of a child who fractured the clavicle and has now the same disability as Dr. Stone's case. My opinion is that these cases were all caused by paralysis due to injury to the nerve.

Dr. Stone in closing: I have never seen any such cases as my colleagues speak of. In the two cases I have mentioned both were present at birth, and the X-ray shows an un-ossified coracoid process. I cannot go back on my opinion that there is in this case a deformity or non-ossification of the coracoid process in these two cases. I do not see how a nerve injury

would allow that process or end of bone to be so soft that you could feel it with thumb and finger like a little piece of gelatine or gristle.

DISCUSSION (DR. WILKINS' PAPER).

Dr. Maynard: I have put down just a few things noted in Dr. Wilkins' paper. One of these is the poisonous effects of small doses. I had a patient who had been all around, troubled with what she called catarrh of the stomach. She had acute pain in the epigastrium, followed by pain right down through the bowels, watery movements, sometimes green and occasionally bloody. She had had homœopathy, osteopathy and about everything. The first time I saw her I gave her mercurius. She seemed to have very typical mercurial symptoms. I gave her mercurius in several different strengths but got no results. Then I gave other remedies. Finally I found she had those attacks mostly at night, sometimes a good deal of sweat: every time it looked more like mercurius. I happened to find out that she had four, perhaps five, large amalgam fillings. I had those taken out. That was two years ago. Since then she has had one attack. She has never been to me since for trouble of the stomach. At one time during her last pregnancy she had a few symptoms, but they cleared up under pulsatilla. So that cleared up that condition which she had had for six or eight years. That really meant pretty small doses of mercurius.

I used to think if patients had a sweaty head they were either calcarea or silica patients, but I found that mercurius had just as much of the sweat about the head.

I had one case of trouble with the ear. It started in with simply a cough. I stopped the cough in about fifteen minutes, but it began again next day. I prescribed for that cough for about three months, then they concluded they would have somebody else. They took the patient, a little girl about eight years old, into Boston to a stomach specialist, and he said there was nothing the matter with the stomach, and ad-

vised removing her tonsils, which was not done. He prescribed nux vomica and cod liver oil. He was an allopath, I believe. The patient took it for about two months, got no better, then came back to me. I found the child was sweating a good deal at night, had two or three enlarged glands on the left side of the neck, and was pretty restless at night, impatient, and kicked the covers off, always seemed to be pretty warm. I had given the patient calcarea once or twice without result. This time I gave mercurius. Within twenty-four hours the patient had a profuse, very offensive discharge from the ear, although she had had no ear symptoms since I had her. When very small she had otitis media. The cough stopped at once and she has had no cough since. The ear cleared up in the course of a month or so. I do not know what the ear condition had to do with the cough, but when the discharge started the cough stopped.

In grippe sometimes I have used the biniodide when there was a great deal of restlessness, headache, sensation of heat, and some sweating. Also in tonsilitis starting on the left side, with the general mercurius symptoms, but with more headache.

In summer diarrhea of children Dr. Wilkins spoke about mercurius dulcis. I have never used it at all, but I have noticed something rather peculiar about those bowel troubles. It has been this way with me that one summer the cases would run to one or two remedies, the next summer those remedies would not be indicated.

I remember one summer about all the cases I saw called for mercurius as near as I could make out. This last summer I have seen none which required mercurius; last summer not more than one or two. I have noticed the same thing in cases of malaria and grippe.

The yellow iodide of mercury—the books speak about tonsilitis and the yellow tongue. I have not seen many cases calling for this remedy.

Mercurius dulcis. I had a patient two or three months ago who had a case of tonsilitis, and was sick in bed about ten days;

was treated by a homœopath with *mercurius dulcis* in one-tenth grain doses. I do not know why, but it did not cure, and the patient dragged along until she was given *lachesis*.

Mercurius corrosivus. I have noticed that *mercurius corrosivus* does very good work in dysentery, but I have not seen many cases. At the same time with the tenesmus of the rectum there is tenesmus of the bladder which is just about as painful as the trouble in the rectum.

Dr. Sherman: Dr. Wilkins' paper brings to mind some experiences I have had with *mercurius*, and I will relate two cases. The first was in 1858 on the island of Nantucket. The patient was a lady about thirty years of age, who was in fair physical condition barring a subacute dyspepsia, which was making life almost unbearable. She had been under allopathic care for quite a while without avail. I treated her for a week or so with like result, then I concluded to try *mercurius dulcis* in the first decimal trituration, and after her taking a powder three times a day for six days I was called to see her. Found her sitting upright, cuspidore in hand, and seemingly having all she could do to keep her mouth clear of saliva. I can't tell you my feelings when I took in the situation. There was a sickening stench in the room, and the scene was depressing, but I assured the patient that the medicine was having the desired effect. Ordered a saturated solution of chlorate of potash for a mouth wash and gargle and some powders of *sac. lac.* The fetor of the breath was speedily removed, the secretion of saliva arrested, and in a few days the patient could eat without fear of distress. She called on me four years subsequently in San Francisco, and told me she never had been troubled with her stomach after I treated her.

My second case was one of diphtheria of septic type, in a delicate girl of nine or ten years, my minister's daughter. I was very anxious about the case, as the child had not the appearance of average resisting power; my faith had been shaken in the *certain* efficacy of peroxide of hydrogen, and it was before I knew about antitoxin, practically, at least. And I re-

solved to try mercurius corrosivus in Fairchilds & Foster's essence of pepsine, so that the patient should get a thirty-second of a grain every three hours when awake. Before a grain had been taken the disease yielded, the patient was on the road to recovery, and no unfavorable after result followed. I believe this assisted the antitoxin which nature was secreting to antidote the toxin in the system.

Dr. Percy: I feel a certain amount of responsibility for a supposition which the facts bear out, which Dr. Maynard has referred to, that is the possibility of small doses of mercury producing very serious effects. I mean by that I have for a good many years been at loggerheads with my dental friends on the subject of amalgam fillings, and I have been still more at loggerheads with them in regard to the red gum plate. I am firmly convinced that I have seen many chronic cases where ill-health in various forms was clearly attributable to one of those two causes.

One of the most notable instances was a case of mercurial tremor. That is a very unusual consequence, and it is one of the manifestations of mercury after a long time, but this was a nurse who had been under the care of some of the most noted nerve specialists of Boston, and the difficulty had been variously diagnosed. After carefully going over the case it seemed to me that two red gum plates in her mouth were responsible for the condition. I said, "This thing is worth testing." I referred her to an uptown dentist, who saw that the difficulty was rectified, and with the removal of those plates the whole difficulty has disappeared.

In regard to personal idiosyncrasies. We all have people on whom very small doses produce unpleasant results. I have in mind a case of erythema. Twice within the last ten years when the patient, a man, has been away, suffering from some difficulty of the bowels, catarrhal trouble, and a physician has given him mercury in forms as low as the third trituration, he has invariably had erythema. He is equally subject to the vegetable mercury, podophyllum.

To my mind, in many instances the most marvelous and most remarkable cures that are made with mercury are made with preparations which are of the type Dr. Wilkins has referred to, that is, in the lower preparations, in the treatment of those most painful cases, congenital syphilis in babies. I know of nothing which so moves me to pity, and makes me feel as though this was one of the things which ought never to be. When you see a child covered with the peculiar rash, even to the palms of the hands and soles of the feet, with the wizened look which betokens its depraved condition, and see how quickly this clears up under the lower preparations of mercury, then you are grateful for the knowledge that there is a very striking homœopathicity between the mercury and those serious diseases such as syphilis.

Dr. Stone: I had a case very much like the one Dr. Percy has described, where I discovered it was mercury. I worked on this until my faith gave out. Then I sent the patient to a dentist, and the case was cured as soon as the gum plate was changed.

Dr. Moore: I want to give my testimony to the fact about amalgam fillings. When you have a chronic patient in your office presenting mercurial symptoms, look at the teeth. Examine the plate, and you will find the unmistakable cause of chronic mercurial poisoning. Tell him he must go to the dentist; but before he goes forewarn him that the dentist will say it is not so, because the dentists as a class do not recognize the possibility of poisoning in such small quantities.

I want to add one word in testimony to this very practical paper. Every condition and indication that Dr. Wilkins mentioned, coming under the head of *mercurius*, is so. *Vivus* in jaundice; *dulcis* in cases of yellow or green mucous, slimy discharges; the cyanide of mercury in diphtheria, second in my mind only to antitoxine; and then the two iodides in all glandular affections in the throat.

The Society is certainly indebted to Dr. Wilkins for contributing this extremely practical paper.

ABSTRACTS FROM BOOKS AND JOURNALS.

RETARDING THE SETTING OF PLASTER OF PARIS.—This may be accomplished by adding to the water powdered althea root in the proportion of 2 to 4 per cent. When dry such casts may be sawed, filed and turned. An addition of 8 per cent. of althea retards setting for a full hour, and the mass may be kneaded, rolled, and otherwise shaped. The addition of a little alum or ferric chloride produces a very hard cast.

Bulletin of Pharmacy.

URINE, PRESERVATION OF.—Boracic acid is the most practical urinary preservative that we possess when used in the proportion of 5 grains to 4 ounces ($2\frac{1}{2}$ grains to 2 ounces) of urine. Formaldehyde should be used only by the physician or a responsible person. It should be remembered that 1 drop of the solution will preserve a pint of urine for about a week, and that 1 drop can be used in 4 ounces of urine without harm. Other substances than boracic acid and formaldehyde should not be used. The name of the preservative and the quantity that has been used should always accompany the specimen to be examined.—*Dr. J. B. Ogden, in Boston Medical and Surgical Journal.*

CHANGES IN THE UNITED STATES PHARMACOPEIA.—The attention of the profession should be called to the recent action of the committee on revision of the United States Pharmacopeia. Some important changes have been made in the strength of some of the preparations, in order to conform to the standards adopted by the International Conference on Potent Remedies, held at Brussels, in 1902.

The tincture of aconite has been reduced from 35 per cent. to 10 per cent., that of tincture of veratrum from 40 per cent. to 10 per cent. while the strength of tincture of stropanthus is now 10 per cent. instead of 5 per cent. Until such time as the new standard becomes generally adopted, it would behoove every practitioner prescribing these preparations to indicate clearly the strength of the tincture desired. The science of medicine is uniform throughout the civilized world and yet we find a great variation in the preparations of the same drugs in

different countries. The action of the International Conference in attempting to render more uniform the various preparations is therefore a step in the right direction.

Such a radical change as the adoption of a single pharmacopœia for the whole world would hardly be possible for years, but so long as the potent remedies are standardized the possibility of harm will be considerably lessened.

THE EAVESDROPPING SCIENCE.—Physical diagnosis is the science which seeks to point out the condition of things in enclosures which it may not enter, concerning which all conjectures must be made from the outside. It is, therefore, exceedingly difficult work, and occasional mistakes should, rather than surprise us, be taken as a matter of course. Among such is that noted by R. N. Wilson (*Med. Notes and Queries*), who has seen a caseous pneumonia with amphoric breathing, a tympanic percussion note, a brilliant cracked pot sound and whispered pectoriloquy, in which the autopsy showed no cavity to be present. Wilson suggests the use of the tuning fork in the diagnosis of cavities; and we believe much can be made of this suggestion if it be thoroughly worked up. It is no more odd than the consideration of pitch intensity, quality and duration of the percussion note upon which we now rely. Wilson places the stethoscope over healthy lung tissue, and the tuning fork, set in rapid vibration and placed with the handle touching the skin, is made to approach the bell of the stethoscope. As the fork passes from normal tissue to a consolidated area the pitch rises and the note becomes much clearer; it may, indeed, become evident for the first time. If next it passes over a superficial cavity the note takes on a clear, sweet, musical character, which is never simulated by any other condition.

Medical Times.

NASAL HEADACHE.—Two general causes of headache, partial or complete stenosis, and acute or chronic sinusitis, are considered by the author. In intractable headache of any form the nose should be carefully inspected. In acute empyemas, headache is almost always present; in the chronic forms it is less frequent. The order of frequency is frontal, occipital, ver-

tical. The varieties are similar to those from other causes, neuralgia or hemicrania predominating. Usually the pain is constant in its relation, changing its position when other intranasal tissues are consecutively involved. The intensity varies with the severity of the local disorder and the general condition of the patient. If portions of the nasal interior are in contact, neuralgic headache results. Stenosis produces frontal pain and weight, while the most violent and constant pains result from pressure in the accessory sinuses. In chronic obstruction from any cause, especially hypertrophy of the turbinates, headache is a common symptom. Severe epistaxis is often preceded by congestive headache. If the bleeding is profuse the headache may follow it. In headache from sinusitis in general more than one cavity is usually involved. There may also be nasal disease, with or without suppuration and with intermittent headache, to which, however, it has no direct relation.—*Somers (Medicine, July, 1905).*

SYSTEMATIC TRICKS OF IMMIGRANTS TO PASS HEALTH INSPECTION.—Aside from the difficulties encountered at Ellis Island in preventing indigent immigration, there is a grave menace confronting the health department of the city of New York. Reference has been made before in the Bulletin to the large number of cases of glaucoma which arrive, and which required at one time the capacity of a single hospital to detain all the cases appearing among immigrants and to prevent the dissemination of this communicable disease. The foreign emigration bureaus make it their business to instruct the emigrant what to do when preparing for inspection on this side of the water, and such emigrants as may be suffering from any inflammatory condition of the covering of the eye are supplied with a solution of adrenalin. This pharmaceutical product has the power of causing a constriction of the blood vessels, and its action is instantaneous. Immigrants having any suspicious redness of the eye disappear for a moment in the crowd or behind a screen, a few drops of the preparation is rubbed into the eyes and they are ready for inspection. This does not in any way cure the disease, but simply blanches the external covering of the eye. The immigrant is then free to go and, not being held

for hospital treatment is permitted to mingle in close contact in a crowded tenement-house with others, permitting the extension of the disease.

The government officials are alive to these attempts to run the gauntlet of inspection, but with all their efforts they feel that more stringent regulations should be established. Severe fines imposed upon the steamship companies who cater to this class of imposters would oblige them to demand more thorough inspection before accepting their passengers.

The Monthly Bulletin.

AFTER PARACENTESIS IN ACUTE OTITIS MEDIA.—After making sure that the drum is thus well opened, all discharge and blood clots are quickly removed with a clean cotton probe and the canal filled with carbolyzed glycerine 5 per cent., and not again interfered with for twelve to twenty-four hours, except to change as it becomes moist, the iodoform or borated gauze which is to be kept constantly in the outer end of the canal and pinna.

Although I was formerly in the habit of syringing the canal after paracentesis, several times daily with warm bichloride, soda or borated water, I have lately, I think, had better results unless the discharge is very profuse, from carefully wiping out the canal down to the membrane once daily and directing that in the interval there be instilled 6–8 drops of the warmed 5 per cent. carbolyzed glycerine every three to five hours.

When, however, the patient cannot be seen frequently by the physician, I believe the syringe should be used 1–4 times daily, depending upon the amount of discharge. In my hands the old piston syringe has been entirely displaced by the safer, cleaner soft rubber ball to be found in every pharmacy. Those of white or grey rubber should not be used on account of the powder of zinc and sulphur which comes from the surface.

Black or red rubber may be boiled safely without doing it harm.

To hasten the emptying of the discharge from the drum, gentle Valsalvian or Politzer inflation may be practiced *so long as the opening in the drum head is large*. If there be doubt as to this it is much better to dispense with such aid.

The greater my experience with these cases, the more I am inclined to the let alone plan of after treatment.

In certain cases of unruly children when each dressing has been attended by violent and exhausting struggles, I have abstained from further interference than the gentle wiping away of the discharge from the outer end of the canal and the instillation of the carbolized glycerine, and the result has been satisfactory.—*Dr. C. M. Thomas, in The Hahnemannian Monthly.*

PERSONAL AND GENERAL ITEMS.

DR. ALICE M. STEEVES has removed her office for dental work to 229 Berkeley Street, Boston.

By the will of the late George Hart the Melrose Hospital will receive \$5,000.

DRS. MARION E. HORTON and Elizabeth E. Shaw, B. U. S. M., 1905, are doing post-graduate work in Europe.

DR. W. I. PIERCE, whose residence is at 117 Pearl Street, Somerville, has opened an office at 417 Highland Avenue. Office hours, 2 to 4 and 6.30 to 8 P.M. Telephone connection.

DR. HENRY AMSDEN, B. U. S. M., 1896, has removed from Attleboro, Mass., to Concord, N. H., where he has taken the practice of Dr. Ezekial Morrill.

DR. ANNA T. LOVERING, 10a Park Square, Boston, will assist members of the profession and others, as in former years, in the preparation of books, or of papers for societies; research work, revision, proofreading, etc.

THE *Homœopathic World*, London, calls attention to renewed requests for homœopathic physicians for South Africa, and mentions a practice in Kimberly, the centre of the diamond fields, where a homœopath is wanted. The publishers of the *World* will furnish particulars.

THE Brockton Hospital is now possessed of more complete facilities by the opening of the new Douglas Surgical Pavilion, the gift of Governor William L. Douglas. The dedication exer-

cises took place Oct. 31, the Welcome H. Wales memorial ward, the gift of Mrs. Lois K. Wales in memory of her husband, being also dedicated the same afternoon.

A canvas of the retail, wholesale and manufacturing druggists in Mississippi and Louisiana indicates that 3,000,000,000 arsenic tablets were used by the people in those states during the six weeks when the yellow fever was at its height. This on the authority of the daily press, which adds that the craze was started by Dr. R. B. Leach of St. Paul, who claimed that arsenic tablets taken three times a day in one-tenth grain doses would prevent yellow fever. The medical society would have nothing to do with him, and his theory was not tested. But many people, impressed by his theory, swallowed his preventive.

CHANCELLOR E. B. ANDREWS of the Nebraska State University, in an address delivered to the delegates of the National Prison Congress at Lincoln, Neb., Oct. 25, said: "Obdurate murderers would immeasurably benefit the human race if their living bodies could be used for experimental purposes by scientists, biologists and physiologists." He advocated the adoption of this plan only in the case of criminals willing to undergo experimentation on the chance of recovery, and the assurance of subsequent remission of other penalties. The idea seems an excellent one.

AT Pawtucket, R. I., announcement was made Oct. 11 of the proposed erection and equipment of a large modern hospital as a gift to the city by Frank A. Sayles, the institution to be a memorial to his mother and sister. It is expected that work upon the construction of the hospital will commence next spring, and that it will be ready for occupation in about a year from that time. It is the intention of Mr. Sayles to present the hospital to the city at its completion.

DR. I. ROLAND BOOTHBY, B. U. S. M., 1905, and nephew of the late Dr. Alonzo Boothby, has located at Bangor, Me. Dr. Spencer D. Whiting, of the same class has located at Butte, Mont. The following members of the class received hospital appointments: Drs. Bernard H. Byam, Grace Hospital, New Haven, Conn., Eben C. Gould, Homœopathic Hospital, Melbourne, Australia, Ralph W. Hayman, Massachusetts Homœopathic Hospital, Walter A. Jillson, Trull Hospital, Biddeford, Me., Howard Moore, Massachusetts Homœopathic Hospital, E. Parker Sanborn, Grace Hospital, New Haven, Conn., Alonzo J. Shadman, Emerson Hospital, Forest Hills, and Henry Watters, Newton Hospital, Newton Lower Falls, Mass.

At the meeting of the International Sanitary Convention, held in Washington the middle of October, the forty-nine articles of the Paris Convention of Dec. 3, 1903, were accepted, with only a few modifications required by the conditions in tropical countries. These articles, which are now engrossed in Spanish and English, will secure for practically all of the American continent one system of quarantine and preventive measures. This is calculated to put an end to the evil of good work in one State being undone by the negligent methods in a neighboring State.

It was decided that the United States Pharmacopeia should be translated into Spanish, and that a first edition of 5,000 copies should be published.

Dr. L. O. Howard, the entomologist of the Department of Agriculture, who has made a special study of the yellow fever mosquito, read a paper on the spread of that insect in the United States and in some parts of Mexico. Since it has been generally agreed upon that yellow fever can be spread only by mosquitoes, it is of the greatest importance, he said, to know where these mosquitoes are found. In regard to the distance they are able to fly out on the sea (a question of great importance when determining how far ships under quarantine shall stay away from shore), he stated that it has been found possible for mosquitoes to move out as far as 500 feet. Special stress was laid upon the fact that when doing away with the breeding places of the yellow fever mosquito often not enough attention is paid to the most dangerous ones. Dr. Howard said that the yellow fever mosquito does not breed in large patches of open water, and that a broken bottle which contains a little water is by far more dangerous, and he asserted that the font which contains the holy water in churches is in many instances a breeding place and a grave cause of danger.

THE report of the President of the Board of Health of the territory of Hawaii for the six months ending June 30, 1905, has just come to hand, and in connection with it, it is interesting to note the remarks of the resident physician at the leper settlement, Dr. W. J. Goodhue, on the treatment of the lepers giving the best results:

“Strychnine arseniate in doses of 1-100 of a grain gradually pushed until physiological effects are observed and then gradually reduced to the minimum dose, has been a signal benefit in several cases under close observation, the remedy being well adapted to both the mixed and tubercular cases. In the latter class of cases I also give extract of thyroid gland as an eliminant and absorptive and to reduce the frequent edematous

infiltration of extremities, in which complications it is of marked value.

"Hoang Nan is of benefit in paralytic cases and as a general nerve tonic, and this remedy has some strong advocates in the settlement who are taking it regularly since the new year.

"A few patients whom I began to treat with a prescription composed of fluid extract of sarsaparilla, cascara sagrada and tincture of nux vomica over a year ago, have been so much improved in health that the number taking this preparation has increased since the beginning of the year to over fifty.

"Alterative and eliminant remedies, with the exceptions noted below, are strongly indicated in leprosy, and with tonic and nutritive compounds, good diet and hygiene, constitute a more rational treatment for leprosy than all the so-called specifics constantly being foisted upon an over-credulous public. Emulsions of cod liver oil with the hypophosphites, supplying at once nerve food and general nutritive qualities are invaluable in debilitated cases, frequently restoring bedridden patients to normal health and activity.

"Iodide of potassium and iodoform internally are contra-indicated in leprosy unless there is acquired or hereditary syphilis.

"Iodine, iodoform and derivatives, externally, are of value as in other diseases and conditions where their employment is indicated. Mercurial preparations seem to be of negative value, but not especially harmful, although salivation seems to be readily superinduced in the leper."

OUR much lamented confrère, the late Dr. William L. Jackson, left among his professional effects a nearly new, specially constructed Nauheim bath-tub, exactly like those used at Nauheim. This varies markedly in size and shape from the ordinary tub, and is especially adapted for giving the Nauheim baths. Mrs. Jackson would be glad to sell this tub to anyone interested in the Nauheim treatment and having use for it, together with a quantity of the residual salts from the natural Nauheim water used to reinforce the bath. Anyone wishing information concerning the above will please address Mrs. W. L. Jackson, 43 Highland Avenue, Newtonville, Mass.

Case of "Spotted Fever" with Complications.

The patient, Mr. P., was brought to Burns June 17. He had been employed about a sawmill and lumber yard in the pine timber twenty-five miles northeast of Burns, where the elevation is about 7,000 feet, and I at once suspected spotted fever, and inquired about tick bites, and he replied that he had been bitten many times recently. There was no eruption at that time but on the next day but one, to wit, the fourth day of the fever, it began to appear about the arms and hands and upon the breast. The eruption was characteristic and slowly spread all over the body, and appeared even in the conjunctivae; and wherever he had scratched himself it showed a tendency to run together and form bullae, scabs, and later purulent sores. About the middle joint of the little finger of the right hand there was a callous which he had paired off with his knife. About this there formed something like a blood blister, and later suppuration took place, and a considerable amount of pus, a drachm or more, was discharged. Upon recovery there was restriction of motion to some extent which still persists. The eyes were deeply injected, and late in the case there was irregular dilatation of the left pupil and a reddish zone about the cornea, as though there might have been a mild irido-cyclitis. The distortion of the left pupil seemed to be of a paralytic nature rather than the result of inflammation, as the pupil was irregularly elongated laterally rather than contracted in any diameter.

There were also several small punctate openings in the skin of the arms, without redness, that seemed to communicate with subcutaneous excavations filled with pus.

The temperature gradually rose until constant sponging was necessary to keep it down, and once or twice it reached 104.5 degrees.

At first the appetite was surprisingly good; but about the sixteenth day of the fever, although the temperature had fallen to about 101 degrees, and he required very little sponging, his appetite failed, and he began to complain of sore throat. On examination there appeared upon the palate, the same as upon the skin, the eruption of spotted fever, and as my experience with the eruption upon the skin had taught me the uselessness of local treatment other than cold sponging, I only prescribed a mouthwash and occasionally touched up the throat with peroxide of hydrogen, and finally did not look at it for about a day. On the following morning his wife discovered something that alarmed her, and sent for me. On looking into his throat I saw a grayish gangrenous patch about the size of the end of a lead

Continued on last page.

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ORIGINAL COMMUNICATIONS.

PROCIDENTIA RECTI WITH RADICAL OPERATIONS FOR RELIEF.

BY FREDERICK W. HALSEY, M.D., BOSTON, MASS.

[Read before the Massachusetts [Homœopathic Medical Society.]

Prolapse and procidentia, both from the Latin and signifying a falling down, being synonymous terms, hardly allow of the differentiation some authors have attempted to make. Allingham, for instance, confines prolapse to a falling or protrusion of a one-sided or limited portion of the circumference of the bowel, confining true procidentia to a protrusion of the entire circumference of the gut. There are, however, three distinct degrees noticed: The first, where the prolapse begins at the margin of the anus and is continuous with the skin surrounding the sphincter ani; the second, where the prolapse begins an inch or two above the anus, and descends through the portion of anal bowel which remains *in situ*, protruding through the anus; the third, where the prolapse begins higher up, sometimes from the region of the sigmoid, extends down into the rectum, but does not protrude from the anus. These different varieties all occur, and are easy to demonstrate. The first form is seen more commonly than the others.

It is not my intention to go into the causes that lead up to this condition, causes with which you are already quite familiar, nor shall I discuss those mild cases particularly seen in children

which are susceptible of conservative treatment, or a cure by the indicated remedy. The surgical treatment of procidentia has not been attended with the most satisfactory results in the past, and it is owing to this fact that the presentation of a method somewhat new may prove of interest and provoke profitable discussion. In the more simple forms of this disease where the protrusion occurs only on one side, or where the entire circumference of the anal margin is not involved, the relief by operation is not so difficult and is usually attended with success. Particularly is this true if the prolapse is complicated with hemorrhoids, and mainly due to their existence. When this is found to be the case, the usual operations done for the removal of the hemorrhoids will generally suffice. Where, however, the entire circumference of the bowel is involved, and the procidentia has existed for some time, and particularly when it has reached the size of a hen's egg or larger, the protrusion being persistent, the cure becomes more difficult. Many operations have been devised and used for its relief, one of the most common being a narrowing of the anal outlet by excising V-shaped or elliptical portions of the mucous membrane and cellular tissue, cutting into the sphincter muscle itself, removing a portion of the same. The relief given from this operation has been very transitory, the sphincter and surrounding tissues soon stretching out as before, and allowing the relaxed bowel from above to press out.

Another method recommended by Allingham, consists of a cauterization of the entire extruded mass, with fuming nitric acid, the idea being to set up an inflammation of the submucosa, thereby shortening the fibrous connection between it and the muscular coat of the bowel, and hence drawing the whole bowel up. Another, and more elaborate method advocated by Van Buren, consists in burning concentric rings around the bowel, from one-quarter to one-half of an inch apart, down to the muscular coat of the bowel but not through it. From two to five rings are thus burned, using the thermo-cautery for the purpose. The gut is now oiled and returned

to the rectum. Two deep burns are now made on each *side* of the anal margin, well into the sphincter muscle rather than antero posterior. When healing is complete, the bowel is supposed to be shortened by the contraction that takes place during the healing process, and the anal outlet is narrowed from side to side by the healing in this direction due to the deep cauterization of the muscle, thus offering better support to the relaxed bowel. This operation either in my own or the hands of others, has not met with the flattering success which its originator seemed to think possible. It seems more than probable that the reason for failure in both of these methods mentioned, may be due to a faulty working out of the anatomical principles involved. In the large majority of cases, when prolapse takes place, it is not due to a separation of the mucous from the sub-mucous coats, or indeed a separation of any of the various coats of the bowel from each other, but rather a slipping down of the entire gut, frequently I might say generally, dragging down the peritoneum with which it is covered higher up.

The rectum, as we know, equally with the bowel above, consists of four coats counting from within out, mucous, sub-mucous, muscular, and serous. The peritoneum invests the bowel from above downward, being deflected forward, and passing over the bladder a few inches above the anal outlet. The point at which this deflection occurs has been conceded by the best anatomists to be about two and three quarter inches anteriorly, and three and one half inches posteriorly. Were it not for this peritoneal covering, and the fact of its close adhesion to the bowel in most severe cases of prolapse, a complete amputation would be the simplest and most effectual treatment. As it is, however, if the prolapse is at all extensive, should we amputate, the peritoneal cavity would be entered by our high incision, and a perfect closure is by no means sure or easy, a fatal result being invited by a failure. If this close attachment of the peritoneal coat of the bowel, was not sufficient to disprove the theory of the separation of

the varied coats of the bowel from each other, resulting in prolapse, the failure to give relief by both these operations based on this theory, would add great strength to the argument. In no other way could we account for the good results obtained from the conservative operation for prolapse by deep injection into the tissues of irritating fluids, like carbolic acid, particularly when the prolapse is one-sided, and complicated with hemorrhoids.

The operation which I wish to bring to your notice this morning, was first done by Dr. George W. Fowler, of New York. It has been practiced since by other surgeons successfully; I have had several cases in my own practice, and the result has been very satisfactory. The operation has been called rectopexy, or suspension, or more properly speaking, fixation of the rectum on the sacrum. In principle, it is similar to ventral fixation of the uterus. It appealed to me as a surgical procedure mechanically correct, and I believe it will to you. The patient being well prepared the night before operation by a thorough purge, followed by a copious enema, the parts are thoroughly scrubbed, shaved, and an antiseptic dressing applied and allowed to remain over night. The patient under an anesthetic, is placed on the left side, the hips being raised by a pad; the bowel, if not already out, is drawn down by an assistant and held out. A curved incision from above downward, about two and one half inches in length is made between the coccyx and anus; this incision is carried down to the bowel properly by careful dissection, the bowel is now stripped from its attachments below the incision if there are any, and from above under the sacrum and coccyx as high as the meso-rectum, and on the sides as far as the lateral ligaments, this separation can be effected by a blunt dissector, or better by the finger of the surgeon. The assistant now pushes the prolapsed bowel back through the anus, and forces it out through the incision newly made. The protruding bowel is now curetted lightly, four running sutures are now taken through and well into the muscular coat of the bowel, but not

intending to penetrate the mucous coat, the sutures are placed at equal distance from each other, silk worm gut being the material used, and the full length of the gut is left after they are in position. It has been recommended at this step or before, that the under surface of the sacrum and coccyx be curetted. With the manipulation necessary to separate the bowel from its connections at this point this would seem superfluous, but it can do no harm. One of the upper sutures is now threaded with a Peasly needle and is carried through the incision under the sacrum to the upper point of the separation of the bowel and brought through just outside of the sacrum. The suture on the opposite side is treated in the same way. The second row of sutures are passed in a similar manner, being brought through about half an inch lower down. This is continued until all the sutures have been placed. The bowel is now returned to the rectum and pushed up in its new position by the assistant, the operator drawing the sutures all taut and tying them over a good sized piece of gauze, thereby relieving the skin from too much tension. All oozing is stopped, and the incision is closed first with buried cat gut and then with superficial sutures. If the prolapse has existed for some time and the sphincter muscle has become stretched and weakened, and particularly in aged persons, an attempt is made to tone up and stimulate this muscle. For this purpose a needle threaded with good sized cat gut No. 4 or 5 is passed deeply into the muscle, and a suture taken not over a quarter of an inch long, the needle being returned to the muscle; by this procedure a running stitch is woven into the muscle entirely encircling the anus. This is now drawn fairly taut, and tied over the finger of the assistant introduced into the anus. While no cutting has been done at the anal margin, no mucous membrane having been removed, there is no question but that the procedure is followed by good results. In one of my cases, an old lady over 70 years of age, the prolapse had so weakened and destroyed the tone of the sphincter that under ether the bowel having been returned to its nor-

mal position, without speculum or any dilatation the parts presented the appearance of a yawning cavern, a view of the upper curve of the rectum being possible.

It can be seen at a glance that this operation, admirable as it may be, will not apply to the form of procidentia already spoken of as the third form where the bowel drops down from above but does not show outside of the anus, or yet in cases where the prolapse comes from the sigmoid flexure or region thereof pushing its way down and out of the anus. Here nothing but a laparotomy will suffice. The mesenteric attachment of the bowel must be drawn up and stitched to the abdominal wall.

CARE OF THE EAR BY THE GENERAL PRACTITIONER.

E. R. JOHNSON, M.D., BOSTON, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

This paper is not intended as any dictation to the general practitioner as to the limits of his work or even the manner in which he shall do it in this particular line, except by suggestions which I trust will be found of interest and value.

The writer, after ten years of general practice, the greater part of which period has been spent in special work upon the ear, nose and throat, has had ample opportunity of seeing the unhappy effects of expectant or careless treatment of the diseases of the ear.

The condition of the organs of hearing determines very largely the career of the individual. Defective hearing places an indestructable barrier in the way of the individual, whether he be the ambitious youth or the bread winner in the very prime of life. Socially he is disfigured and lost sight of; practically he is hampered in every pursuit of life. Surely then, everything that can be done to conserve so important a sense as that of hearing must be done. Who of us would so

neglect a little patient, who in after years must be so handicapped and so unhappy?

The care of the ear many times begins with the care of the new-born babe. The vast majority of ear affections leading to more or less deafness in after years begins in childhood.

Reflected light is absolutely indispensable for a thorough examination of the ear. The head band and mirror are as valuable as the stethoscope for diagnostic use, and I believe it a far more valuable aid than the extent of its general use would indicate.

In the hidden fevers of infancy it becomes of especial value when it is so difficult to establish an early diagnosis, in fact, when the diagnosis is only made after two or three days waiting when the ear has begun to discharge. With a simple kitchen lamp or the light from a north window, we can, with the aid of the mirror and an ear speculum perfectly well watch the oncoming storm of an otitis media which if left to itself, will wreck the organs of hearing.

First then, familiarity with the head band and mirror, which with a little effort anyone can acquire, is the first important step towards intelligent care of the ear. Various ear specula are to be found on the market, but the set of Gruber's specula is the best. Drawing the ear upward and backward a little, in order to straighten the canal, one can see its entire length, unless such view is impeded by a tortuous canal, or by a foreign body or new growth. Such an examination will reveal the whole extent of the canal, whether there is any cerumen, or to what extent the canal is filled with cerumen, if at all. It will also reveal the appearance of the membrana tympani. Whether it is normal in color, position, and general appearance, or whether it is congested and generally inflamed, or whether there is a perforation with discharge, and the character of the discharge, if any. All these things are very necessary to the proper care of the ear, and yet are only possible to ascertain by the use of the head band and mirror.

An abscess of the auditory canal, which may be mistaken

for middle ear inflammation, will be readily outlined with a good light and mirror, and treated as an abscess in any other part of the body, namely, opened as early as it properly should be.

Cerumen is most easily removed when in small quantity by a ring curette, devoid of any sharp edge. But if, as frequently occurs, the wax has been years accumulating, it is better to soften it with a few drops like

R Ac. Carbolic

Soda Bicarb. One-sixth grain each.

Glycerine.

Aquae. One-fourth drachm each.

Ten to twenty drops of this put in the ear each night while the patient lies on the opposite side for one-half to one hour, will so soften the wax that at the end of a week it may easily be removed by syringing with tepid water. The entire lumen of the auditory canal should never be closed with the tip of the syringe, lest too great pressure be exerted against the delicate mechanism of the middle and internal ear. At least one-half of the lumen should be open for the outflow of the cerumen and water. Unless some care is taken this is a very easy error to make. Careful inspection should follow the syringing in order to be sure that all wax has been removed. The writer has frequently spent one hour with a patient who has come some distance, only to be obliged to prescribe the drops mentioned, and ask the patient to return one week later, not daring to work longer on the ear. I mention this only to show how difficult it is many times to remove all of the wax after it has been many years in forming and clogging into a horn-like mass. The auditory canal should always be wiped dry with a little cotton wound on a cotton carrier, and a little pledget of cotton be left in the ear to be removed by the patient that night before retiring.

Acute inflammation of the middle ear is always indicated by characteristic symptoms. One symptom that should always

make us suspicious and should always be followed by careful attention, is pain. Too often the bounds of safety have long been past, while parent and physician are each trying to assure the other "that it is only an earache," and all children have earaches.

Otalgia that is not dependent upon acute catarrhal inflammation is extremely rare both in children and adults. The head band and mirror, and specula, with good light will tell the whole story. If acute inflammation of the middle ear has started up the membrana tympani will appear congested and inflamed, or even bulging with serum, and a little later with pus. If only congested there may be yet time to save the patient from perforation of the drum membrane and consequent dangers. The first important step in the care of such a patient is to place him at complete rest, equalize the circulation, produce free action of the bowels and prescribe the indicated remedy. If the pain increases, and the pulse and temperature increase with no abatement beyond thirty-six hours we may be sure that perforation will occur. If accustomed to the use of the head band and mirror, one can render much aid at the proper time, by making an incision in the membrane, relieving the pressure, and releasing the pent up serum or pus. This should be done under strict surgical cleanliness. The incision should be made about three-sixths of an inch in length in the postero-inferior quadrant, or at any bulging point. This should not be done early, for the antiphlogistic effect, but should be done when by a careful examination, we find rupture of the membrane imminent. It should be done lest by too great delay the inflammatory products would be forced through the auditus to the mastoid cells, with all the consequent danger to life and suffering that such an unfortunate accident would entail.

One of the most important periods in the care of the ear, is the period immediately following the perforation of the ear drum, with discharge, first of serum and later of pus. Cleanliness is the keynote. The assistance of the nurse or parent,

properly instructed, is necessary. The cleansing is best accomplished by wiping the canal perfectly dry twice daily, and putting fresh cotton in the auditory canal frequently, to soak up the discharge. If the discharge is thick and difficult to remove in this manner, syringe with warm sterile water and wipe dry after syringing. Parents and nurses should be instructed how to wind a bit of cotton on a toothpick in such a manner that the cotton extends over the end of the toothpick at least one-half inch, thus avoiding any possible contact of a hard point against the membrana tympani.

After the ear has discharged four or five days, the amount of discharge will begin to be less, and then the dry treatment should be started, *i.e.*, no syringing. An effort should be made to empty the middle ear daily. This is best accomplished by the use of a Siegle's autoscope or by placing one end of a soft rubber tubing, small enough to engage, into the outer part of the auditory canal, and by suction draw out through the perforation or incision as much of the pus as possible, then this should be carefully wiped away with cotton. This process should be carefully and constantly repeated once or twice daily until there is no discharge. If this method is pursued, the course of the disease will be shortened to a period of from a few days to two or three weeks, when the discharge will have stopped, and in due time the perforation will close. A pledget of cotton should always be kept in the auditory canal until the perforation has closed.

I will not mention the longer list of remedies that are of inestimable value in the care of the acute inflammations of the middle ear, or detail the symptoms calling for them, but the following remedies have proven their worth in my hands: Aconite, belladonna, capsicum, hepar sulphur, hydrastis, mercurius cor., kali bichrom, kali muriate, etc.

What can we do for the chronic otitis media, the case that comes to us after months or years of discharge from the ear? Again the reply, cleanliness, surgical cleanliness. But this is not easy, and only possible under close inspection with the

head band and mirror and speculum. The ear should be syringed and wiped dry. Upon examination, we may find a polypus or general necrosis, or a large perforation, with part of the malleus destroyed, etc., etc. A treatment which should be carried out at home, but under the frequent observation of the family physician, might well be outlined as follows:

Put twenty drops of dioxogen in the ear, and after leaving it there five minutes syringe with warm sterile water, to be followed by careful drying with cotton and powdered with aristol or calendulated boracic acid, or, if there is much fetor, the following formulae may prove of greater value:

R Acidi Borac. Calendulae. One-fourth drachm.
Acidi Carbolici. 10 grains. M.

Sig. Use as dusting powder in the ear.

or

R Acidi Boracic. Three drachms.
Iodoform. One drachm. M.

Sig. Insufflate in the ear.

Corrosive sublimate one grain, to water, one-fourth ounce, or 1-2000 placed in the ear in a similar manner to be followed by syringing, drying and powdering, as above outlined, will frequently prove of more value than the dioxogen. All of this treatment should be done under close observation in order to get the best results.

Necrosis of the bone may keep up a discharge for a long time. This many times will yield to a few applications of the following:

R Water heated to 115 degrees. One ounce.
Glycerinum Pepticum (Fairchild's.) One drachm.
Hydrochloric Acid dilute. Sixteen minims.

Sig. Put twenty drops in the ear after syringing and drying, to be left for one-half hour, to be followed by syringing and drying and powdering, as above outlined.

This digests the necrotic tissue, destroying the source of con-

stant infection, and many times proves successful where other methods fail.

If the discharge and odor do not yield to this treatment in a reasonable length of time, we may be sure the necrosis covers too large an area, or is not reached by this antiseptic treatment, and requires more vigorous treatment, *i.e.*, curetting away and removing all diseased bone. But the discussion of such an operation, and other operations which follow chronic discharge from the ear, cannot be considered within the scope of this paper. Where careful treatment accomplishes nothing, and the more radical measures become necessary, we should not fail to inform our patients of the dangers of neglecting such efforts, for by so doing infection may readily reach the meninges through the tegmen tympani, or floor of the middle fossa, which separates the attic from the brain structures by a mere wafer of bone, or mastoiditis may develop gradually with all the possibilities which follow such a condition.

Catarrhal conditions of the nose and naso-pharynx are unquestionably responsible for most of the affections of the middle ear. The care of the nose and naso-pharynx has been outlined to-night in another paper, but I want to emphasize the important duty of every physician who has the welfare of his patients at heart, to study these conditions, knowing that any catarrhal condition of either the nose or naso-pharynx is bound to lead to the ears sooner or later, and that such conditions can be prevented by judicious care.

A spur or ridge, or irregular septum, or congested and hypertrophied turbinals with contact points, are acknowledged to be the usual irritants which cause and continue catarrhal conditions of the nose.

Adenoids are the most frequent cause of catarrhal conditions of the naso-pharynx, and therefore of the ear in childhood. But these conditions cannot be seen and recognized without the use of the head band and mirror. When recognized, these prolific causes of diseases of the ear should be removed before deafness, tinnitus, pain and discharge from the

ear drives the patient to our care, too often all too late to derive any benefit from any treatment.

Normally the act of swallowing should open the eustachian tubes, or with closed mouth and closed nostrils, swallowing should surely open them. If not, we have an unequal air pressure. Upon the outside of the drum there is a pressure of fifteen pounds to the square inch, and no pressure on the inside. Such a condition if properly cared for early, will save much trouble for the patient in after years. This condition can be remedied by using the Politzer bag and caring for the general condition of the nose and naso-pharynx.

Patients should be warned against putting hot oil, the core of an onion, flaxseed poultice, etc., etc., in the auditory canal, which only serve to obstruct the outflow of discharge, and also add another possible source of infection. Gentle syringing with warm sterile water will do all that these measures can do. Patients should be instructed not to dig out their ears with all sorts of household implements, but to go to their family physician, who will probably examine the ear, and syringe it clear of wax if it needs it. They should also be properly and carefully instructed how to use a nasal douche if they use a nasal douche. They should be instructed not to "blow out the ears" by holding the nostrils, and blowing into the nose. Children should be instructed how to blow the nose.

Everything that tends to better the general health of the patient, as proper food, sufficient sleep, and in well ventilated sleeping rooms, regular exercise, preferably out of doors, the morning cold sponge, followed with friction of the body, proper clothing, in fact, normal and intelligent habits of life will do much toward preventing catarrhal conditions of the nose and throat, and therefore also of the ears.

SUMMARY.

In the care of the ear in general practice

1. Neglect to observe accurately and continuously care for the ear affections leads to loss of hearing in after life.

2. The head band and mirror, with good light, and speculum are indispensable to the intelligent care of the ear.

3. Foreign bodies and cerumen are best removed by syringing.

4. The auditory canal should always be dried after syringing and cotton kept in the ear as long as a perforation exists.

5. Paracentesis should not be performed for its antiphlogistic effect, but should be done for safety long before rupture can occur.

6. Cleanliness is the keynote to the care of suppurative diseases of the middle ear.

7. Most catarrhal conditions of the middle ear are caused by a similar condition in the nose and naso-pharynx.

8. It is the imperative duty of every physician to equip himself and to instruct his patients in such manner as best to conserve so important a sense as that of hearing.

VARIATIONS IN THE SYMPTOMS OF APPENDICITIS.

BY CHARLES T. HOWARD, M.D., BOSTON, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

Since the recognition of appendicitis as a distinct disease, four symptoms have been regarded as cardinal, and upon the presence of these symptoms in their proper sequence, has depended the diagnosis and determination of the necessity of operation. These classic symptoms, as found in a typical case of appendicitis, are as follows:

First: Pain, beginning about the navel and locating over the appendix.

Second: Nausea and vomiting.

Third: Tenderness over the appendix.

Fourth: Rise in temperature and pulse.

With these cardinal symptoms, splinting of the right rectus muscle, constipation, accumulation of gas in the intestines, and cutaneous hyperesthesia are often associated.

Now, if all of these symptoms were always present, and in the same orderly sequence, the diagnosis of appendicitis would be child's play, and the merest tyro would never make a mistake. Insomuch, however, as nearly all the acute abdominal troubles demanding operation run a nearly parallel course in the early hours, the diagnosis is oftentimes most difficult when most necessary.

When we come to analyze these symptoms, too, we find so much variation that should we early form our diagnosis upon any one or two symptoms, we should often make mistakes and live in a state of chronic remorse for our blunders.

With an inflamed appendix, pain is nearly always present, but its severity is no criterion of the severity of the attack, and its character and location are very variable. In a typical attack it is colicky and intermittent in character beginning about the umbilicus and after a few hours locating itself over the appendix. If the appendix is abnormally located, as is not infrequently the case, the pain may be high up in the hypochondrium, low down in the right inguinal region, or even to the left of the median line. The pain usually continues with a varying degree of severity until subsidence of the inflammation, or until rupture takes place. With the rupture an almost complete remission of the pain occurs for a few hours, to begin again with increased severity.

Nausea and vomiting usually begins soon after the onset of the pain, and is present in a majority of the acute cases. It varies very widely, however, in its persistence, and, it is its persistence, I believe, which is of importance in the determination of the severity of the attack. In the ordinarily mild catarrhal cases, vomiting usually continues only until the stomach is empty, in more severe obstructive cases it is liable to continue until subsidence of the attack, and in those associated with peritonitis, until operation. This, in my experience, is not a safe rule to be guided by, for occasionally comes a case with rupture of the appendix and peritonitis which gives a history of little or no vomiting throughout the

attack. So that it is only in combination with other symptoms that vomiting is of value. When, however, we do get persistent vomiting, a bad appendix may usually be looked for. Tenderness over the appendix is, I believe, the most reliable symptom of appendicitis. Almost invariably does tenderness at this point, even in the absence of all other symptoms, mean appendicitis, and almost invariably when the other symptoms point to appendicitis can a tender point be found. Not always at McBurney's point, not always by external palpation, for when the appendix is over the brim of the pelvis, it is often only a rectal or vaginal examination that will reveal the tender point.

Elevation of temperature and pulse at some time during an attack, are, I believe, pretty constant symptoms, notwithstanding the fact that a surprisingly large number of serious cases are admitted to the hospital with normal temperature and pulse. But, where we are able to get the history from the physician, we usually find that there has been some fever, oft-times low, but high enough to suggest an inflammatory condition. With an acutely inflamed appendix, without peritonitis, the temperature is almost always elevated; where, however, there is an intense general peritonitis, or a gangrenous appendix, or a circumscribed abscess of a few days standing, the temperature may be normal or subnormal, and the pulse accelerated.

Splinting of the right rectus muscle is usually present over an acutely inflamed appendix or where the peritoneum is involved, and not infrequently absent in the gangrenous cases.

Hyperesthesia of the skin over the appendix, which has been made much of by some men, to my mind is of little importance, occurring in a few cases and absent in many.

In order to draw definite conclusions as to the constancy of the four cardinal symptoms, I have, since beginning to write this paper, closely questioned all the available cases of appendicitis. I have preferred not to go back and look up records

because I felt that under those circumstances the exact condition of the appendix at time of operation would be uncertain. Of the cases quoted, however, I have operated upon seven, assisted at two, and know definitely about the other one, so that I have obtained definite histories, and know definitely the conditions found.

Case 1. Mr. O. H. Taken sick three days previous to admission, with severe pain in the chest. The same evening pain began in the epigastrium, the pain in the chest, however, continuing. The patient then began to vomit and vomited three times in quick succession, after which nausea ceased, and did not return. The next day he felt much better and wanted to get out of bed. Some soreness present in the abdomen, but worse on the left side. Temperature, 99°; pulse, 80.

The next morning the temperature rose to 101°, the pulse to 90, and the tenderness became localized in the right side. No abdominal splinting, and the tenderness only slight. Operated upon, and an appendix gangrenous for its entire length removed. By gangrenous here, I mean, absolutely rotten, dull gray in color and coming away in pieces. Drainage.

Case 2. Mr. W. Taken suddenly with pain about the umbilicus, three days previous to admission. The next morning he felt much better, and continued to feel much better throughout the day. At night was again seized with pain, this time in the right side. The next day the pain was extreme and the patient vomited once. Aside from this once he felt no nausea whatever. Temperature and pulse elevated.

Examination previous to operation revealed practically no tenderness anywhere in the abdomen. No muscular splinting. Temperature, 103°; pulse, 98. The operation disclosed an unusually large, acutely inflamed appendix, firmly bound down by adhesions and containing a calculus, such an appendix as might have ruptured in another twenty-four or forty-eight hours. The tenderness in this case was probably not manifest by external palpation because it was located low down over the pelvic brim.

Case 3. Miss T. Admitted to the hospital six days after the beginning of her illness. Had had previous attacks. Present attack began with pain about umbilicus, accompanied after the first two hours with nausea and vomiting very severe in character, and which continued until operation. Tenderness over the appendix from the first. The pain continued about the navel, and did not go down into the right side at any time. Had fever throughout the attack, at time of operation, reaching 102° , and pulse 120. Appendix found ruptured, general peritonitis and bowels very dark, seeming almost gangrenous. Gauze drainage throughout the abdomen.

Case 4. Mrs. O'M. Taken ill three days previous to admission with pain in right side over the appendix, hard and colicky in character. The next day it almost entirely ceased and began again that night, when she vomited for the first time and continued vomiting until operation. When admitted, there was marked tenderness over the appendix and splinting of the muscle. Temperature, 100° ; pulse, 84. The appendix was found highly inflamed, containing a calculus and surrounded by adhesions.

Case 5. Mr. B. Sick two days before operation with colicky pains about the navel which went down into the right side two or three hours later. Retched three times and then nausea entirely ceased. Tenderness over the appendix early. Temperature elevated throughout the attack. Bowels loose.

Case 6. Miss E., aged twenty-nine. Last December had slight attack. In June had attack keeping her in bed three days. In August had attack lasting two days. With all the attacks she vomited and was very tender over the appendix. Three weeks previous to operation she was taken with cramps all over the bowels. Extreme nausea, but could not vomit. The pain remained general, and she was tender to the touch over the greater part of the abdomen. Bowels very constipated. The operation showed an appendix which, although not markedly inflamed, was bound down close to the cecum

so that it was necessary to cut through the peritoneum and dig it out, and very much enlarged. It was distended to the size of one's little finger, with purulent fluid, and entirely obliterated at its base. Temperature, 98.8°; pulse, 84.

Case 7. Mr. S., aged sixty-five. Taken sick Saturday night, Sept. 30. Only slight discomfort, rather than real pain about the navel. Sunday it located over the appendix, but was still very slight. No nausea or vomiting whatever. Very marked tenderness over appendix. Splinting of muscle. Temperature, 100°; pulse, 100. Bowels loose. Operation Sunday night, twenty-four hours after the initial symptoms, showed an appendix surrounded by protective adhesions. The appendix very much thickened and inflamed, and covered on its peritoneal surface with membranous exudate.

Case 8. S. M., aged thirteen. Taken ill with the mumps July 8. The onset being accompanied with severe vomiting. Temperature, 101°; pulse, 100. July 9, much better and vomiting ceased. July 10, began to vomit again and continued vomiting at intervals. July 11, had some pain in the bowels when moving. Tenderness over the left ovarian region. Temperature, 101°; pulse, 100. July 12, tenderness over the right side low down which became more general as the day advanced. July 13, when I saw her first, she had a severe diarrhea, the movements coming about every twenty minutes. Vomiting frequent. Tenderness of the whole abdomen. Distension of the abdomen and marked splinting of the muscles. Operation the same day revealed a ruptured appendix, with general peritonitis.

Case 9. H. D., aged fifteen. Taken sick two days previous to admission. Woke up in the night and was conscious of pain in the right side. Had none whatever in the epigastrium. Tenderness over the appendix. Had no nausea or vomiting at any time. Examination showed marked tenderness over the appendix. Splinting of the right rectus muscle, and a large bunch in the right side. Temperature, 101.3°; pulse, 112. Operation revealed a ruptured appendix, a large abscess cavity well walled off.

Case 10. Mr. S., aged twenty-two. Had been sick one week previous to admission, with considerable pain about the navel. Did not notice it in the right side at all. Had absolutely no nausea or vomiting. Very constipated, not having had a movement for a week. Examination showed a very slight soreness over the appendix. A decided bunch, however, could be felt. Temperature, 98.3-5°; pulse, 98. Operation revealed a ruptured appendix, and a very small abscess. The appendix was so firmly incorporated in adhesions as to make it very difficult to differentiate, and very laborious to enucleate.

In order to gain some idea as to the constancy of the cardinal symptoms, I have tabulated them with the following results.

Pain beginning about the navel and localizing in the right side, 4.

Pain beginning about navel or in epigastrium and remaining there, 4.

Pain beginning over the appendix, 2.

Nausea and vomiting pronounced, 3.

Slight, 4.

None at all, 3.

Tenderness over the appendix, 9.

No tenderness over the appendix, 1.

Fever at some time during attack, 8.

No fever at time of operation, 2.

From this table it can be seen that the pain does not follow the classical course in sixty per cent. That nausea and vomiting is present in only seventy per cent. of the cases. That tenderness over the appendix is present in ninety per cent., and that fever is present in eighty per cent.

Of course, as small a number of cases as is here presented does not form a reliable basis for drawing accurate conclusions, but I do feel that they must be pretty close to the truth, for these cases were taken absolutely at random, simply taking care to select the cases for report where operation had revealed very much diseased appendices.

PROSTITUTION AND VENEREAL DISEASES.

BY A. HOWARD POWERS, M.D., BOSTON, MASS.

[Read before the Massachusetts Homœopathic Medical Society.]

Prostitution is impossible without the prostitute. In the popular mind there seems at times to be a certain cloudiness or confusion as to the exact meaning of the term; hence a word of definition is wise in commencing.

A prostitute is one who practices promiscuous sexual intercourse for hire. Thus a prostitute differs from those who from depravity or passion, appetite or desire, yield themselves to unlawful intercourse.

In regard to gonorrhœa it may be said to be universally accepted that sexual congress is the only method by which this contagion is extended. Of course, there are children, and a few adults, who acquire the disease from mediate contact, but these exceptions prove the rule, and this disease is scattered broadcast by unlawful cohabitation. In other words this disease would almost, or quite cease to exist if all men lived pure, virtuous lives. I do not forget the wives and husbands who are innocently infected, but if they remain innocent the infection stops with them, or at most is returned to the unfaithful partner from which it was derived, and after a time would cease to infect either party.

When we consider syphilis, however, we find a much different condition, and the numbers of extragenital initial lesions and the myriad chances for such infection show at once the possible innocency with this disease. Authorities differ as to the percentages of extragenital lesions but these, together with the wives and husbands innocently infected, make the sufferers from syphilis insontium a mighty host. Still, I think we may agree, that were illicit intercourse completely stopped this disease would probably cease to exist in the course of years. Thus I believe we are agreed that these venereal diseases would disappear were it not for the fact and practice of unlawful sexual intercourse.

When we come to estimate the influence of the prostitute, in extending these diseases, it is my belief that the popular conception is far from correct, and the belief that prostitutes are almost the sole causers of this disease is based on insufficient evidence. I am not here to defend the prostitute, but twenty and more years of experience in the practice of medicine has led me to believe that, as a rule, they are so well informed as to these diseases that it is relatively infrequent that they carry these infections. The female prostitute is not more passionate than her more virtuous sisters, and the reason for her life is that she finds it more agreeable to her to make her living in that way than any other. She is fond of dress and the attention of men, and to gratify these desires she, for money, follows her mode of life. As a result of her mercenary character she learns early that she must be and remain free from these diseases if she is to ply her trade successfully. She uses much care to prevent infection, and in the coterie of her class much useful knowledge is passed from one to another.

Thus some infection is prevented which is none the less all too common. From my personal observation I could almost count on the fingers of my hands the cases of gonorrhoea which came directly from prostitutes, while large numbers give a history of a single illicit intercourse. Again and again comes the story of a supposedly safe excursion outside the lawful domain, with a long period of woe and suffering as a result.

The long period in which a syphilitic may carry the virus to another makes any such person a source of great danger, but the number of men and women who have the disease for months and years without knowledge of their condition, accounts for much of the prevalence of syphilis in our midst. The source of syphilis in a given case is harder to trace than in gonorrhoea, since the longer and possibly much prolonged period of incubation. However, it is my belief that here, as in gonorrhoea, the prostitute does not cause the larger per cent. of infection. I know that this idea is not in accord with

the popular belief, but it is because I think this popular belief wrong that I have raised the question. I would not say that the prostitute was less dangerous than the public as a whole believe her to be, but I would say that the illicit intercourse which so often occurs is a means of extending these diseases, of the dangers of which the public has no adequate knowledge.

What then is our duty as a company of professional men? It is to educate the public in this and many other respects, and in that way help to prevent the all too many from becoming the awful wrecks which we can hardly save from complete disaster. I am aware that I have inadequately touched on one point of the vast topic of prevention of these diseases, a topic too large to introduce at this time, but if discussion and exchange of ideas at this time shall help us to better work in this direction the object for which this paper was written will have been attained.

USTILAGO IN MENORRHAGIA.—A long continued menorrhagia in a young lady of twenty-five years of age, a tall brunette, resisted all remedies that had any apparent bearing on the case. The discharge was dark, grumous and passive in its nature; no pain; a complete apathy of the uterus. Ustilago crude, one grain tablet every two hours cured the case.—*Medical Visitor*.

HAHNEMANN'S CHARACTER.—When any great revolution or crisis comes about in the providence of God, and for the revelation of truth to mankind, the man suited for the work is always raised up. To accomplish this revolution in medicine, to preach what is tantamount to a revelation of God's law for the true treatment of disease affecting the creatures that are made in His likeness, a man of genius, of learning, of unique observing powers, of logical acumen, of indomitable energy and determination, and of the noblest character was required for the occasion, and such a man was Samuel Hahnemann.—*Medical Times*, (London.)

 EDITORIAL.

Books, exchanges and contributions—the latter to be contributed to the GAZETTE only, and preferably to be typewritten—should be sent to the Gazette Associates, 279 Dartmouth Street, Boston; personal and other news items to Dr. A. T. Lovering, 10A Park Square, Boston; subscriptions and all communications relating to advertising, etc., to the business manager, Dr. W. K. Knowles, 40 Mt. Pleasant Ave., Roxbury, Mass.

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 BOSTON UNIVERSITY SCHOOL OF MEDICINE.

It is surely a matter for congratulation by the homœopathic physicians of New England that the students entering Boston University School of Medicine this year so far outnumber those graduating, and, furthermore, that the quality of the new material, so to speak, is so excellent.

Of all our institutions the medical school is perhaps the most important as conducing to the support and perpetuation of homœopathy, and this fact, if no other, should secure for it our most cordial support; but aside from this the intrinsic merits of the school are such as to commend it to all thinking men and women seeking a thorough medical training.

Its government by an Executive Committee consisting of seven members of the faculty constantly on the alert to learn and adopt every advantageous educational method, assures a liberal and progressive policy; while its laboratory, hospital and dispensary resources make it possible to offer to its comparatively limited number of students *clinical advantages superior to those to be found in any similar institution.*

This school in the thirty-two years of its existence has made a remarkable record of accomplishment.

It has at the present time, owing to it gratitude and fealty, nearly a thousand alumni—in actual numbers 957—scattered

not only throughout this broad land, but to the far corners of the earth; and whether in China or Japan, or in India, or in Australia, or in America, or wherever their fortune may have led them, they are doing noble work, redounding to the credit and honor of their proud and fostering mother.

These alumni should never forget that, always a leader in medical progress, their school was the first in this country to require entrance examinations; the first to establish a four years' course; and has ever maintained the highest standard of medical education.

Never descending from the heights of professional dignity to the level of commercialism, it has been content to stand upon the quality of its work rather than upon the number of its students. It has thus sought, in addition to their scientific training, to imbue its students by example and precept with a true conception of the lofty purpose of their life work, and to instill into their minds the sentiment that the honor, not only of their profession, but of their Alma Mater, is to be placed in their keeping.

This consistent, and, as it would seem, ideal policy has had the inevitable result of winning the respect and confidence of the scientific world for our school. Its educational exhibits are eagerly sought for by national conventions, medical and lay, and never fail to receive most gratifying commendation. For such exhibits gold medals have been awarded by the St. Louis Exposition, and, more recently, the Lewis and Clark Centennial Exhibition at Portland, Oregon. Alumni of the school have been awarded gold medals for original research work, and for original technic in pathology. The demand for its graduates to serve as internes in various hospitals throughout the country, and to fill other positions of responsibility is greater than can be supplied. In short, on every hand the school is receiving a kind and an amount of recognition that could result only from the highest merit.

It must be evident that such a high standard of excellence could not have been maintained without not alone the most

faithful effort on the part of the corps of instructors, but also the expenditure of large sums of money for equipment, pecuniary aid to worthy students, etc. This has resulted in a slowly but steadily diminishing surplus in the treasury, until at the present time the financial needs of the school are urgent, and must be met at once by the alumni securing rich endowments in order that this grand institution of learning may continue to occupy a position second to none in the field of medical education.

We bespeak for Boston University School of Medicine the profound respect and the earnest, active support which it has earned, so that those in whose hands its interests have been placed may be encouraged to continued effort—not alone by putting within their reach better means of instruction, but also by holding them up to the highest standards of noble manhood and womanhood, to render the recruits to homœopathy from our representative school worthy of the growing influences and widened scope of their profession, not alone by their technical accomplishments, but also by the strength of their character, and the elevation of their aims.

NAUHEIM AGAIN.

So much has been said and written on the subject of Nauheim-treatment within the last six or more years, and so much of unfavorable comment has found its way during the past six months into both the medical and the daily press in this country and abroad, that a few observations from one very lately on the spot may not be without interest.

It cannot have escaped the notice of the readers of the *Gazette* that many circumstances have combined of late to draw both critical and most uncritical attention to these justly celebrated baths, circumstances among which may be mentioned the fact that the so-called Nauheim treatment in various modifications has become a part of heart therapeutics the world over. Moreover, the vaunting on the part of enterpris-

ing doctors and municipalities in every health resort,—with or without saline, carbonic acid, and foruginous waters,—of their own local means and measures, and the failure of Nauheim to come up to unreasonable expectations in many cases, more particularly in that of our late secretary of state so widely discussed in the daily press, have caused a distinct reaction to set in against the claims of Nauheim. It is true, also, that the hygienic and sanitary provisions of the town are by no means what the great annual influx of visitors would warrant those who seek relief and health there to expect, the dense smoke from the salt-works lying heavily over the region, and the half-dry, stagnant brook creeping through the beautiful park and the center of the town, adding to the unwholesomeness of the atmosphere.

But, on the whole, these are secondary matters, as are the defects in the bathing establishments of which so much has been written in adverse criticism. The main consideration is the efficacy of the treatment, and here there can be no question of the therapeutic value of the measures in use. That they are capable of abuse, and that their routine employment without discrimination in all the varied classes of cases presenting themselves from all parts of the world, is objectionable, is most certain. The same is true of every treatment unscientifically applied. But of the results obtained at Nauheim there can be no question. The number of intelligent physicians yearly to be found there for treatment of their own cardiac and other affections, and the increasing numbers of patients constantly returning at longer and shorter intervals for the unfailing relief they have learned to expect with confidence, bear ample witness to the benefits to be derived from the baths and other therapeutic agencies which have made the name of Nauheim famous.

The unhappy cases which have excited so much comment should not be laid to the door of either the Nauheim methods or the physicians who use them. On the contrary, they are to be put down in part to the pernicious practice of many doc-

tors of sending desperate cases from their homes, and in part to the widespread ignorance on the subject of the special classes of cases for which the Nauheim treatment is particularly adapted.

The most promising of these latter are without doubt the cases of neurasthenia affecting the force and rhythm of the heart's action, dilatations following from chronic myo-carditis and valvular insufficiency, and failing compensation before secondary changes in other organs, notably the kidneys, have progressed to a marked degree.

On these points, however, it is needless to dwell at this time, since we learn with great satisfaction that Professor Schott is expected to arrive in this country early in the coming winter, prepared to lecture before a number of the foremost medical schools on his specialty. That he will bring most valuable information of highly scientific and most practical character is to be confidently expected and we are not without hope that he may be heard in Boston. In view of the discussions and criticisms above referred to his visit will be most timely.

“WHAT IS WORTH DOING IS WORTH DOING WELL.”

It is a popular notion that a person who is writing a biographical sketch or a history, as a prerequisite to his writing, shall be familiar with at least some of the prominent points in the lives of the individual, institution or nation of which he is writing. It is also a popular idea that a writer's mental bias may color more or less his narrative, even if he try to state only facts. But lack of familiarity with his topic would seem to disqualify one for writing on a subject, historical or biographical. Naturally one who is familiar with the development of an institution or a country has his feelings somewhat stirred by gross misstatements concerning the things with which he is familiar.

Meditations of this nature are called up by a perusal of “The History of Homœopathy” which has recently issued from the

press. Just how the homœopathists of Massachusetts will regard this history depends more or less upon their interest in and knowledge of the subject. Attention, however, is asked to the following quotations and running comments thereon.

“ . . . In treating of hospitals and other kindred institutions in Massachusetts these annals can furnish only brief mention. That which demands first attention is of a distinctively public character, not a private nor yet a *specialty homœopathic institution*, although the legislative power of the commonwealth gave its *medical department* in charge of homœopathic physicians.”

Upon those acquainted with the facts, the italicized portions of this sentence make a curious impression. The institution referred to is, and has been from its very inception, very specially *homœopathic*. It has been at no time anything else. Its friends are not aware that it has, or ever had any other than a medical department. Of course like all large institutions it has its culinary department, its large productive farm, its pathological department and so forth. But even these have been under the care of its administrative head, who is acknowledged to be a capable homœopathic physician.

“ . . . The institution to which allusion is thus made is that known as the Westborough Asylum for the Insane, which dates its foundation from an act of the general court of Massachusetts, passed June 3, 1884, although the asylum as a means of administering to the physical and mental needs of its charges through the medium of homœopathic system of medicine was not formally opened until December 6, 1886. *Since that time it has been under homœopathic medical supervision*, and reports show that under the system *at least as good results* are accomplished as under any other school of medicine in any similar institution in this state or elsewhere.”

It may be flattering to know that the results of treatment at Westborough have been “at least as good” as those obtained elsewhere. Massachusetts homœopathists have been particularly proud of the excellent record made at the Westbor-

ough hospital, and recollect very well how, a few years ago, comparative statistics showed that the results obtained at Westborough were vastly superior to those obtained at any similar state institution.

Apropos of the "Massachusetts Homœopathic Hospital" we read: ". . . Failing in an endeavor to enlist state aid for the proposed hospital, the trustees instead of attempting to maintain such an institution with all its attendant expense, wisely *determined to limit their operations to a dispensary foundation*, and to that end secured the incorporation (May 28, 1856) of the Homœopathic Medical Dispensary, *which was carried on with gratifying results for several years.*"

Here again in a short sentence, we find misstatements that are highly perplexing and irritating to those who know the facts. Only one of the original incorporators of the Dispensary was connected with the Hospital corporation. The Dispensary was from the very start and always has been quite independent of the Hospital. Those who know the facts, know well that the Hospital was for years more or less dependent upon the Dispensary, for it was in the building owned by the Dispensary that the Hospital had its first home. Friends of the Dispensary will hardly realize that the Dispensary is a thing of the past, as is suggested by the phrase that its work "was carried on with gratifying results for several years," for the Dispensary is still in active operation, treating in the neighborhood of 20,000 patients a year, a fact which is indicative of a very active life. Later on in the paragraph from which the last quotation was made, we read ". . . A permanent home for the hospital was found near the Boston University School of Medicine in a *building which was once a female medical college.*"

Here again is a statement that is as far from representing the true facts as anything can well be. When the Hospital moved from the Dispensary in Burroughs Place into its new home, it moved into an absolutely new building, and never at any time was connected with a building that was once a Female Medical College.

It is erroneous statements like the foregoing that weaken and even destroy one's confidence in a work that pretends to the dignity of a history.

ANOTHER GOLD MEDAL.

It is perfectly natural to the healthy and active individual or institution to try to excel. The desire to do something better than somebody else can do it is the aspiration that underlies athletics; that leads to social and commercial competition. To have one's ability or work recognized as of good quality, or of excellent quality, is gratifying and encouraging. In the medical profession approbation and rewards are probably fewer than criticisms, and when they come they are therefore highly prized. Word has just reached us that there is rejoicing in Boston University School of Medicine from the unexpected announcement that it had received another medal in recognition of the scope and quality of the work done in certain of its departments. The award of a gold medal at the Louisiana Purchase Exposition in St. Louis, a year ago, to the school has been made known and sufficiently commented upon. It so happened that, at the close of the St. Louis Fair, the Board of Managers for Massachusetts requested that the exhibit of Boston University School of Medicine be included in their own exhibit at the Lewis and Clark Exposition. This request, of course, was granted, and the school at the present time has the gratification of announcing that that exhibit has won added honors for the school in the shape of a gold medal.

LETTER TO THE EDITOR.

To the Editor of the Gazette:

SIR:—I would like to call the attention of the profession to certain needs of the Pathological Museum of the B. U. Med. School, which is now on what may be considered a firm founda-

tion and well supplied along many lines, particularly those in connection with gynecological surgery. But a more complete collection is our aim.

I am experimenting with several new modes of preparing and preserving the fœtus, and would be glad to receive any specimens of such coming into the hands of physicians and which they do not wish to retain for their own purposes.

It should be borne in mind that we are desirous of receiving from all members of the profession any unusual specimens that may come to their attention, and any unusual tissues or tumors worthy of preservation and of interest as means of instruction or research.

Any physician possessing such unusual specimens and not disposed to part with them wholly, may if he so wishes, loan them to the museum, where they will be held subject to the order of the owner and preserved with all possible care.

In this way we may be able to obtain the use of specimens not otherwise available, for instruction of the students, and at the same time both serve the further purposes of the museum and guard the rights of the owners of the specimens entrusted to our hands.

Respectfully yours,

W. H. WATERS.

Curator of the Museum.

SOCIETY REPORTS.

BOSTON HOMŒOPATHIC MEDICAL SOCIETY.

BUSINESS SESSION.

The regular meeting of the Boston Homœopathic Medical Society was held in the hall of the Boston Society of Natural History, Thursday evening, November 2, 1905, at 7:45 o'clock, the president, J. Herbert Moore, M.D., in the chair.

The records of the last meeting were read and approved.

D. A. Babcock, M.D., of Fall River, was proposed for membership.

The following physicians were duly elected to membership:

Arathena B. Drake, M.D., of South Boston.

Anna M. Skinner, M.D., of Watertown.

Dana F. Downing, M.D., of West Newton.

Deborah Fawcett, M.D., of Newton.

Henry M. Emmons, M.D., of Jamaica Plain.

Wilson F. Phillips, M.D., of Dorchester.

A letter from Mrs. William L. Jackson, in response to the resolutions on the death of her husband, was read by the Secretary.

The president appointed the following committee to nominate officers for the ensuing year: Dr. H. E. Spaulding, Dr. J. H. Sherman, and Dr. N. H. Houghton.

SCIENTIFIC SESSION.

PROGRAM.

1. "Homœopathic Remedies in the Therapeutics of Obstetrics." Sarah S. Windsor, M.D.

Discussion opened by Mary E. Mosher, M.D.

2. Society Organization and State Reciprocity in Medicine. W. H. Prescott, M.D., Treasurer of the Suffolk District Medical Society.

Discussion opened by Frank C. Richardson, M.D. and Henry E. Spaulding, M.D.

3. American versus European Surgery. Horace Packard, M.D.

DISCUSSION (DR. WINDSOR'S PAPER).

Dr. Mosher: It seems to me that in no field of medicine do we get better or quicker results than in obstetrics. Sometimes if we get results in twenty-four hours we are very much pleased, but in delivery we often get results in half an hour or less. I believe that the women who are cared for during their pregnancy with homœopathic treatment for every even slight variation of the normal, get through better, quicker, and stronger than if left to nature alone, and during delivery I have seen remedies work favorably in an astonishingly short time—for instance, belladonna in rigid os with belladonna cerate locally. It is seldom we have a case which cannot be relieved by the indicated remedy.

In the last twenty years I have had about eight hundred cases with, I believe, seven forceps cases. I believe the small percentage of forceps deliveries is due to homœopathic remedies, and to application of heat at the time of delivery. Pulsatilla and nux vomica have been the remedies most commonly used by me. The most essential feature of the proving of pulsatilla is its action on the female generative organs. By its prominent action on the mucous and synovial membranes it causes either increased or retarded secretions, with an irritated and depressed nervous system, and through its influence on the cerebro-spinal system causes marked action on the generative organs. I have also found it to work equally well with strong philosophical dispositions as with those who weep. In nine cases out of ten pulsatilla will be of benefit from beginning to termination of pregnancy. Pulsatilla is indicated at all times by its provings in either increased or retarded secretions, dry or loose cough, depression or irritability of the nervous system, for varicose veins or rheumatic conditions. It is the main remedy in varicose conditions, and is especially useful in pregnancy. It is the first to be thought of in enuresis of pregnancy, in violent and incessant fetal movement, and aided by nux vomica, especially for vomiting, it will help physician as well as patient. In special conditions

other remedies will be brought in to help. In hemorrhoids, *æsculus*, and *hamamelis* internally as well as *cerate* locally. *Pulsatilla*, with hot water applied as compresses, for varicose conditions.

DISCUSSION (DR. PRESCOTT'S PAPER).

Dr. Richardson: Mr. President, Ladies and Gentlemen:—The subjects before us this evening are certainly of the greatest possible importance. The subject of reciprocity is so very large that one feels in approaching it a good deal like grasping a ball so large that one can get no hold on it. That the present condition of affairs works hardship to members of the profession everywhere I think there can be no doubt. We have repeated instances. For example, one of our number has a summer home in Maine at which he spends several months each year. While there he is frequently called upon to prescribe for his neighbors. That has occurred so frequently that some of the physicians in the vicinity have raised objections, and a notice has been served upon this Boston physician that he shall no longer practice in the state of Maine, not having passed the State Board examination. This is but one instance of many.

The question is how to arrive at some proper adjustment. As is well known to all of you, the requirements of the various State Boards differ so widely that it seems to me at present that reciprocity is impossible. Our representatives on the Massachusetts State Board will no doubt be able to speak more definitely and wisely upon that subject than I possibly could. Efforts are made in a vague, unsatisfactory fashion to adjust that, but I think no concerted effort has yet been made, and I sincerely hope that it may come about in the near future, some effort looking toward securing uniformity of requirement.

In regard to medical organization, of course we all know it is necessary for the welfare of the profession. I have been very much interested in the doctor's exposition of the organ-

ization of the older school, and it seems to me that there are a great many features which we might copy to advantage. This matter of having district societies a part of the main organization, the matter of the management of the state organization, the participation in its management by officers of the various local societies, seem to me an excellent idea and well worthy of our consideration. I hope that we shall bring that matter up for discussion.

I had the honor and labor of being secretary of the State Society for ten years and know something of the duties, perplexities and discouragements. It is certainly in a great measure true what the speaker says in regard to the work falling to a few. The one thing which impressed me during my term of service was that in order for a society to do its best work the one great principle of unselfishness must govern its members, and I have thought many, many times that could we absolutely abolish the matter of self we might be of far greater use to the society and profession at large than I fear many of us are at the present time. I do believe that one-half, at least, of the actual "boredom" which we are subjected to in many of our society meetings arises from this very human attribute of selfishness. I do not imagine that can ever be eliminated entirely, but this is the first time I have had a good chance to express my mind in that respect. I could not do it very well while in office, but here where we are all more or less unselfish and I am no longer in office I feel at perfect liberty to speak in this way.

The doctor said that none of the treasurers were getting rich on the percentage accruing from collections. I should like to know, as a matter of curiosity, what the percentage of loss to the Society is in collections, or how particular the physicians of the older school are in keeping up their dues and incidentally, perhaps, how important they regard their duty toward the society as far as attendance is concerned and as far as showing by active society work their allegiance. I do believe the average practitioner does not appreciate fully the

importance to himself of membership in a reputable medical society. It is, of course, the badge of respectability and legitimacy, and I feel that that thought should be "hammered in" upon every occasion. There is so much to be said that I feel I may just as well stop here and give way to others.

Dr. Spalding: I have been greatly interested in hearing how the older society began and how it has been organized step by step. Some of this is entirely new to me. You probably all know that this year our national medical society, the American Institute, inaugurated the new rule for admitting members, that every applicant for membership must first be a member of his state society in states where there are state societies. As chairman of the special committee on new members this year I found that rule stood in my way very greatly in getting the large list of members we started out to get. The general stirring up which we gave the profession in the way of getting new members did result in this, that we worked not only getting members for the national society, but incidentally for the state societies also. It seemed at first that this restriction of membership was not working to the advantage of the Institute, but I believe that in the end it will be an advantage to the Institute and to the profession at large. I think our state societies will grow in strength and numbers by this very fact of our national society taking this stand.

The national society, however, made no provision for any official connection with the state societies, and I introduced an amendment to the by-laws to be acted on next year, that secretaries of the state societies shall, *ex officio*, be auxiliary secretaries of the American Institute, and lists of members shall be expected from each state society on the first of January each year, so that our national society may have the exact list of members of the state societies who were not members of the Institute. Whether we can go further than that to advantage, and make our local societies auxiliary to our state societies, I do not know. I think it is time for us to consider that. Certainly it must succeed very well in the older organ-

ization, and I do not know why we cannot adopt something of the same kind.

I feel that our medical colleges should impress upon the minds of the students of every graduating class that one of their first duties is to join the medical societies. The young man says he cannot afford it. The price of two theatre tickets would pay his dues in this society for a year.

One word in regard to reciprocity. Some of you know that I have pretty decided opinions about our State Boards and registration laws. The more I read the rules and regulations governing our State Boards the more I am mystified and wonder how they could have gotten up so many absurd rules. Hardly any two states are exactly alike. There is a list of states which require no examinations for physicians. Alaska and Colorado (discretionary), Kentucky, Nevada, New Mexico (admits graduates from state colleges requiring a four years course. I understand from that that a graduate from Harvard would not be admitted because it is not a state college), Philippine Islands (grant license to physician to practice having a diploma. A physician not having a diploma can come before them for examination).

The states not requiring a diploma are few, including Massachusetts, Arkansas, Mississippi, Missouri, North Dakota, Oregon, Philippine Islands, Tennessee, Texas and West Virginia. In Kansas it is discretionary with the Board, but the applicant must show that he has studied in a medical college four years of six months each year. In Massachusetts it does not matter whether a man has had a diploma. According to two compilations of the various state laws they do ask that he shall show that he has attended a medical college, but do not stipulate how long he shall attend the college course. Anybody can come up for examination.

As regards reciprocity, there are two states where it is entirely discretionary with the Medical Board to reciprocate in giving licenses to those who have licenses from all other states, namely California and Iowa. All they require is that the

states whose physicians' licenses they recognize shall also recognize their licenses. But in all the other states California is not recognized and yet California's laws governing licenses are very exacting. Iowa's licenses are recognized by a few states.

There is reciprocity between certain states. Maine with New Jersey and Illinois. Maryland with the District of Columbia. New Jersey with Maine, Virginia, Texas, Illinois and Washington. Pennsylvania with New York. Texas is the most liberal of all the states in this matter.

I want to refer to one peculiar feature of the laws in New York. They are supposed to be quite as strict as in any state. A question came up in one of the medical societies about midwifery in New York City. It was found that midwives attended nearly one-half the cases in New York City. While physicians are obliged to go before a Medical Board, pass an examination, and pay a fee of, I think, twenty-five dollars, an uneducated person can go and get a license to practice midwifery for fifty cents, with no examination. This was the law and as far as I can learn, is now. When we consider that there is no branch of the science of medicine and surgery demanding greater efficiency and promptness of action than midwifery, we see one of the glaring inconsistencies of our laws governing the practice of medicine. The percentage of still-born children in New York City is, as might be expected, enormous.

I have referred to Massachusetts holding, as it seems to me, a position which she ought not to hold in relation to the other states, in that she allows physicians who are not graduates to come before the Board for examination. The four years' course of study and a diploma from a recognized medical college should mean something, and yet here, apparently, it means nothing. And we cannot expect, as long as that rule prevails here in Massachusetts, those other states, who demand that all who have licenses shall be educated physicians, to recognize our licenses to practice. And as long as that remains on

the statute book as it is we can have no reciprocity with other States. For that reason, at the last spring meeting of our State Medical Society I introduced a resolution asking the legislature to correct what I believe to be an error, and I will ask the Secretary to read that resolution.

(Resolution read by the Secretary.)

I would say that this resolution was unanimously adopted by the State Society. It was referred to the special committee on legislation, and it is hoped that the other societies will join us in helping to carry this thing through and relieve us from this stigma which we believe is placed upon us in our relations with physicians in other states.

(Voted: That this Society approve this resolution passed at the October meeting of the State Society, and that the Committee on Legislation be instructed to act in conjunction with the committee appointed by the State Society.)

Dr. Calderwood: The reciprocity question is, as you all know, a big one. We must bear in mind that the medical laws are new. Massachusetts has had her medical laws only ten or eleven years and of course they are full of errors. One of the serious errors is, I believe, the examination of non-graduates. Dr. Spalding, as I understand, did claim that it required attendance at some medical school, but that is a mistake. Any person may make application to the Board of Registration in Massachusetts and be entitled to examination. I will say that very few of those applying do pass the Board but they may come there. I believe this is a serious error in our law.

There is one thing that we must bear in mind also. Very many of the men who come from other states to practice are the roving class of men. They are not our good physicians. The Massachusetts Board is obliged by law to give an examination in writing, but it may be partially oral. With the better class of men coming from other states we give the oral examination, and I think if our friend Dr. Prescott should be treated in other states as we treat men of his standing in our

state, no fault would be found. I think a man who is qualified would seldom be refused. I think one way to remedy this might be by having a recommendation from the State Society, and also a recommendation from the State Board of Registration in the state in which he has passed his examination, and let that be considered by the Board of Registration in the State to which he intends to apply. That, until the laws are changed, might be a benefit in some cases, but the question is a very large one and I think it should be left rather to the profession than to members of the State Board.

Dr. Perkins: I myself am in favor of reciprocity. I want to correct Dr. Spalding in one word. He spoke of the rules and regulations of the State Board. They are laws given us by the legislature, and not rules formulated by the Board.

I want to give an interesting experiment which was tried at the July examination. There is an organization of the New England State Boards of Registration. Last July the same questions were used in Massachusetts, Connecticut, Rhode Island and Maine on the same day. The reports have not as yet been tabulated from all the states, but I have here the reports from Rhode Island and Massachusetts which are quite interesting. In Rhode Island the averages in anatomy were 77.30 per cent.; in Massachusetts 70.15 per cent.

Physiology: Rhode Island, 79 per cent.; Massachusetts, 72 per cent.

Pathology: Rhode Island, 73.60 per cent.; Massachusetts, 69.26 per cent.

Obstetrics and gynecology: Rhode Island, 87 per cent.; Massachusetts, 76 per cent.

Diagnosis and practice: Rhode Island, 77 per cent.; Massachusetts, 73 per cent.

Surgery: Rhode Island, 77 per cent.; Massachusetts, 75 per cent.

Average, Rhode Island, 78 per cent.; Massachusetts, 72 per cent.

Massachusetts is not such a bad state after all. They cer-

tainly do not pass with as high percentages in Massachusetts as they do in Rhode Island. They may have had better material, or they may have been more liberal in their marking. I do not know the number rejected in Rhode Island, but the number of graduates examined in Massachusetts last July was 141, the number successful, 119, failed, 22. The percentage of failures was 15.60. I have not that part of the Rhode Island report. In due time the report from all the states will be received. I believe the problem of reciprocity will in time be worked out in a manner satisfactory to all; a more uniform code of laws in the different states will do much to hasten this.

Dr. Prescott (in closing): I think the first question Dr. Richardson asked was how much the treasurers lost by members not paying.

Dr. Richardson: The idea was what percentage of dues remained unpaid.

Dr. Prescott: I thought you meant did the treasurers lose money by the members not paying, but they are not responsible for the dues not paid. I can only speak of my own society, and I have a pretty good clientele. The bills are sent out on the 15th of April, the beginning of our fiscal year. I always get them into the mail the night of the 14th, so the members get them on the 15th. Before the night of the 15th I have ten per cent. of them back, and before the annual meeting, I have had, as a rule, the last five years, an average of 505 out of an average or 580 to 610 members, so that the Suffolk District Society generally gets a pretty good slice of the dividend which the Massachusetts Society gives to the district societies.

The other question I believe was how much do the members of the society appreciate what membership in the society does for them. I think as a rule they do not appreciate what membership means. They think it usually means five dollars a year, for which they only get a dinner, which until the last few years has been a poor one.

Dr. Strong requested that a substitute be appointed in his place on the Committee on Legislation, as he was also a member of that committee from the State Society. The President appointed Dr. F. B. Percy as a substitute.

Dr. Packard's paper was entirely informal, and was not discussed.

Adjourned at 10 P.M.

B. T. LORING, *Secretary.*

LINGERING LABOR FROM SHORT FUNIS.—Mantel (Ann. de Gyn. et d'Obst.) made observations of two labors in one patient where there was delay in the first stage due to relative shortness of the cord. In neither instance was the shortness extreme, but in both another agency involved more shortening. In the first labor the funis measured 11 3-4 in., but was inserted marginally on the uppermost limits of the placenta. In the second labor the insertion was central, and the placenta was inserted on the fundus; the cord only measured 9 3-4 in. In both labors the head receded markedly after each pain, and there was total absence of any desire to bear down. The head and body, held back by a short cord, made practically all the shorter by its insertion, remained for long as though suspended in the uterine cavity, only resting on the pelvic floor during contraction and bearing down. To this absence of contact between the pains Mantel attributed the absence of any desire to bear down. In the second labor, where the insertion of the placenta was so high and the cord at the same time absolutely short, there must have been considerable danger of inversion. In neither labor was the cord twisted round the fetus.—*Exchange.*

BOOKS AND READING.

Medical, literary and scientific publications will be reviewed in this department. Books and journals should be marked **NEW ENGLAND MEDICAL GAZETTE**, and sent to the Business Manager.

LECTURES ON HOMŒOPATHIC MATERIA MEDICA. By James Tyler Kent, A.M., M.D., Professor of Materia Medica in Hahnemann Medical College and Hospital, Chicago, etc. Philadelphia: Boericke & Tafel, 1905. pp. 965. Price, \$7.00.

It may well be said that no more sincere and useful work on materia medica has been offered to the profession for years. We think the book loses nothing by being written in the colloquial style the author deplures. It is a style peculiarly well adapted to impressing salient points on the memory, and one that to a considerable extent was adopted by Farrington in his valuable contribution to materia medica text-books. Dr. Kent has merely transferred to print his characteristic manner of presenting remedies, which has made him an exceptionally successful lecturer. He takes up over two hundred drugs, and discusses each in comparison with others showing greater or less similarity. As a practical assistant in acquiring a working knowledge of indispensable remedies, and in supplementing facts briefly stated in other text-books, Dr. Kent's lectures will be found invaluable.

MANUAL OF CHEMISTRY. A Guide to Lectures and Laboratory Work for Beginners in Chemistry. A Text-book specially Adapted for Students of Medicine, Pharmacy, and Dentistry. By W. Simon, Ph.D., M.D., Professor of Chemistry in the College of Physicians and Surgeons of Baltimore, etc. Eighth edition, thoroughly revised. Illus. Philadelphia and New York: Lea Brothers & Co. 1905. pp. 643. Price, \$3.00.

A student's text-book could hardly be more complete, certainly none can be more modern than Dr. Simon's. The subject matter is arranged in seven sections: Chemical Physics; Principles of Chemistry; Non-metals and their Combinations; Metals and Their Combinations; Analytical Chemistry; Consideration of Carbon Compounds, or Organic Chemistry; Physio-

logical Chemistry. There are eight colored plates, representing sixty-four chemical reactions. In the course of this work will be found incorporated the changes and additions of the new edition of the United States Pharmacopeia.

A TEXT-BOOK OF PRINCIPLES OF BACTERIOLOGY. A practical manual for Students and Physicians. By A. C. Abbott, M.D., Professor of Hygiene and Bacteriology, and Director of the Laboratory of Hygiene, University of Pennsylvania. Seventh edition. Illustrated. Philadelphia and New York: Lea Brothers & Co. 1905. pp. 689. Price, \$2.75 *net*.

It is in many ways almost needless to review a book with such a favorable reputation, and one that has received sufficient attention from the medical profession as to justify a seventh edition. This latest edition will continue to merit the reputation which those preceding it have made.

It is carefully written, in good English, and gives in a most satisfactory manner the more important data necessary in the early study of bacteria and their phenomena. The only criticism that might be made lies in the fact that the arrangement of the various diseases seems quite uncertain. To the casual reader the diseases seem to be considered without any particular reference to the bacterial classification. Except for this, the book should prove of decided value to all members of the medical profession.

W. H. W.

A TEXT-BOOK OF CHEMICAL AND MICROSCOPICAL DIAGNOSIS. By Francis Carter Wood, M.D., Adjunct Professor of Clinical Pathology, College of Physicians and Surgeons, Columbia University, New York. Pathologist of St. Luke's Hospital, New York. Illustrated. New York and London. D. Appleton & Co. 1905. pp. 745.

The volume contains many useful methods for the laboratory investigator, and will be to a somewhat less extent of service to the general practitioner. The chapter on blood, its examination and the differential diagnoses connected therewith, is the most satisfactory of any yet seen in a book upon general diagnosis.

This is particularly true of the consideration of the other diseases characterized by marked blood changes. The description of the anopheles mosquito, and the method by which it transmits malaria, is very satisfactorily treated.

Throughout the entire volume, the illustrations, many of which are original, are clear and instructive. The treatment of the examination of the gastric contents is careful and accurate but seems to give much more complicated tests than can be readily performed by the general practitioner. This same comment can be made in connection with many of the tests for various urinary constituents.

A pleasing feature is the inclusion of many simple tests for certain drugs in urine. It is somewhat of a surprise to see so freely advocated the use of tuberculin as a diagnostic aid in the treatment of the human individual.

Taken as a whole, the book is very satisfactory, and should prove of value to all interested in the lines of which it treats.

W. H. W.

ABSTRACTS FROM BOOKS AND JOURNALS.

ANATOMICAL PECULIARITIES OF A GALL-BLADDER AND AN APPENDIX.—An instance of inclusion of a gall-bladder in the substance of the liver presented itself recently while Dr. W. K. Bouton of Melbourne was operating for gall-stones. After opening the abdomen in the manner recommended by Mr. A. W. Mayo Robson for this kind of operation the liver presented itself in the operation wound and what appeared to be a hydatid cyst was seen on the anterior surface of the right lobe—a slightly rounded elevation of pale yellowish color. On lifting the liver forward a similar though somewhat more projecting eminence appeared on the posterior surface which when viewed through the substance of the liver was quite translucent. It was in the normal position for a gall-bladder but the surfaces, both anterior and posterior, were continuous with the liver substance. As no gall-bladder could be discovered an incision was made on the posterior surface into the swelling when bile gushed out, and on further exploration two large gall-stones, one barrel-shaped and the other conical, were secured; there was an additional facet on the barrel-shaped stone showing that a third stone had been

present, but as a probe passed the whole length of the common duct without striking one it had evidently been passed previously. The edge of the incision into the gall-bladder at the time of operation was at least three-eighths of an inch thick, the circularly arranged coat of the gall-bladder being marked off very definitely from the liver substance on the one hand and the mucosa, etc., of the bladder on the other. Having secured a specimen for microscopical examination the usual procedure for closing the abdomen and draining the gall bladder was undertaken. On examination with the naked eye after the usual hardening process the specimen measured about three millimetres and showed the same three layers as already mentioned. Under low power the layers were made up of (1) an outer thick layer of connective tissue, probably a continuation of Glisson's capsule; (2) a circularly arranged layer of connective tissue, evidently the true covering of the gall-bladder; and (3) the mucosa, muscular tissue, etc., of the gall-bladder. The thickness of the anterior surface of the bladder and liver appeared to be slightly more than that of the posterior surface, but no section was made of it.

Curiously enough on the same day at another operation for appendicitis a divergence from the normal was seen in the appendix. On lifting the cecum into view, a small elevation on the anterior surface of the cecum, about five inches from the extremity of the gut, was seen from which a little pus oozed. At first sight it looked like a perforation of the cæcum itself, as no trace of the appendix connected with it could be seen, but on further examination, a little loop of appendix with a diameter of half an inch sprang from the extremity of the gut and, passing upwards, appeared to end in the cæcum half an inch away from its origin. No elevation appeared on the smooth peritoneal surface to indicate that the loop had any connection with the perforated elevation four and a half inches distant. However, taking the loop as a guide and carefully dissecting away the peritoneum the appendix was traced until it ended in the elevation. The appendix was then stripped off the cecum and removed in the ordinary manner. The exposed surface beneath was the muscular tissue of the cæcum and it bled freely. After careful application of a continuous suture of fine catgut through

the free edges of the peritoneum, including some of the muscular layer, the bleeding was stopped, and for further security a second row was inserted invaginating the first and including the stump of the appendix. The abdomen was then closed.

Both cases did excellently. I am indebted to Dr. Bouton for permission to publish them.—Dr. Ferguson Lemon in *The Lancet*.

OBITUARY.

DR. JOSEPH W. HAYWARD.

Dr. Joseph W. Hayward, one of the foremost citizens of Taunton, and a homœopathic physician of recognized ability, died November 22, after many months of illness and suffering.

He was born in Easton, Mass., in 1841, was married in 1866, and is survived by four children. Dr. Hayward was a member of the American Institute of Homœopathy and of the Massachusetts Homœopathic Medical Society. He was appointed Lecturer on Dislocations and Fractures at Boston University School of Medicine in 1878, and afterwards held a full professorship, remaining a member of the faculty until his death. He was a most affable and genial man, very charitable, and greatly beloved by his associates and by those who profited by his professional skill. A more extended notice will appear in the next issue of this Journal.

PERSONAL AND GENERAL ITEMS.

DR. EDWARD E. ALLEN has removed to 32 Monument Square, Charlestown.

DR. F. R. TRIGG has located at 217 Cumberland Street, Norfolk, Va.

DR. ALICE S. WOODMAN has opened an office at 816 Blue Hill Avenue, Dorchester. Office hours, until 9 a.m., and 2 to 4 p.m.

DR. FRANCES M. MORRIS has removed to 803 Boylston Street, Boston. Office hours, 10 a.m. to 2 p.m., and on Tuesdays, 10 a.m. to 12 m.

DR. NATHANIEL W. EMERSON resumed practice November 20th, at 1069 Boylston Street, Boston. Dr. Emerson's office hours are 2 to 4 p.m., Monday and Thursday; other days by appointment.

DR. E. PAKENHAM RUGGLES now has his office and residence at 420 Washington Street, (near School Street), Dorchester. Office hours: 2 to 3, 7 to 8 p.m. Telephone, Dorchester, 8.

PRACTICE FOR SALE.—J. F. Shattuck, M.D., of Wells River, Vt., wishing to remove to a warmer climate, would like to sell his homestead and office supplies to a Homœopathic physician. Practice established twenty years.

ELLISON HALL, the new building at the Newton Hospital, is the gift of Mr. and Mrs. F. A. Day, and is a beautiful modern brick structure, erected at a cost of upward of \$30,000. It will furnish accommodations and comfort for between 30 and 40 nurses. The new home was given in honor of the late W. P. Ellison, ex-mayor of Newton, Mrs. Day's father.

NAUMOV, a Russian physician, succeeded in removing a number of warts from his hands by simply concentrating upon them the solar rays for a period of some thirty seconds. He used a convex lens from his ophthalmoscope, and found that nutritive blood vessels of the warts became occluded and that they, therefore, atrophied. A slight induration of the skin remained after

the warts had fallen off, only to disappear in its turn after a week or so. It has long been known that the Roentgen rays will destroy warts, but the above method is applicable by every practitioner.

THE Practitioners' Course of the New York Homœopathic Medical College and Hospital (see advertisement) opens May seventh, and we believe a more interesting and practical schedule than ever before will be presented. Special importance will be given to *materia medica*.

Men of well-known reputation residing outside of New York, beside those connected with the College, are engaged to give both clinical and practical lectures.

The morning hours will mainly be devoted to practical laboratory work and each one will be provided with a microscope and, by individual instruction, will become familiar with the recent methods of medical and surgical pathological diagnosis.

The afternoon hours are fully occupied with the clinics in the various departments of practice and surgery. It will be a clinical practical course for practical practising physicians.

THE surgeon-general of the navy has made a strong plea for the employment of women nurses in the naval medical service. "That women nurses are by natural endowment and aptitude," says he, "superior to male nurses for much of the duty required in the care of sick and injured men is generally admitted. Every war of modern times has demonstrated this fact.

"The medical department of the army is now provided with a corps of trained women nurses, and their adaptability to service conditions and efficiency in institutions under military control have been fully established. Their services would be more useful in the naval hospitals, insuring for the sick of the navy as careful nursing as is now given to the sick of the army.

"In time of peace the number of such trained women nurses would be very small, but the organization should be such as to admit of ready expansion to meet extraordinary needs without delay or confusion. The recommendation of the bureau that congress be asked to authorize the appointment of trained women nurses has heretofore met with the approval of the department, but necessary legislation has so far failed of enactment. The bureau has renewed its recommendation that legislation authorizing the employment of trained women nurses for the navy be requested of congress."

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