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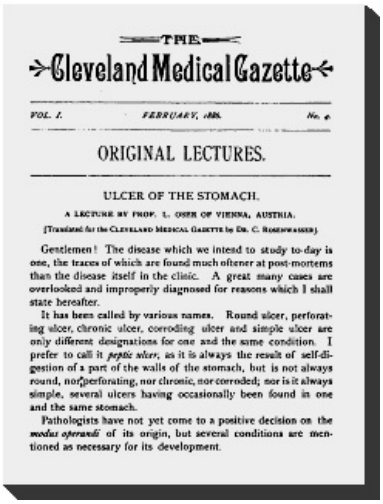
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ORIGINAL LECTURES.
ULCER OF THE STOMACH.
A LECTURE BY PROF. L. OSER OF VIENNA, AUSTRIA.
[Translated for the Cleveland Medical Gazette by Dr. C. Rosenwasser].
Gentlemen! The disease which we intend to study to-day is one, the traces of which are found much oftener at post-mortems than the disease itself in the clinic. A great many cases are overlooked and improperly diagnosed for reasons which I shall state hereafter.
It has been called by various names. Round ulcer, perforating ulcer, chronic ulcer, corroding ulcer and simple ulcer are only different designations for one and the same condition. I prefer to call it *peptic ulcer*, as it is always the result of self-digestion of a part of the walls of the stomach, but is not always round, nor perforating, nor chronic, nor corroded; nor is it always simple, several ulcers having occasionally been found in one and the same stomach.
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Pathologists have not yet come to a positive decision on the *modus operandi* of its origin, but several conditions are mentioned as necessary for its development.

1. The self-digestion of a part of the stomach by the gastric juice. « 146 »

2. Disturbances of the circulation of the blood in the walls of the stomach.

3. The alkalinity of the blood circulating in the walls of the stomach prevents the digestion of the mucous membrane. If this action on the walls of the stomach is prevented in any way, the development of an ulcer is aided. This clause has been accepted until recently, when it has been rendered somewhat doubtful by the results of certain experiments.

The first clause is sustained by the fact that the peptic ulcer is only found in those parts which are brought into direct contact with the gastric juice. It is further proven by the softening of the stomach so frequently found at post-mortem. But as long as the circulation of the blood in the walls of the stomach is normal, ulcers do not form. The formation of an ulcer in the stomach presupposes a local disturbance of the circulation. It is usual to find thrombi and diseases of the bloodvessels in cases where ulcers of the stomach occur. For this reason the latter is more common in anaemic persons where the circulation is retarded and the bloodvessels frequently subject to fatty degeneration.

Virchow regards embolism of a small vessel as the origin of ulcer of the stomach. Cohnheim disproved this beyond doubt by showing that there is an abundant circulation in the walls of the stomach by which the parts affected are again quickly supplied with blood. Klebs takes for granted a spasmodic contraction of single bloodvessels as the cause of the retardation of the circulation, while Rindfleich attributes it to the poor anastomotic connection of the gastric veins. He calls attention to the frequent coincidence of ulcer and hemorrhagic infarct in the walls of the stomach. Cohnheim injected chromate of lead into the gastric branch of the splenic artery in animals, and when he succeeded in cutting off the arterial supply of the mucous and submucous layers *only*, he found as a result large ulcers with sharp, well-defined margins and a circular base. If the animals were examined in the second week after the experiment, they showed several small ulcers in place of the larger one. In the third week the ulcers were found to have healed. « 147 » From these experiments you can see that the gastric ulcer has a natural tendency to heal when not interfered with. By experiments such as these it has been proven beyond doubt that disturbances of circulation of a small part of the stomach may lead to ulcer. But the causes of these disturbances, and the reasons why some ulcers do not heal, are still disputed questions.

Pavy claims that the alkalinity of the blood prevents the gastric juice from acting on the walls of the stomach. When he introduced acids into the stomach and allowed the circulation of the blood to continue, no ulcers resulted; if he impeded the circulation, the stomach was digested by its acid contents. Samelson instituted experiments to test the statement of Pavy. He introduced large quantities of various acids into the stomach of his animals without observing ulceration as a result; he also neutralized the blood by the injection of weakened acids into the bloodvessels, but no ulceration followed. But he did not impede the gastric circulation in his experiments, while Pavy did, hence the difference in their results. Clinical experience, however, favors Pavy's views. We can prevent the further progress of the gastric ulcer by the use of alkalies, while acids only favor its growth. These questions still need additional research before they are definitely solved.

Gastric ulcer may occur in any part of the digestive tract which is exposed to the action of the gastric juice; hence it is found in the lower part of the œsophagus, any part of the stomach and the upper part of the duodenum. It is found most frequently in the pyloric end of the stomach, because this part is most frequently subjected to mechanical irritation and to the action of the gastric juice.

The shape of the ulcer is usually conical or terraced, its diameter being largest in the mucous membrane and smallest at its base, in the deeper structures.

The gastric ulcer must be very common. In about five per cent of all cadavers we find ulcers in the stomach or else scars as traces of former ulceration. Ulcer of the stomach is frequently passed over without recognition, because most physicians do not decide upon this diagnosis, unless hæmatemesis occurs. Gastric hemorrhage, however, is not necessarily a concomitant « 148 » feature of every gastric ulcer, and the hemorrhage may occur without vomiting, the blood being either digested and absorbed or passing on into the bowel and causing dark stools. Thus occasionally the only symptom of hemorrhage of the stomach is the appearance of darker stools, a symptom of doubtful value when taken alone, but of some importance when in connection with others.

A few years ago an elderly lady was admitted into the hospital on account of severe pain in the stomach and the appearance of dark stools. While in the hospital vomiting of blood set in, continuing three days, and then the patient died. At the post-mortem we found that an ulcer of the stomach had burrowed through the diaphragm and pericardium into the wall of the left ventricle, perforating finally with a small opening into the left ventricle. I can only explain the length of the time between perforation and death (three days) by assuming that part of the gastric fistula leading through the walls of the heart was firmly closed during systole, and only allowed a small quantity of blood to ooze through during each diastole.

Symptomatology. If you were to rely upon the occurrence of gastric hemorrhage in making your diagnosis, a great many blunders would necessarily occur, as this symptom is present in but one quarter of all the cases. I can give you an exact picture of the symptoms from experience on

myself, having repeatedly been a sufferer from gastric ulcer and having studied every phase of the question carefully upon myself, frequently experimenting to get at various truths.

One of the most important and characteristic symptoms is the *localized pain or soreness* which is felt in a small, well defined area, and either originates or is increased by chemical or mechanical irritation. This spot always was sensitive both to warm and cold food. Salty food, alcoholic or sour articles brought on pain. I could feel when the food passed the spot. It was always more sensitive about an hour or two after a meal, when the process of digestion was most active. My ulcer was on the anterior wall of the stomach, so that I could greatly ease the pain after meals by lying upon my back, while lying upon the abdomen greatly aggravated it, as the « 149 » food then came in contact with the ulcer. I was a student yet when first suffering from this trouble, and was treated by one of our prominent professors for heart disease. He even gave me a certificate stating that I was suffering from beginning hypertrophy of the left ventricle. I was not improving under this treatment, and was taken one day with violent pain in the stomach, followed by vomiting of a large quantity of blood. Now the state of things was cleared up, and under the proper treatment (for ulcer of the stomach) I soon regained my health. I remained well for a long time, but in the course of the last twenty years have passed through several relapses. One of these, I distinctly remember, occurred while I was making a tour through the Alps. I had walked quite a distance that day and being very thirsty drank three glasses of water in quick succession. I immediately felt a pain in the stomach, and could distinctly feel how one of the old scars was again rent asunder.

During these repeated attacks I found that the painful sensation was really divisible into three distinct periods, that of constant increase, during which the ulcer is developing and extending, that of remaining at one height, and that of gradual decrease during the period of healing. I could distinctly tell from these various changes how my ulcer was getting along.

Two different kinds of pain are felt, the one constant and the other occasional. The *constant pain* is usually present where the ulcer has extended deeper into the tissues or when the surrounding tissues are implicated. This pain is increased during digestion or when pressure is made on the parts from without. The *occasional pains* are either of a dyspeptic type, caused by the catarrh which usually accompanies the ulcer, or of a cardialgic (neuralgic) type, the result of irritation of the exposed nerve-endings with the ulcer. These cardialgias are acute attacks of very severe, excruciating pain, which occur during or between the periods of digestion and are felt in the epigastrium and back mostly, but sometimes radiate over the entire abdomen, into the chest and even into the limbs. These attacks differ in no respect from those occurring in some diseases of the gall bladder, kidneys, peritoneum or uterus, and are consequently not characteristic of « 150 » gastric ulcer. The dyspeptic pain partakes more of the character of feeling of fullness, a sense of oppression in the epigastrium, heartburn, etc., such sensations as occur in catarrh of the stomach and are felt during digestion.

The characteristic pain in ulcer of the stomach is a localized feeling of soreness. It is not always prominent. Chemical or mechanical irritation of the ulcer brings it on, or if already present, aggravates it. Especially acids, both mineral and vegetable, have this effect, while alkalies allay it. This pain only occurs during the process of digestion, when the food or gastric juice comes in contact with the ulcer, or when the stomach is distended with gas, and tension exerted on the tender spot. During the periods when the stomach is at rest it does not occur.

Vomiting occurs in about three-fourths of all cases of gastric ulcer; vomiting of blood, however, only in about a quarter of all the cases. The latter occurs oftener where the ulcer is deep. In cases where the stomach is dilated, the amount vomited may be enormous, and contain food which has been retained in the dilated portion for several days.

As a result, also, of the accompanying catarrh of the stomach and the consequent diminished absorption of fluids, we find *constipation* and *diminished secretion of urine* in cases of ulcer of the stomach.

Perforation of the stomach is most frequently caused by gastric ulcer, and may be said to be a characteristic symptom; but it usually occurs too late to be made use of in the treatment of the ulcer. It is occasionally the first symptom which calls the patient's attention to the fact that his stomach is and has been seriously diseased. By the agglutinations of the base of the ulcer with neighboring organs, through inflammatory processes, perforation can take place into these organs. The most frequent forms of perforation under such conditions are those into the liver, spleen or pancreas, but cases have occurred where perforation into the colon or pleural cavity has taken place, or even into the pericardium, the heart or lungs. Some time ago I saw a case of gangrene of the lung, the result of the perforation of a gastric ulcer into this organ.

A few days ago I saw an interesting case, where an acute gastritis culminated in the vomiting « 151 » of a large quantity of pus. The patient had been having high fever for a few days, with incessant vomiting and great tenderness in the epigastrium. Evidently an abscess had formed in the neighborhood of the stomach, and finally opened into this organ, with the given result.

Diagnosis. There are two classes of characteristic symptoms—those originating from the exposure of nerve-endings, and those caused by ulceration into bloodvessels. The first class includes the painful sensations, the characteristic soreness, which occurs in about four-fifths of all the cases; the second class, the hemorrhages, occurring in only one-fourth of all the cases. You can readily see why pain occurs more often than hemorrhage. Even a very superficial abrasion may expose nerve-endings to the irritation of the food, while it takes a deeper ulceration

to lay open a larger bloodvessel. In order to make a positive diagnosis, these two symptoms should be present.

Vomiting of blood alone need not necessarily be caused by a gastric ulcer. There are a great many other conditions which may cause it. It should, however, put you on the guard, and can, in a great many cases, justify a diagnosis of probable ulcer of the stomach.

The localized pain occurs, according to my experience, only in cases of ulceration of the stomach; that is, in gastric or peptic ulcer and in cancer of this organ. In order to differentiate between these conditions, it becomes necessary to observe whether the patient is cachectic or emaciated or not, and whether a tumor can be felt in the region of the stomach. But even these symptoms can be deceptive, as an abnormal hardness or resistance—the result of perigastritic infiltration—may occur in cases of simple ulcer, making the diagnosis almost impossible. This is true especially in cases of ulcer of the pyloric regions, while ulcers of the anterior wall of the stomach are rarely accompanied by such infiltrations.

The pylorus is the most sensitive part of the stomach, and frequently the seat of pain, when no lesion can be detected post-mortem. The other parts of the stomach only become painful when attacked by ulcerative or other pathological processes. Another point worthy of consideration is « 152 » that all forms of pain in the stomach are usually referred to the pyloric region by the patient, even if they originate in other parts.

From all this you can see that no positive diagnosis can be made where any one of these symptoms is presented unaccompanied by the others. A careful consideration of the symptoms present will frequently, however, be of aid in making a diagnosis. Intelligent patients will tell you that they have a feeling of oppression, a feeling of distress in dyspepsia, but will describe their feeling as that of distinct pain in ulcer. Pure neuralgic pain is not always localized, but radiates into distant parts, is not constant, but sets in all at once and disappears with equal celerity, sometimes intermitting for days and weeks, and then again setting in on the slightest nervous excitement. Such pain is not aggravated by local pressure, shows no relation to the digestive functions, does not depend upon the quality or quantity of food taken, and may as well occur during a fast as during a feast. Often such patients will tell you that their pain does not cease until they have taken a hearty meal.

In cases of peptic ulcer, you will find that the pain is in direct relation to the amount and quality of food taken; that the patient has little or no pain when the stomach is at rest; that coarse foods as well as acids cause or aggravate the pain, and that indifferent foods, such as milk, do not bring it about, though they may sometimes cause a sense of fullness or oppression. Some patients with ulcer will tell you that the position of their body has an influence on their pain. If they are so placed that the food, by its gravity, lies on the ulcer, the pain is brought on or increased, while if the patient under such circumstances then changes his position, he is relieved of his pain partially, or even entirely. Yes, some such patients must assume abnormal positions while their stomach is active, in order to avoid this suffering. Some patients with gastric ulcer cannot digest *any* food without great pain, and frequently live on a very scanty diet, rather than risk taking more food and enduring these excruciating pains again.

Anomalous Cases. Occasionally cases will occur in which the symptoms presented do not justify the diagnosis of ulcer of the stomach, only those of dyspepsia or else of gastric catarrh « 153 » being present, while we are still compelled to assume the diagnosis of ulcer from the result of the treatment. Such cases resist all kinds of treatment based upon the diagnosis of dyspepsia or catarrh, and can only be cured by a strict "ulcer cure."

Another class of cases only presents gastralgic pain without any other symptom. Such are frequently patients who have had gastric ulcer before. Others will come to you with intercostal neuralgia on the left side. They have, perhaps, tried all the usual anti-neuralgic remedies, have gone through a course of treatment by electricity, and spent a large amount of time and money, without obtaining permanent relief, until some physician puts them on a strict milk diet and cures them in this way in a short time.

Some cases of ulcer of the stomach present the queerest symptoms. For instance: they complain of pain after drinking milk, or even after taking a morphine powder, while they can eat the coarsest food without any harm. Others run along without presenting any symptoms at all, until they, as well as their physicians, are surprised by the perforation of a gastric ulcer.

All these abnormal cases, which form about one-fifth of all the cases occurring, are so indistinct that they frequently remain unrecognized throughout their entire course, and baffle the skill of the best diagnosticians.

In order to be able to make a sure diagnosis, there must be a localized pain, together with tenderness on pressure from without on the painful spot. A great many persons in good health are tender in the epigastrium, so that you have to be on your guard in this direction, too. From the occurrence of hæmatemesis in an otherwise healthy person you can, with great probability, diagnose ulcer of the stomach.

Differential Diagnosis. In order to differentiate *between catarrh and ulcer*, it is simply necessary to keep in mind the difference in the character of the pain, the fact that local pressure is more liable to aggravate the pain in ulcer than in catarrh, and the occurrence of hemorrhage in « 154 » the former. The two conditions, however, frequently occur in the same patient.

The differentiation between *ulcer and neurosis* has already been discussed. The direct connection of the attacks of pain with the introduction of food, and the character of the pain will soon clear up the matter. Should you still be in doubt, a course of treatment, such as an ulcer would demand, will soon clear up the matter. If the case is one of ulcer, it will have been cured or materially benefited, if it was a pure neurosis the patient will if anything feel worse than before.

By far the most difficult question to decide in making a diagnosis is whether the case is one of *ulcer or cancer* of the stomach. Here close attention to several points will usually clear up the diagnosis. Cancer sufferers always have a sallow complexion, a worn, emaciated, cachectic appearance, no matter what or how much they eat. Ulcer patients frequently have a robust, healthy appearance, and are emaciated or run down only after repeated hemorrhages, or when other grave diseases, such as heart disease, chlorosis, tuberculosis, etc., are also present.

The *presence or absence of a tumor* is a very important aid to the diagnosis, though as I have already stated, not always reliable. Sometimes an ulcer may be covered with granulations, and its surroundings so infiltrated and hardened, that even post-mortem the naked eye can not tell whether it is cancer or simple ulcer, and the question has to be decided by microscope. Such are likely the cases which form the bases of cancer cures which are reported from time to time to have been effected by the use of various remedies.

Vomiting of blood is a symptom common to both cancer and ulcer of the stomach, but is usually more copious in the latter. If the absence of acid in the gastric juice of cancerous stomachs proves to be as reliable a symptom as has been recently asserted, this will be an important feature in the differentiation from ulcer.

You will frequently be astonished by the success of your treatment if you think of ulcer in doubtful cases of stomach trouble, such as occurs in young girls with chlorosis and institute a « 155 » strict milk diet with the measures adopted for the cure of ulcer.

Prognosis. From what has been said you can see that in general the prognosis of ulcer of the stomach is good, that with proper avoidance of all irritation, the ulcer has a tendency to heal of itself. This tendency has been observed even in large ulcers, where death was perhaps the result of some intercurrent disease.

Ulcers of the anterior wall of the stomach are more dangerous than such as occur on the posterior wall, for the reason that in the latter case adhesion with the neighboring structures are more easily formed, and thus fatal perforation prevented. The anterior wall takes a much more active part in the peristaltic movement of the stomach, and as a result does not enter so easily into adhesion with its surroundings. Even after an ulcer has healed it always remains a weak point, and cases of rupture of the stomach in old cicatrices are described by Chiari.

Treatment. The pain is the most important criterion as a guide during the treatment. It is the signal by which I judge of the present condition of the ulcer. According to the variation of its character and intensity, I can judge whether the ulcer is healing, is remaining stationary, or is spreading and increasing in size or depth in spite of the treatment. If the pain has been removed permanently the ulcer has been healed. From the relation of this symptom to different kinds of food you can also judge of a progress or improvement of the ulcer.

Theoretically considered, that form of treatment would seem the best which gives the stomach absolute rest, entire abstinence from food, a fast of several weeks. But this can not be carried out in practice. The patient could be nourished per rectum, you might say, by means of nutrient enemata. In my opinion this method of nourishment does not amount to much. I believe that very little water is absorbed by the rectum, the patient would suffer from thirst and you would then be compelled to allow him to drink water at least.

Luckily we do not need to resort to such extreme measures in the majority of cases. With the exclusive use of the proper bland, liquid food, we usually attain the same results. In the « 156 » treatment of gastric ulcer I lay the main stress on the restriction and regulation of the diet, and put the patient on an exclusive milk diet. Milk contains all the constituents necessary for the nourishment of the human body.

I begin by giving every half hour to one hour a small quantity of skimmed, boiled milk, which has been cooled on ice. The patient must rest in bed or on a lounge, as he is weakened by the treatment, and can not follow his usual avocation. I forbid all other articles of food. With this diet a patient with ulcer should have no pain and usually has none. Should there be pain it is necessary to find out whether the feeling described as such be not simple oppression, or a feeling of weight in the stomach. Some patients do not seem to digest milk well. It ferments, forms gases and then they have this feeling of oppression. Some drink the milk too fast and take too much at a time, swallowing a lot of air with the milk, thus distending their stomachs unnecessarily. The patient must be instructed to drink the milk slowly, and only take a small quantity at a time (about one or two ounces). Some patients can not stand iced milk but bear luke warm milk much better. Others seem to prefer milk which has slightly soured.

The patients should adhere to this strict diet as long as possible, regulating the length of time according to the duration and intensity of the disease. They have to observe the above rules one or two weeks at least, several weeks if possible.

Often you will meet with the reply: "I have already tried this diet, I was put on milk diet once before by Dr. —— and it did not help me any, I even felt worse afterwards." If you inquire more

closely, however, you will find that they drank milk several times a day, but ate bread with it, soaking this in the milk. This is what is understood to be a milk cure. Gentlemen! I am sorry to say that this misunderstanding is not confined to the general public, but that some physicians even do not know better, and consider such a course of diet a milk diet. I cannot impress it upon your minds any too strongly not to allow yourselves to be diverted from your purpose by any such assertions, but to order another course of milk diet, wherever you find it indicated, and see to it that it is carried out properly this time. You will thereby occasionally meet with excellent success « 157 » where a previous wrong attempt in the same direction failed.

After the patient has been free from pain from eight to ten days, I then add to his diet soft boiled eggs with a slight addition of salt, beginning on the first day with one half of an egg. If this is well borne I gradually allow more day by day, until he is able to digest four or five a day without difficulty. Eggs do not agree with some patients. In such cases I pass on the use of meat. I have beefsteak chopped fine, roasted in little meat cakes of the size of a silver half dollar. One of these is given to begin with, and if well borne repeated every two or three hours as long as there is no pain. When eggs agree I prefer to give them for a few days before beginning with the meat, waiting until such patients can digest four or five eggs a day. After the meat has been borne well in small quantities for a while, I gradually increase the quantity taken per day until it reach a pound or two.

You cannot be too careful and should instruct the patient to return to the strict milk diet as soon as any pain is felt, no matter how nicely he may have been getting along up to the time. Not until the patient has been entirely free from pain for several weeks is it advisable to allow the use of cereals boiled in milk, such as rice or tapioca. Then he can also be allowed to take a quarter of a biscuit (well baked) at each meal. A full meal, however, in the sense in which it is ordinarily understood, a large quantity of food taken at one time, is still to be avoided. It is better to give small quantities of food oftener, in order not to distend the stomach, and thus run the danger of too great a strain upon the newly healed ulcer.

These meat cakes made of beef can be taken for a week or so, and then if well borne other kinds of meat may be occasionally substituted.

Wine and alcoholic liquors in general are to be avoided for several months.

Beer should never be taken by one who has suffered from gastric ulcer. In fact it is well for all who have stomach trouble to avoid the use of beer, especially such as have had ulcer. Such patients have to be on their guard in matters of diet through the remainder of their lives, and « 158 » must avoid excesses both in eating and drinking. You will occasionally come across persons who can not stand a milk diet in any form whatever. They frequently do not bear eggs well. In such cases I proceed at once, but with great care, to the use of meat in very small quantities, finally chopped and roasted, and have it taken several times a day. You will frequently have to try one article of food and then another, and experiment for awhile before you reach that form of diet which suits the case best.

There are a number of *substitutes*, some of which are really good, while others are worthless. Of them all I prefer the fresh meat juice *ext. carnis recent. pressum*, and have it prepared in the following manner: The meat (beef should be used) is cut into thin slices, placed between pieces of tissue paper, and pressed in a hydraulic press. The juice thus obtained is given in teaspoon doses every half hour or so, just as though it were medicine. In the majority of cases I have the meat juice made by the druggist, so that a large number of the patients think it is medicine. It has a rather pleasant taste and is well borne by the stomach. There are a great many *peptones* in the market, a large number of which ought not to be used, as they are not fresh and more likely to do harm than good. Of them all the English make is the best, as it is usually well preserved, being packed dry.

Patients who can only take a small quantity of nourishment by the stomach can be materially aided by the use of nutritious enemata given luke warm once or twice a day. When the rectum is very irritable a suppository containing one-half to one grain of ext. opii given a half hour before the enema is very serviceable. There are a great many *other remedies* recommended in the text books, but I would advise you not to rely too much on them. Lay your main stress on the dietetic part of the treatment, and use remedies only where they are absolutely necessary to support this. Among the remedies used the alkalies are the most valuable. Bicarbonate of soda alone, or in combination with ext. belladonna when the stomach is very irritable.

℞ Sod. Bicarb., ʒiss. « 159 »
Ext. Belladon., gr ii. Misce et div. in pulv. XVI.
Sig. One in the morning and one in the evening.

Or I sometimes substitute atropia sulph. (1/120 gr. pro dosi) for the belladonna. At any rate the use of alkalies is the most plausible treatment. But the permanent alkalization of the contents of the stomach by the frequent use of large doses of alkalies, as has been recommended in Paris by Debove is not plausible, as by this the process of digestion would be checked entirely.

It is also good to give a dose of Carlsbad salts in the morning every two or three days, in order to correct the constipation usually attendant upon such a course of diet. These salts also aid in rendering the contents of the stomach more alkaline, and in this way aid the plan spoken of before.

I do not think it advisable to send patients with gastric ulcers to *health resorts* or watering

places. They can only regain their health by a strict enforcement of dietetic measures, and these can be carried out just as well at the patient's home as at the health resort. For the treatment of such cases *after the ulcer* has healed, these health resorts can be of great benefit, but the patient must be cautioned not to commit excesses in eating or drinking, especially to the latter must their attention be called, as it is customary in most resorts adapted to such cases, to drink large quantities of the medicated waters in the morning. It is also well to caution the patients with regard to their diet before sending them away. This should be unirritating, bland and easily digestible. Among the European health resorts, Carlsbad is the most suitable for such cases.

There are unfortunately some patients who are not benefited by any method of treatment hitherto thought of, but luckily they are few, and if you will follow the rules I have laid down you will in a great many cases meet with splendid results.

One important question still remains to be answered, namely: "What should be done in case of hemorrhage of the stomach?" Here the patient must be left quiet just where he happens to be—placed in a horizontal position on his back if possible. Ice bags should be applied to the region of the stomach, small pieces of ice swallowed, and hypodermic injections of ergotin given. This is all « 160 » that can be done with benefit in such cases. The patient should not be transported for several hours. Monsel's solution can be of no service, as it cannot be introduced into the stomach in a sufficient concentration to be of benefit.

In cases of perforation of an ulcer all that can be done is to give anodynes to ease the pain and make the patient's condition as comfortable as possible. Schlipp recommends that when perforation is threatened on account of gaseous distention of the stomach, the stomach tube should be used to evacuate the organ.

The mechanical treatment, washing out the stomach with the stomach tube or stomach pump is contraindicated in cases of ulcer, as more damage can be done by such procedure than good.

ORIGINAL ARTICLES

THE RECOGNITION OF MORTIFIED BOWEL IN OPERATIONS FOR THE RELIEF OF STRANGULATED HERNIA.

By REUBEN A. VANCE, M. D., CLEVELAND, OHIO.

The medical practitioner who has been hastily summoned to operate upon a patient with strangulated hernia finds himself confronted with problems, the gravity of which can alone be appreciated by those who have frequently met them. The medical treatment to be adopted, the extent to which taxis should be employed, and the time it is prudent to delay operative interference when other measures have proved fruitless, are grave questions upon the solution of which the life of the patient depends. The operation decided upon, the particular method to be employed and the manner of dealing with the stricture—with or without opening the sac—are matters of minor consequence, and affairs that should be settled in the mind of every practitioner « 161 » by a reference to sound surgical principles and the teachings of experience. There are questions connected with the condition of the parts strangulated that must be solved by the surgeon during the progress of the operation, about which much less is said in works on surgery than their importance warrants. These pertain to the vitality of the part that has been strangulated, and the duty of the surgeon in the premises. If the part is still living, it matters not how much damaged by compression, it should be returned at once into the abdomen; upon this step the patient's life depends. If the part is mortified and dead, to return it within the cavity of the belly is to insure the patient's destruction; if he is to have a chance for life, other measures must be adopted.

Again, the decision of the operator can but rarely be guided or aided by aught but the conditions revealed by his knife during the operation. The state of the patient and the history of the case may indicate the imminence of mortification of the bowel; in the end the appeal is to the senses of the surgeon, and upon the conclusion at which he then arrives will depend the fate of the patient.

Under these circumstances it behooves every man who may be placed in position to make such a momentous decision to at least go to the task, sustained by every aid that can be derived from the experience of those who themselves have been placed in this dilemma and compelled to act with such lights as they then possessed—whose records, next to personal experience, become the best guide for those forced to follow in their footsteps.

The history of the case may throw some light upon the state of the intestine. This is especially so in those cases in which the severity of the symptoms suddenly subsides without the rupture having been reduced. The pain is violent, the abdomen distended and singultus and stercoracious vomiting present; suddenly the patient's suffering cease, and were it not for the cold extremities, flickering pulse and persistent tumor—but above all, the teachings of experience—the surgeon could not but acknowledge that all tangible appearances portended a change for the better. Yet, « 162 » almost invariably gangrene of the gut has taken place, and the fallacious evidences of improvement above noted are in reality its best clinical exponent. Certain almost as these signs are, when present, yet it comparatively seldom happens that the surgeon has their aid in guiding

him in the measures he must adopt; they form, but infrequently, a part of the history of cases submitted to operation. If present, the surgeon is reasonably sure of what he will find when he operates; they may be absent and mortification yet exist. The patient's chance of life depends upon the surgeon's ability to recognize mortification of the bowel when he sees it, and his promptitude and skill in dealing with it when present.

It scarcely need be said that mere darkening in color of the bowel, effusion of fluid into the sac, or exudation of lymph about the stricture are of no special significance in this connection, and bear in no way upon the presence or absence of mortification. It has been again and again repeated in manuals treating of hernia operations that a deep, purplish discoloration of the bowel and absence of circulation indicate mortification; that when these physical signs are present the surgeon should press upon the strictured part, and if the color remains unchanged when the finger is removed, the bowel is dead. It requires but little practical experience in dealing with these cases to appreciate the fallacious character of these signs; the gut may be fairly black from congestion and yet alive; the color may remain unchanged under pressure and still that fact have no bearing on the question of mortification, for a band of stricture, as yet unappreciated, may be the sole cause of the persistent hyperæmia.

It is quite different as regards certain other signs, especially when two or more of them are seen in conjunction. *If the bowel be dark and mottled with grayish spots, of contracted and shrivelled aspect, with a slight amount of discolored fluid surrounding the gut, and a cadaveric odor apparent when the sac is opened*, mortification is certainly present, and the return of the strictured part within the abdominal cavity dooms the patient to certain death. The surgeon's duty is to open the sphacelated gut, apply a poultice and favor the relief of the obstructed bowel by a free discharge of the intestinal contents through the outlet thus formed. An artificial anus is thus established, and the patient, for a time, must be content with this deformity; fortunately it is a condition susceptible of relief, and the surgeon may ultimately free his patient of even this defect.

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JABORANDI AS A GALACTAGOGUE.

JOHN H. LOWMAN, M. D.

Professor of Materia Medica in the Medical Department of the Western Reserve University.

There is a decided difference of opinion among therapeutics as to the effect of jaborandi on the mammary gland. Some claim that it has no effect upon the gland. Some claim that it assists in increasing the secretion of milk.

This note is made to show the action of jaborandi as a galactagogue in the recent puerperal state. The preparation used was the fluid extract obtained from Squibb & Co.

M. S., age thirty-five years, a multipara, of fair health, not well nourished. The babe was two weeks old at the time of this observation, and in good condition. The secretion of milk by the mother began gradually to fail until not one-third the average quantity was produced. The child was then nourished artificially. The fluid extract of jaborandi was given to the mother. The dose was eight minims every three hours. About fifty minims were taken in twenty-four hours. On the second day of the administration of the drug the milk increased in quantity. By the third day it had increased still more, so that the child had nourishment from the mother sufficient to satisfy it. Increased salivary and cutaneous secretions led to a discontinuance of the drug. The milk flowed in good quantities for eight days, and then rapidly diminished. Jaborandi was again used. The plan of administration was the same. Increase of the milk was again noted. The renewed activity of the mammary glands continued for five or six days only. For a third time the drug was used, and its use followed by good effects. In the meantime the nourishment of the mother had been pushed. Iron, quinine and mineral acids were also given. The general health of the patient improved. After the last increased activity the secretion of the gland remained normal for three weeks, after which the patient passed from observation. During the last two weeks no jaborandi was used.

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Whereas in this case the improved condition of the individual was responsible for the permanent increase in the supply of milk, the use of the jaborandi and the temporary increase were apparently more than coincidental. During the first two stimulations the quality of the milk deteriorated; the quantity of cream diminished; the specific gravity fell; no microscopic examination of the milk was made. After the last increase in the activity of the glands the quality of the milk was good.

Two similar cases were noted. B., aged nineteen years, primipara, had a tedious labor. She recovered slowly. She was well nourished and has previously been well. At the end of the second week of convalescence the milk began to fail. Jaborandi was used as in the case just cited. Marked improvement in the milk was noticed the second day the drug was given. On the fourth day the medicine was omitted. The milk continued to flow in sufficient quantities for ten days. The quantity then gradually and rapidly diminished. The medicine was again given for four days with the desired effect, which remained for the following ten days that the patient was under

observation.

D., age twenty-five years, a multipara, was a poorly nourished person, the mother of two children. The confinement was normal. The milk failed soon after its appearance. Following the use of jaborandi the milk increased rapidly in quantity, but diminished in three days on withdrawing the drug. The milk continued to respond to the jaborandi for the four weeks that the patient was under observation, but no permanent result was obtained.

On three other cases the jaborandi was used with scarcely perceptible effect or no effect at all. From a few cases it is impossible to generalize with expectation of a truthful conclusion. We « 165 » can, however, know that the jaborandi has an effect on the mammary gland, and causes an increase of the milk in puerperal women. This effect is by no means a constant sequel to the administration of the drug. As far as my observation is concerned the effect of jaborandi is temporary, and can be useful only where there is a tendency in the gland to assume its normal function. This tendency may at times be subordinated to general influences and even entirely subdued. In such conditions a timely stimulation of the gland may tide over the threatening arrest of function. Variation in the activity of the mammary gland, especially in the early puerperal state, is not unusual. The close relation of the increase of milk and the use of jaborandi justifies, however, the assumption of effect and cause.

No effect was observed on the children. Jaborandi is excreted by the mammary glands, and it was consequently withheld as soon as practicable, lest the child should feel its presence.

INDICATIONS FOR OPENING THE MASTOID PROCESS.

BY A. R. BAKER, M. D., CLEVELAND, OHIO.

The operation of opening the mastoid process is said by some to have been first performed by Riolan in 1649; according to others, by Petit in 1750, and later by Jasser, in 1776. During the latter part of the eighteenth century the operation was performed frequently without definite pathological indications. But after the unfortunate death of the Danish physician Berger (1791) the operation was very seldom or never performed until 1864, by Mayer, following the suggestions made by Tröltsch some years previous. Berger, for chronic deafness without suppuration of the middle ear, had the operation performed upon himself, and died on the twelfth day from meningitis. During the past twenty years the operation has taken its place as one of the recognized surgical proceedings owing to the work of the German physicians Moos, Jacobi, « 166 » Hartman, Bezold, Schwartz and others, who have laid down the real indications for the operation from their extensive clinical observations and pathological researches. The American otologists, Roosa, Agnew, Buck and others were among the very first to perform the operation, and have done much to establish its claim to recognition. And yet it is somewhat remarkable that some of our text books barely mention the operation; and as short a time ago as 1883, Strawbridge, at the meeting of the American Otological Society, said that he had seen over four thousand cases of purulent middle ear disease within twelve years, and yet had not trephined in a single case; and several other authorities looked upon the operation as a questionable one. Knapp took decided grounds in favor of the operation, and cited three fatal cases in which he believed an operation would have saved life. Kipp had seen quite a number of fatal cases in which the post-mortem had shown the mastoid cells filled with pus, which had given rise to cerebral abscess. Dr. C. H. Burnett reported a fatal case which died from pyemia, and he thought if his patient had been operated a year before his life would have been saved.

Gruening said surgery has established that wherever there is a focus of purulent discharge it should be removed. This, (removal of the focus) is a life-saving operation and should be done under all circumstances. Dr. Roosa said that he believed the revival of this operation of opening the mastoid process has saved many lives. Since his first operation not a year has passed that he has not found it necessary to repeat it several times. He says further that "it is true that we shall seldom need to open the mastoid if an experienced practitioner sees a case of acute aural disease early in its course. It is an operation for neglected cases, where suppuration has been allowed to advance from the tympanic cavity in consequence of not having a free outlet through the drum-head. But purulent inflammation of the mastoid may occur in acute cases that have been thoroughly treated by leeching, poultices, rest, etc., from the start."

The most recently stated indications for opening the mastoid process are:

1. Purulent inflammation in the mastoid process appearing in the course of suppuration of the « 167 » middle ear when persistent severe pain in the bone cannot be subdued by the application of the ice-bag, leeches, or by Wilds' incision. (Schwartz).

2. Painful inflammation in the mastoid process occurring in acute and chronic suppuration of the middle ear, in consequence of growths filling up the external meatus or the tympanic cavity. When attempts to remove the obstacle to the free escape of pus have failed, the operation is imperative. (Grüning). The operation is indicated even though the soft parts over the mastoid are not swollen or infiltrated. (Politzer).

3. When the posterior superior wall of the meatus is bulging, and when after incision the abscess is not emptied and the symptoms of retention of pus continue. (Toynbee, Duplay).

4. Persistent pain and tenderness in the mastoid process lasting for days or weeks, in which there is probably an osseous abscess not communicating with the tympanic cavity. (Politzer).

5. In every suppuration of the middle ear combined with inflammation of the mastoid process in which fever, vertigo and headache are developed during the course of the affection, which may indicate a dangerous complication. In such cases the indication for the operation is vital. (Politzer, Roosa, Buck.)

As to the time when the operation should be performed, writers do not agree. While one proposes that the operation should be done as soon as there are symptoms of inflammation of the mastoid process, another defers it till the dangerous symptoms (fever, headache, vertigo, etc.,) set in. The latter proposal must not be followed, as in many cases it would be too late; on the other hand, many cases will recover without an operation. As far as it can be formulated, I would say that in a given case of acute purulent inflammation of the mastoid process I would first apply leeches, poultices, cathartics, antiflogistics. If the inflammation is not promptly subdued, I would make a Wilds' incision, including the periosteum, if the bone is found softened; or if a fistulous opening is found, this should be enlarged at once. If the bone is found healthy and not roughened, if there is no fever, vertigo, headache, etc., I would wait a few days; if the symptoms, « 168 »
pain, tenderness, etc., do not subside, I would then perforate the mastoid process.

For the performance of the operation trepans were formerly used, which were replaced by drills which are still used by Buck, Jacobi, Lucae and others, but by most operators they have been set aside, owing to their uncertain and dangerous advance in the deep parts, and on account of their soiling the wound with splinters. The most rational and safe method is by means of the chisel, as recommended by Schwartz, and is performed as follows: The patient being anæsthetized, a perpendicular incision beginning a little above the linea temporalis, extending an inch and a half in length immediately behind the attachment of the auricle. Formerly I employed a straight incision, but recently have followed the suggestion of Politzer, and from the superior end of the perpendicular incision a second one is made backward at right angles, thus forming a flap, which I have found to simplify the operation very much, as it affords a better view of the locality and extent of any pathological changes which may have taken place, and gives more room for operative procedures, and the periosteum can readily be removed to any desired extent. The linea temporalis and the more or less strongly developed protuberance on the posterior superior orifice of the osseous meatus, so strongly urged by authors, are very nice guides theoretically or to point out on an exceptional skull in the class room, but practically are seldom well enough developed to be of any use to the operator. The best guide to go by is to take the superior wall of the meatus as the upper boundary, and the angle formed by the plane of the mastoid with the posterior wall of the external meatus for the anterior boundary when opening the mastoid. This is best determined by pressing the finger into the meatus. Often in children, and when the bone is diseased in adults, the cortical plate of bone can be removed with the hand chisel, and we come at once upon the pus cavity, or diploe, or cholesteatomatous epidermic masses, or a sequestrum of dead bone, or bleeding granulation tissue, or whatever the case may present. Sometimes the external plate is very thick and we have to chisel our way carefully for almost half an inch before reaching the diploe, or may find the entire mastoid process sclerossed. « 169 »
No absolute rule can be given as to the depth it is safe to penetrate. Schwartz says "never to go deeper than 25 mm." Buck says "it is better to place the extreme limit at 20 mm," about three-fourths of an inch.

Although I do not consider the operation a particularly dangerous one, especially with the chisel where we can watch each step of the operation; and even though we opened into the lateral sinus or the duramater, the injury would not be necessarily fatal. Yet I would not advise any one to attempt it (unless the indications are imperative) who has not performed the operation on the dead subject. Politzer says "no one should operate on the living before having performed the operation at least forty or fifty times on the dead." I cannot close this article better than in the words of Dr. St. John Roosa, to whose admirable work I am indebted for a large portion of this article.

"Yet, hesitation, when the way is plain, or when the chances are largely on the side of the necessity of the removal of pus, cannot be too sternly condemned. No drug has yet been discovered which can be substituted for the scalpel or trephine when pus has actually formed in the mastoid cells. I wish, however, to repeat what I have said before on the subject of surgical operations. I am in full accord with the great English surgeon, Sir James Paget, who, in his admirable lectures, expresses many times his hesitation to perform any surgical operation, however trivial, that is not absolutely required. We have no right, I think, to perform operations to clear up doubtful diagnosis. If in case the operation proves to have been unnecessary, the patient will be decidedly the worse for it. If we put ourselves in the place of our patients, what we may regard as a trifling thing—"a mere cut"—will not be so esteemed. A mere cut, when unnecessary, may have the most serious consequences, and all the history and symptoms should be carefully weighed before even that is undertaken. Such care will never prevent prompt, rapid and thorough surgical interference when demanded.

In teaching medical students, I have always found them, when fully awakened to the dangers of neglecting certain diseases, to be more apt to do too much than too little, especially with the « 170 »
knife and active drugs. It is possible, also, that the crying ignorance and neglect of the previous decades in regard to the treatment of aural disease has had a tendency to cause us, who see many of the afflictions of the ear, to lean toward the side of surgical operations upon the drum, head and mastoid. This is a leaning no less dangerous to the cure of some cases than was the

steering toward Scylla or Charybdis to the safe navigation of ancient mariners."

A CASE OF ANOMALOUS DEVELOPMENT OF THE ANTERIOR PILLARS OF THE SOFT PALATE.

BY B. L. MILLIKIN, M. D.,

Oculist and Aurist to Charity Hospital, Cleveland, O.

Some time since, Mrs. G. D., age about 23, applied to me on account of deafness and tinnitus of both ears. In pursuing my examination I found the following unusual anatomical relations of the anterior pillars of the soft palate, which I deem not unworthy of record.

The uvula and posterior border of the soft palate are normal in appearance and formation; but, beginning about the middle of the anterior pillars, these gradually widen out into thick, heavy, broad, muscular folds, which attach themselves firmly to the sides and dorsum of the tongue, extending two or three lines upon the dorsum. They seem to be intimately connected with the muscle of the tongue itself, making them very firm. The posterior pillars are much less well developed than the anterior, and do not control or prevent the drawing forward of the soft palate when the tongue is protruded. The tonsils are small in size but normally located.

The attachments of these bands give a peculiar appearance to the throat. When the tongue is in a state of rest, in the bottom of the mouth, or, better still, when the tongue is depressed, these bands hang like two large curtains, narrowing very much the faucial opening. When the tongue is « 171 » protruded they are put upon the stretch, and narrow very greatly the faucial opening by drawing forward and downward the whole of the soft palate, so that the posterior border of the soft palate and uvula rest firmly upon the dorsum of the tongue. When the tongue is thus protruded the attachments of these membranes are brought forward almost to the teeth.

In a state of relaxation there is formed back of these folds, on either side, quite a deep cavity, which often collects quantities of solid food, to the great annoyance of the patient. She even sometimes is obliged to remove these obstructions with the fingers, or, by gulping or swallowing frequently, is able to dislodge them. She has no difficulty in swallowing liquids.

There is some impediment in her speech, a peculiar lisping as if she did not have good control of her tongue, which she has always attributed to the fact that she is of German parentage. Her English is, however, very good, other than as above indicated.

In looking up what anatomical literature is at my command, I find no reference to any anomalies of this kind, although I have been able to consult the standard French, German and English works on general anatomy. I myself have never seen a case with an anatomical construction approaching this, so I, therefore, present it for record.

HINTS ON VOCAL TRAINING—THE BREATH.

By BERNARD W. FISHER, A. M.

The prevalence of throat troubles is so marked in America, and by no means least so in this city, that if one hundred individuals, collected at random, had their throats examined, it is probable that four out of every five would be found to have these delicate organs more or less affected. Whatever cause may be assigned by the medical expert in each particular case, the importance of a thorough mastery of the art of correct breathing can hardly be insisted upon too « 172 » strongly. If it be urged that the widely distributed works of Behnke and others must have put an end to any general ignorance of the importance of this branch of vocal training, I can only reply that a defective style of breathing is by no means uncommon even in public singers, while among amateurs it is so rare that a perfect management of the breath excites in a critical observer a feeling of gratified surprise. The name and works of Behnke have, of course, been known in this country for a considerable time, but some of his statements are too striking to be omitted in an article on this subject. When lecturing at the Tonic Sol-fa College, London, he took ten students and measured their lung capacity in cubic inches, by means of the spirometer, with wrong or "collar-bone" breathing. He then showed them how to breathe correctly, that is, midriff and rib breathing. The average increase among the ten was twenty-five cubic inches of air; the least increase twelve inches, and the greatest forty-five. He adds: "I imagine that these figures are more eloquent than any words, and I think it superfluous to make any further comment on them."—('Mechanism of the Human Voice,' page 20.) Now, putting aside the extreme increase of forty-five inches, let anyone consider what an increase in lung capacity of twenty-five cubic inches of air must mean to the vocalist in the execution of difficult passages, to the speaker using his voice by the hour, and, lastly, to the running athlete. It will surprise a young man commencing vocal training to inform him that, at the same time, he will become a better man in the gymnasium and the race; but unless good lungs are an advantage to the athlete in name only, the above figures tell their own tale. I may add that, in teaching young men and boys, I always

put this view of the subject before them, knowing that it will be an incentive to their acquiring a thorough mastery over the interesting art of "taking breath."

Correct breathing cannot *cure* disease. The medical expert must do that. But it will *prevent* disease; and when the throat, under proper treatment, has been brought to a healthy state, it will assuredly be the chief means of keeping it in that condition. The following is a striking instance to the same effect:

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Some years since, an English clergyman had to give up all ministerial duty from "Clerical Sore Throat." Acting under the absurd advice of a London teacher of elocution, he resided in Spain for five years without the slightest benefit. He then returned, and at the house of the elocutionist who had made him an exile saw a copy of Behnke's celebrated work. Coming to the conclusion that the author must be rather clever, he at once consulted him. Following his advice he had his throat made medically sound by Lennox Browne, and then took the usual course in breathing and voice production under Behnke. A short time after I was with Herr Behnke, when a post card arrived from the clergyman: "I preached yesterday in Chichester cathedral, and was congratulated on the strength of my voice and the ease with which I filled the building."

A few weeks since I heard a sermon in a Cleveland church. The preacher took short "collar-bone" breathings, using twice the power necessary for the building, and towards the conclusion was in evident distress (which naturally communicated itself to his hearers), a failing voice and perspiring face. If before entering the ministry he had learned to breathe and use his voice properly, such troubles could never have existed.

There is yet another unpleasant affliction which correct breathing will rarely fail to cure, a high-pitched and effeminate voice in a man. I quote again a case from the same work:

Mr. M——, a tall, thin young man, engaged in evangelistic work, suffered from "weakness of voice." He spoke chiefly in a "child voice," over which he had very little control. His breathing power increased by sixty cubic inches in two lessons. "In one week more," adds Herr Behnke, "I could dismiss him with a full, sonorous man's voice in place of the uncertain child's squeak with which he had come to me."

I must lastly point out that the cure of stammering often entirely depends on the management of the breath, and in all cases it must be an important agent.

The limits of this paper allow but a brief notice of the best course for a breathing instructor to follow. Let the pupil lie down on his back, place the hand lightly on the lower part of the lungs, and tell him to inhale easily through the nostrils, allowing the air to fill the lower part of the lungs, avoiding all motion of the shoulders and heaving up of the chest. When the lungs are fully inflated count four with deliberation, and let the pupil inhale all the air as suddenly as possible. Gradually increase the counting week by week up to twelve, which marks a real control over the unused muscles. The next course is for the pupil to inhale suddenly and exhale slowly. The instruction given is of necessity meagre, but it need hardly be pointed out, no written directions can take the place of personal teaching. From four to six weeks is usually sufficient for the young and vigorous to gain command over the breathing apparatus; older pupils have sometimes great difficulty in mastering the muscles, unruly through disuse.

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Herr Behnke allows no use of the voice beyond ordinary speaking while the breathing exercises are going on. I have followed this rule much modified, and do not find the results unsatisfactory.

The total neglect of this important subject in both American and English schools is to me perfectly astounding. Half an hour a week for three months would be ample for the purpose. These few hours would confer a benefit of the highest value, and lasting a lifetime.

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The Cleveland Medical Gazette.

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A. R. BAKER, M. D., *Editor*. S. W. KELLEY, M. D., *Associate Editor*.

EDITORIAL.

We have mailed the GAZETTE regularly to a number of our friends who have not remitted their dollar. We hope they will do so soon.

MEDICAL DEFENSE ASSOCIATION.

Last month we urged the necessity of the profession organizing a medical defense association. We publish this month the proceedings of the Chicago Medical Society, in which the same question is discussed very fully.

STATE SOCIETY REORGANIZATION.

The editor of the Cincinnati Medical Journal asks the secretaries of local societies to bring the matter before their respective organizations, and suggests that they invite expression upon the following propositions:

1. To so change the constitution of the State Society as to make the members of county societies members of the State Society simply by virtue of their local membership. « 176 »

2. Present members of the State Society to remain members without reference to membership in local societies.

3. All members to stand upon an equal footing, thus doing away with the delegate system.

4. All papers to be presented to the State Society must first be presented to the local society, by which it may be referred to the State Society.

MEDICAL PRACTICE BILL.

A bill to establish a medical board of examiners and licenses, and to regulate the practice of medicine and surgery in the State of Ohio, and to define the duties and powers of such board, will be presented to the Legislature of Ohio. It provides for:

1. A mixed board so far as schools are concerned.

2. No attache of a medical college is eligible to a place on the board.

3. All candidates for the practice of medicine in Ohio shall submit to an examination by this board.

4. None but graduates in medicine and surgery shall be eligible to examination.

5. Licenses may be refused or revoked for criminal or dishonorable conduct.

6. Graduates at present practicing in the State may continue without submitting to an examination, but must register in the office of the probate judge.

These are the essential features of the bill, and on the whole good. It does not interfere with physicians already in practice, which has caused the failure of nearly every bill presented to the Ohio Legislature becoming a law. Excluding college professors from becoming members of the board is fair to the profession, and saves the bill from being the tool of the medical colleges, unlike the Pennsylvania law, and yet it does not ignore the medical schools entirely as « 177 » educational and graduating bodies, like the Illinois and West Virginia laws. It is impracticable, even if desirable, to ignore denominational lines in medical legislation.

PHYSICAL EXAMINATION OF YOUNG GIRLS.

The following remarks were made by the president of the Royal College of Physicians, December 28, and were the result of an inquiry into the conduct of Dr. Haywood Smith, by the college, for having physically examined the girl, Eliza Armstrong, without the consent of parent or guardian:

"It is, in the opinion of this college, a grave professional and moral offence for any physician to examine physically a young girl, *even* at the request of a parent, without having first satisfied himself that some decided medical good is likely to accrue to the patient from the examination, and, also, without having first explained to the parent or legal guardian of the girl the advisability of such examination in general and the special objections that exist to their being made. Moreover, the college feels that a young girl should on no consideration be examined, excepting in the presence of a matron of mature age, and, so far as the physician knows, of good moral character...." The rest of the remarks were put direct to Dr. Smith, and are of no general interest.

The decision of the college was favorable to Dr. Smith; his name was *not* erased from the roll.

SUET BANDAGES.

"These are admirable for dressing. You can make them by melting mutton tallow over a slow fire. Have your bandages of close cloth, ready cut the proper length and breadth, dip them into the suet; when saturated, hold them so as to let them drip off, or the grease may be spread upon the cloth. Hang them over a line where they may be protected from dust; let them cool, fold them, put away for use. These bandages are especially adapted to dress old ulcers and wounds. « 178 »
They are smooth and adapt themselves perfectly to the surface; are agreeable to the patient, and can be medicated with any therapeutical agent you wish."—*American Medical Digest*, quoting Dr. Edwin Brock in *New England Medical Monthly*.

A disadvantage of the tallow bandage is its becoming rancid. Vaseline, not becoming rancid, has been tried, but melts too easily. For most purposes the wax bandage is as good as the tallow, perfectly smooth and does not become rancid, but cannot very well be medicated. A useful material for a bandage of this kind is the paraffine, as recommended by Tait.

The tallow bandage can be put to another use by those who do not live convenient to an instrument dealer. When made wide the tallow bandage can be rolled into a very good rectal bougie, large or smaller as you wish by a few more or less thicknesses of the cloth. By the same means a very good vaginal dilator can be extemporized for cases of stricture or vaginismus. But where it is to remain long *in situ* for these cases beeswax or a mixture of beeswax and tallow, which are generally available in the country, make a better substitute. "Cere cloth" was formerly much used by gynecologists.

We observe that Dr. Piffard has retired from his editorial connection with the Journal of Cutaneous and Venereal Diseases. The Journal will be continued under the sole editorial charge of Dr. P. A. Morrow. We may remind our readers that this is the only publication in the English language devoted to Skin and Venereal Diseases, and during the three years of its existence it has won for itself a high reputation for scientific excellence as well as practical utility. In addition to presenting all that is new and valuable in these special departments, the colored lithographs and wood engravings with which the original articles are illustrated are worth more than the price of subscriptions. Judging from the handsome appearance of the January number, which is enriched by an admirable chromo-lithograph and a number of well-executed woodcuts, and the eminently practical character of its contents, this high standard will be maintained in the future.

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SOCIETY PROCEEDINGS.

CHICAGO MEDICAL SOCIETY.

OFFICIAL REPORT.

Stated Meeting, January 18th, 1886.

PRESIDENT PRO. TEM., D. W. GRAHAM, M. D., IN THE CHAIR.

Dr. E. J. Doering read a paper entitled

MUTUAL PROTECTION AGAINST BLACKMAIL.

The author stated that among the many trials which physicians have to encounter in the practice of their profession is the ever-existing liability of being blackmailed. This may either assume the more frequent form of a so-called malpractice suit, or the relatively less frequent charge of a criminal assault, according to the viciousness of the complainant. Such suits against physicians are increasing. One reason quoted was the fact that every city is overrun with petty lawyers, who have little or nothing to do, and are always willing to encourage any suit whatever, if there be the least prospect of getting something out of the defendant. The author stated that since investigating the matter he became convinced that many of these blackmail schemes were settled before being made public. Many a physician preferred being robbed of one or two hundred dollars, rather than incur the publicity, the loss of time and the endless expense of a lawsuit. Again, the average jury, composed of the ignorant and illiterate, will always have a strong leaning toward the complainant and against the defendant in a malpractice suit, as physicians are popularly supposed to be capitalists. The author stated that personally he had never been sued or even threatened with a suit, and it was therefore from no motive of selfish interest, but from a sincere regard for the welfare of the profession, that he advocated the formation of an association for the mutual protection of physicians against blackmailing suits of all kinds. His plan is to organize a society composed of two or three hundred members of the « 180 »
regular profession, all of whom shall be of acknowledged ability, possessing a good moral character and standing in the community. Said association to employ the best legal talent attainable, by the year, to furnish the members such legal advice as they may desire at any time and defend any suit against the members arising in the discharge of their professional duties. It was stated that the expense to each member of an association composed of about two hundred would not exceed five dollars per annum, and that an initiation fee of five dollars would create a

sufficient fund for court expenses. Such an association would be a power in preventing suits. Let it be known that the individual physician is backed by the financial and moral support of a few hundred of the best physicians, and aided by the best legal talent obtainable, and he will be let severely alone by the offscouring and dregs of society who constitute, almost without exception, the blackmailing element in our professional life. The author stated that he was not aware of the existence of such an association as the one proposed in any other city, but the principle at least has been carried out recently by the New York County Medical Society, in voting $500 to assist in the defense of the Drs. Purdy, members of the Society, in the case of Brown *vs.* Purdy. After reading a number of letters from prominent physicians in favor of forming a protective association, and presenting several legal opinions sustaining the advisability, practicability and legal status of such a society, the author concluded by stating his firm belief that such an association for mutual protection was needed, that it would be a power for good, that it would draw the profession closer together, that, in short, it would be based on the principles of a common brotherhood, viz.: equality, harmony, justice and unity.

Dr. F. C. Hotz said that the extract of his letter to Dr. Doering, which was incorporated in the paper, indicated that at the time it was written he did not think favorably of the project. And, after listening with much interest to the doctor's arguments, he saw no reason for changing his opinion. Professional reputation and honor is the most personal of all personal property; if he lost « 181 » it, it does not hurt anybody but himself, and therefore if any attack be made on it he should certainly wish to employ among the able lawyers the one in whose ability he had the greatest confidence. But he was not sure whether the lawyer retained by this protective union would be the one to whom he should like to trust the defense of his reputation. The attorney might be able, or abler, than the lawyer of his own choice; but should the case go against him, he should never feel satisfied that the lawyer had done all that could be done for him unless he had full confidence in him. It is with the lawyer as with the physician, a question of confidence, and his patrons find no fault with his treatment as long as they have implicit faith in his ability.

An objection of greater weight, however, has been urged by several of the doctor's correspondents in asking what possible effect it might have if the fact was brought out in court that the defendant belonged to such a union? The lawyers whose opinions were obtained and read by the doctor, say it cannot legally affect the case. There is no doubt but what this is true. But the verdict of a jury in malpractice suits is not determined by the legal aspect of the case; and circumstances which cannot have any legal effect upon the case have often made a deep impression upon a jury and decided the case against the physician. To illustrate: In Dr. Bettman's first trial, the experts of the prosecution testified so unreservedly in the doctor's favor that had the case been submitted to the jury without arguments, the doctor would have been acquitted at once. To fortify his cause Dr. Bettman's lawyer called a number of experts, whose testimony was of course only cumulative. Now what did the prosecuting lawyer do? Did he make an effort to break down the expert evidence by scientific arguments? No, sir; but he wiped out its effect upon the jury by the mere waving of his hand, speaking thus: "The defense has piled up a mountain of expert evidence. But, gentlemen of the jury, what does it all amount to? These doctors are working together in the same hospital. Don't you see they have a common interest to sustain each other, because every one of them may be in the same fix some day? Don't you know they are clannish? They wont admit that one of them can make a mistake. O, no!" One could fairly see the « 182 » impression this harangue made upon the jury, and they rendered a verdict against the doctor, though it is certain the lawyers will say the fact of his being associated with the experts in the same hospital should and could legally not prejudice the jury. But it evidently did, all the same. And after such experience, can you for one moment believe it would not damage the physician's cause if he and his experts belonged to a society formed for the express purpose of mutual assistance in malpractice suits. A mighty poor lawyer he would be who could not make a great deal out of it before a jury.

Very interesting was that part of the paper in which the doctor evolved his idea how his new society could prevent, ward off, malpractice suits. He believes the shysters would not be so eager to engage in this business if they knew they had to fight a corporation with plenty of means to employ the best legal talent. Why this should discourage those fellows it is hard to understand. They do not sue poverty-stricken doctors. Whom they select for their victims they suppose to be rich, and consequently able to employ a good lawyer. They do not expect to have all easy game, but why should they not try it? They don't risk anything by it. The blackmailer's stake is only two dollars and a half for filing his application, and his lawyer's stake is his time, which is not worth much anyhow. So you see they have nothing to lose, but much to gain. What difference should it make to them whether the opposing counsel is engaged by one physician or by one hundred? If you wish to devise means by which this blackmailing nuisance can be stopped, or at least reduced to a minimum, you must try to get to the roots of the evil; that is, you must find the causes which usually bring it forth. And you will not go far to find them, for you find them right at your door, in your own profession, in the shape of *indiscriminate dispensation of gratuitous services and of unkind remarks of one physician about another*. Physicians are altogether too quick to give their services gratis to almost any body at any time. But you know very well people do not value very much what they can get for the mere asking; they do not think much of what « 183 » they get for nothing. And it is also a widespread notion (especially among the lower educated people) that the quality of service is regulated by the amount of money they pay for it; that the treatment at a free dispensary, because gratuitous, is not the same, not as good as at a physician's office where they have to pay for it. These people cannot persuade themselves that a physician will take the same interest in a case whether or not he is paid for his services. The poor, therefore, are always suspicious that they do not get their full share of attention. They are

quickly ready to charge their physician with carelessness if the case goes wrong. And with a patient in this frame of mind, it takes but very little encouragement to begin a suit for damages. And in nine out of ten cases, doubtless, this encouragement is furnished by the members of our own profession. He did not mean to charge physicians with purposely, wilfully, instigating a lawsuit against a brother. Though this has been done, such extraordinary baseness is a rare exception.

What Dr. Hotz had reference to is the inconsiderate careless, thoughtless habit of expressing an opinion about a case, or a colleague. To illustrate: A physician at a dispensary shows a bad case to professional friends, and without thinking of the possible evil consequences, makes in the presence of the patient some remark like this: "Well, perhaps I ought to have done this or that." The patient, already laboring under the impression that he was not fairly treated because he could not pay, sees in the doctor's remark the strongest confirmation of his suspicion, goes to a shyster and begins a suit for damages. And doubtless, in a similar way the mind of a patient is often poisoned and set against his physician by a careless or unkind remark of another physician. So many physicians are always ready to express their opinion about their colleagues in the presence of anybody, or to criticise their professional acts upon the information received from a patient or some old woman. Now you all know how these people misconstrue the words of a doctor; how they pervert the facts inadvertently. You must admit you cannot rely on what patients tell you, and you cannot form an opinion that is worth anything of a case you have not « 184 » seen or been informed about by the attending physician. Why, then, don't you say so when somebody asks you what you think about the case of Dr. H.? Or if you know the physician, say he is competent to attend to his own business; if you don't know him, change the subject. But at all events, unless he be a notorious quack, refrain from uttering any words which even only insinuate the possibility of a mistake or want of skill of your colleague.

Stop running each other down; stand by each other; sustain each other, "stick together and be clannish;" let it be understood in public that no reputable physician will prostitute himself by going to court as expert for a blackmailer. If all the reputable physicians of this city adopt and act on this principle, blackmailing the medical profession would soon be a thing of the past, and malpractice suits more effectually prevented than by the organization of a protective union.

Dr. P. S. Hayes said that, from his costly experience in a malpractice suit, he felt that an association such as suggested by Dr. Doering would be of great service. The lawyer employed by such an association would speedily acquire such a fund of medical knowledge that he would be considered an expert in malpractice cases. He would not require an amount of coaching necessary to prepare for any given case, as would be requisite in the case of a lawyer who had no experience in such cases. His opportunity for obtaining information in a given case would be largely extended, for each member of the association to whom he might apply would be interested in giving him the desired knowledge. He would soon become acquainted with medical witnesses and know which would give the best testimony in any case.

An association of the character suggested by the paper might be a means of educating its members in regard to laws bearing on the rights of physicians and their patients, now not generally understood. For one he is heartily in favor of such an association, and should give it his hearty support.

Dr. G. C. Paoli said Dr. Doering's paper is not only a valuable one, but contains such a high, noble, charitable feeling that the Society ought to be grateful to him. He wondered that such « 185 » steps had not been taken before, because so many of our professional brethren have not only suffered annoyance, but pecuniary loss as well. How can we expect, from an ignorant jury, a decision based on scientific knowledge and justice?

Dr. F. M. Weller said that the subject of the paper was worthy of consideration; that the discussion of the formation of an association with an object so widely different from the Medical Society seemed out of place; the one essentially scientific, the other in the nature of an insurance. The right to form such an organization was unquestioned; the policy should be considered by each individual. That while any one might be made the object of blackmail, he believed that charges of malpractice more frequently arose from the ignorance of physicians of the statutes affecting the practice of medicine, especially those of the criminal code, and of the rulings of the courts in cases.

PROCEEDINGS OF THE CUYAHOGA COUNTY MEDICAL SOCIETY, NOVEMBER 5, 1885.

[Reported for the Gazette by L. B. Tuckerman, M. D., Cor. Sec.]

COMPULSORY VACCINATION.

Dr. Himes presiding.

Dr. Hart said that thirty years ago, in a country region of western Pennsylvania, he met an epidemic of smallpox. Over thirty years earlier, under a State law, the whole community had been vaccinated. Out of about fifty persons exposed to the disease the most were adults who had been

vaccinated at the time referred to, or earlier. Referring to an article on the epidemic prepared at the time, he finds that fully half had the disease in some form, from the mildest varioloid to confluent smallpox, one case of secondary smallpox occurring. While he believed that fifty per cent. of those vaccinated in infancy are protected for a lifetime, still he regards the presence of the most distinct cicatrix as no criterion by which to determine who are thus secure. From twelve to twenty years of age, probably, fully one-half will have a more or less perfect result from « 186 »
revaccination, and will in most cases be thenceforth protected from all ordinary exposure to smallpox. But in the presence of the varilous atmosphere of an epidemic of the disease, revaccination is the only absolute safety. He has always revaccinated himself as often as exposed, and advised the same course for others. While smallpox prevailed here, say from 1865 to 1873, where patients were not removed to a pest house, and the only precaution enforced was the notice on the house, he attended a considerable number of cases. He always insisted on vaccinating every exposed person, and although there were often unvaccinated children and adults who had a thorough effect from revaccination, he never had a second crop of calls in the same house.

He referred to the complete revaccination of the Forty-first Regiment, O. V. I., before going South. Many of the men with a fair cicatrix had a perfect revaccination, while two hundred or three hundred had more or less result. Humanized virus was used. During their term of service, while repeatedly exposed to smallpox, and where other regiments about them suffered severely from the disease, they entirely escaped. This immunity could only be referred to their revaccination, and certainly affords the strongest proof of its prophylactic power.

While frequent renewals of the humanized virus is desirable, he regarded it, when selected with the care which ought to be observed, as milder in its effects and much more certain than cowpox. In vaccinating with cowpox he has had severe effects follow much more frequently than when he made use of the humanized virus.

Dr. Dutton did not believe that the profession should insist on compulsory revaccination, at least until it was proven that revaccination was absolutely necessary. A second vaccination often produces a serious inflammatory sore, quite unlike the true vaccine pustule, and an ulcer sometimes follows.

Dr. Preston stated that, as he had observed, a large percentage of those who were not revaccinated were liable to have varioloid.

Dr. Scott stated that we must either vaccinate or inoculate. He was vaccinated by his mother « 187 »
fifty years ago, and was protected yet. He had been revaccinated many times without effect. He regarded the humanized scab the best. He believed that the proportion that take again is less than Dr. Hart is inclined to suppose. Every community has a right to compel vaccination, and the question here is not of revaccination. Bovine virus removes the danger of the communication of syphilis, but the cultivation of the virus should be under State control. Much of the trouble had come from scabs or points from pustules where the lymph had been drawn off and the pustules allowed to refill. A refilled pustule can communicate almost anything.

Dr. Smith said he had seen some of the worst arms he ever saw from revaccination. He would rather have a mild case of varioloid than such a case. It is not certain that a second sore is evidence that the patient will not have varioloid.

Dr. Corlett stated that in the London Smallpox Hospital they had for twenty years made it a rule to vaccinate every attendant, and for twenty years there had been no case of smallpox among the attendants. There is more attention paid to instruction in vaccination there than here. Each student must go at least six times to one of the dozen government stations and receive instruction. Vaccination is done from arm to arm. As soon as the vesicle is formed, and before pustulation, a capillary tube is inserted and a portion of the lymph withdrawn. They do not believe that there is danger of scrofula or syphilis if there be no admixture of blood cells, either white or red, with the lymph. He believes that the cases of eczema and scrofula so often attributed to vaccination are really due to a dyscrasia of the patient.

Dr. Millikin inquired how long the lymph retained its activity after being withdrawn into the capillary tube. Dr. Corlett stated that it could be used for six weeks or two months.

Dr. Vance stated that the Germans of Cincinnati, irrespective of creed, preferred inoculation to vaccination. Hence there was always smallpox in Cincinnati. In spite of the stringent laws against it, inoculation was systematically carried on. The parent would take the infant to a neighboring hillside and leave it with a dollar-bill beside it, and go away. In a few minutes he would return, « 188 »
the dollar-bill would be gone, and the child was inoculated. The law against it cannot be enforced.

CORRESPONDENCE.

NEW YORK LETTER.

THE USES OF COCAINE IN SURGERY.

It is not the object of this communication to speak of the discovery of this drug and the

experiments which were necessary to bring it before the profession as a reliable and trustworthy agent. That cocaine is a valuable addition to the armamentarium of the surgeon, I think no one will doubt, but how beneficial, I think but few fully realize.

Cocaine is constantly growing in favor with the surgeons here in New York. New fields of usefulness are opening, and in nearly all of the minor and many of the major operations it is taking the place of ether and chloroform. These older anæsthetics, although so useful, were accompanied by danger, and many deaths are attributed to their use, while so far, I know of no well authenticated case where death or serious symptoms have resulted from the use of this new anæsthetic. Its first use was restricted almost exclusively to the eye and mucous membrane, but the hypodermic syringe has made it as useful to the general surgeon as to the oculist.

There is not a day passes but that we see operations of more or less magnitude performed under its influence at some of the clinics or hospitals of New York. Circumcision, hemmorrhoids, fistula in ano, felon, ingrowing toe-nails, hydrocele, cutting for foreign bodies, removal of small tumors, etc., are some of the operations for which we very seldom see an anæsthetic given.

At St. Luke's hospital an operation for ventral hernia was performed by the use of cocaine alone, where it was necessary to open the abdominal cavity for three inches and reach into the « 189 »
abdomen with the fingers to draw up the peritoneum, and all done with perfect success. Amputations of the fingers and toes are not uncommon, and amputation of the leg and fore-arm have been successfully performed by its use.

External and internal urethrotomy and cleft palate are usually performed by its aid. I have seen large stones removed from the urethra in this way without any expression of pain from the patient, he talking with the surgeon about the case while it was in progress.

Dr. Corning, of New York, has devised a method by which the local effect of the drug may be indefinitely prolonged. His theory was that the drug was washed from the tissues of the blood and its effects thus lost. To prevent this he applies elastic ligatures around the part, between the injection and the heart, about two or three minutes after the injection is made. When the injection is on the body or face where the ligature can not be used, he uses large rings to surround the part, so arranged that firm pressure can be made upon them, and thus cut off the active circulation. He claims for this that a weaker solution can be used and the effects continued for a much longer time.

The mode of proceeding is usually to inject from ten to fifty drops of a 4 per cent. solution around the part to be operated upon, using an ordinary hypodermic syringe. From three to five drops of this solution are injected at short intervals in a zone surrounding the part to be operated; or a larger quantity is injected near the body of the nerve supplying the part. If this is reached the anæsthesis is complete. In two or three minutes the knife can be freely used, and the patient feels no pain, although they look at the knife as it divides the tissues. In the throat clinic a solution of cocaine is used with an atomizer to allay the irritability of sensitive parts, that a more thorough examination may be made. At the eye clinic cocaine is used as a mydriatic, atropia being seldom used for the purpose of examinations.

Patients usually dread the action of an anæsthetic; the nausea, headache, and lassitude following its administration are things not pleasant to contemplate, but with this new drug none « 190 »
of these are encountered.

The conclusions are, then, from our present experience, that cocaine is a pleasant, safe and efficient local anæsthetic.

O. T. Maynard.

BALTIMORE LETTER.

At the last meeting of one of the city medical societies one of the members reported a case of typhoid fever in which the pulse had remained quite low for over a week. Several questions were asked concerning the *normal* pulse of the man. The doctor insisted that he knew the normal pulse was higher, as he had examined it many times in health. This was strange and so many members plied the doctor with questions that he finally confessed that the young man was a member of the family when he (the doctor) was courting his (the doctor's, not the patient's) wife. Of course the entire society understood at once that the doctor felt the pulse of the entire family during this love-sickness. There are many ways of courting—Josh Billings had a very good way. Some fellows buy the old gentleman a cane (very appropriate and often *useful*); the small brother a box of candy, so that he will vacate the parlor—and for the baby sister a wax doll with long flaxen hair—which she invariably informs the neighborhood was given to her "by Sallie's beau."

We once knew a nice young man who had been told that the best plan was to court the mother for a while. He heeded the advice and was getting along very finely, when one day he received an invitation to attend the marriage of his girl to the fellow who had been courting *her* and not her *mother*.

This little occurrence turned our minds to the humorous things of our experiences, and after adjournment of the society a number of "funny" things were related as we walked homeward.

The following is interesting to the gynæcologists:

A young married woman (without children, or she would have other things to require her attention) had been for some time afflicted with uterine trouble. She had been treated by several « 191 » physicians. Various pessaries had been worn. The last attendant discovered that it mattered not what kind of pessary was used, nor in what position it was placed in order to afford satisfactory relief. Finally an abdominal supporter, with cup and stem attachment was wanted and obtained. This by far surpassed any other, until one day it "hurt a little." The patient at once thought of an improvement. She removed the cup and stem, detached the cup and reintroduced the stem. It gave perfect satisfaction and has been worn with comfort for about three months. We sincerely hope this simple instrument will be able to permanently retain the displaced—mind—in proper position. We offered it to the profession as the finest instrument yet discovered for such cases. It is not patented, no royalty is received by the discoverer, and no extra charge is made for the thread on the internal end of the stem.

The medical colleges have resumed their regular lectures, the students having returned from their Christmas visit to their—mothers.

One of the societies inaugurated the new year by a banquet, which was a most delightful affair. It was given at the Eutaw House, was well attended, substantial, and well served. The toasts formed no small part of the enjoyment. Some of the reminiscences of the older members afforded much merriment.

A very interesting case of the heart displaced to the left side was exhibited to the Clinical Society by Dr. McSherry at the meeting of January 8. It is rare, and only a few cases are reported. Displacement to right side is not of unfrequent occurrence, and a number of cases are recorded. The apex beat in this case is heard two inches to the left of a perpendicular line through the left nipple. The first line of dullness is one inch and a half to the left of the center of the sternum. Attachment to a contracted lung due to phthisis is the probable cause of the displacement. At the same meeting there were reported two cases of laparotomy for intestinal obstruction. Both terminated in recovery.

A somewhat novel, but said to be successful, treatment for cases of "wry neck" due to neuralgia or "cold" was mentioned at the Medical and Surgical Society on the 14th. It is to sit for one half hour or more near a very hot stove, placing the affected side opposite an open door. A screen should be placed beyond the patient so as to confine the heat as much as possible to his immediate locality.

It was suggested by the mention of a case, in a child eleven years old, which had continued four weeks, in spite of treatment. One physician thought the Faradic current a specific in such « 192 » cases.

I have read with pleasure a little work which, if I mistake not, will be most welcome to the profession. It is a book of nearly seventy pages, entitled 'Practical Notes on the Treatment of Skin Diseases.' I am glad to say also, that it is written and published by a Baltimore physician, Professor Rohé, whose 'Text Book of Hygiene' I took occasion to mention in my last communication.

I suppose all country practitioners, if not those of the city also, who are busy from morning till night with hardly two hours a day for reading, have felt as I have on many occasions, the need of some concise practical text books not given to speculations and generalizations! Especially is this needed in "Skin Diseases," because of the meager knowledge that we common practitioners have of the subject. There has seemed to me to be a tendency to call most skin diseases "eczema," just as it undoubtedly is to call all vague pains throughout the body "rheumatism."

Dr. Rohé very truly remarks that "most text books on dermatology have as their besetting sins complicated classifications or 'systems,' an awkward nomenclature, great prolixity and a lack of definiteness in the description of typical diseases, and an undue multiplication of morbid processes." No one better understands this than a practical physician who has spent half an hour hunting through one or two large text books for light on a case in hand and finally "falls back on" his 'Dunglison.' It seems quite clear that without a fine atlas most of the large works on dermatology are for the most part unintelligible.

Dr. Rohé's book is one of a series, the others to follow shortly if this is accorded a hearty reception. This first series is devoted to the diseases of the perspiratory and sebaceous glands. Their anatomy and physiology are briefly stated, then follows the descriptions of the diseases commonly met with, as well as the rarer forms, in terse, plain language. The last few pages contain formulæ which experience has shown to be of value. The subjects of "prickly heat" and "acne" are especially well treated, and either of them is more than worth the price of the book.

I have dwelt at much length on this subject because I feel that this little work ought to be in the hands of every busy practitioner who is not well acquainted with diseases of the skin. It can be had by sending twenty-five (25) cents to the author, Dr. George H. Rohé, 139 North Calvert street, Baltimore, Md.

F.

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