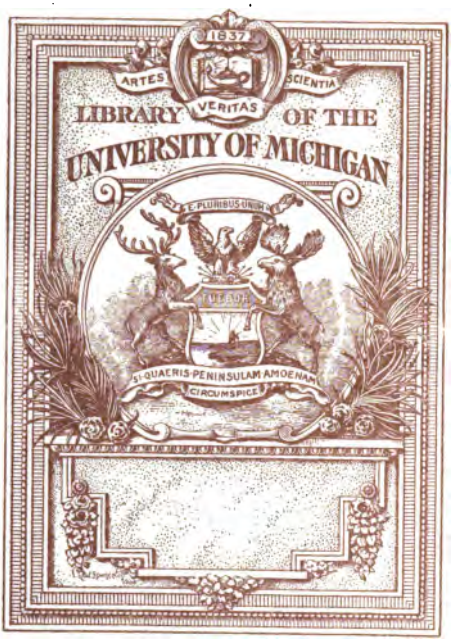
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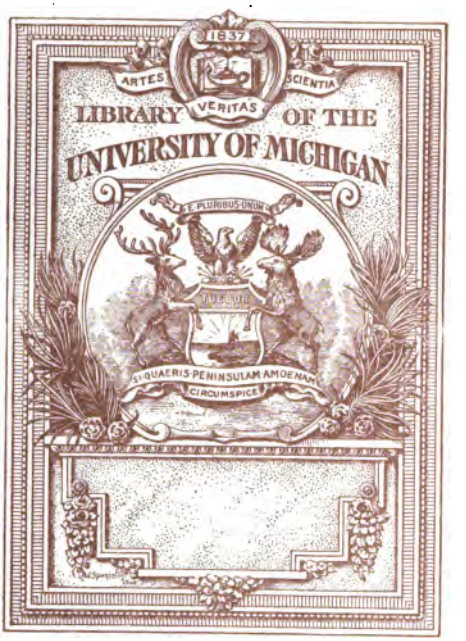
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PROCEEDINGS

—— OF THE ——

Fortieth Annual Session

—— OF THE ——

Homeopathic Medical Society

—— OF THE ——

STATE OF OHIO,

Held at Columbus, Ohio, May 10th and 11th, 1904.

EDITED BY THE SECRETARY.

Cott's Quick Printing House, Columbus, Ohio.
1904.

To the Members of the
Homeopathic Medical Society of Ohio:

We respectfully submit the proceedings of the Fortieth Annual Session of your Society, held at Columbus, Ohio, May 10th and 11th, 1904.

W. B. CARPENTER, President.
C. E. SILBERNAGEL, Secretary.
T. T. CHURCH, Treasurer.
Committee on Publication.

December 1, 1904.

OFFICERS.

1903—1904.

PRESIDENT—W. B. CARPENTER, M. D., Columbus.
FIRST VICE-PRES.—J. H. WILSON, M. D., Bellefontaine.
SECOND VICE-PRES.—KATHERINE KURT, M. D., Akron.
SECRETARY—C. E. SILBERNAGEL, M. D., Columbus.
TREASURER—T. T. CHURCH, M. D., Salem.
NECROLOGIST—D. H. BECKWITH, M. D., Cleveland.

CENSORS.

LINCOLN PHILLIPS, M. D., *Chairman*, Cincinnati.
H. H. WIGGERS, M. D., Cincinnati.
H. C. RUHL, M. D., Leipsic.
D. L. MOHN, M. D., Ashland.
SARA E. FLETCHER, M. D., Columbus.
A. B. SMITH, M. D., Springfield.

1904—1905.

PRESIDENT—J. H. WILSON, M. D., Bellefontaine.
FIRST VICE-PRES.—SARA E. FLETCHER, M. D., Columbus.
SECOND VICE-PRES.—J. A. MITCHELL, M. D., Newark.
SECRETARY—C. E. SILBERNAGEL, M. D., Columbus.
TREASURER—T. T. CHURCH, M. D., Salem.
NECROLOGIST—D. H. BECKWITH, M. D., Cleveland.

CENSORS.

T. M. STEWART, M. D., *Chairman*, Cincinnati.
C. A. SCHULZE, M. D., Columbus.
G. J. JONES, M. D., Cleveland.
H. E. BEEBE, M. D., Sidney.
J. P. HERSHBERGER, M. D., Lancaster.
J. W. MEANS, M. D., Troy.
C. E. WELCH, M. D., Nelsonville.

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CONTRIBUTORS.

PROCEEDINGS

OF THE

Fortieth Annual Session

FIRST DAY—AFTERNOON SESSION

Promptly at the hour of 1 o'clock, in the assembly hall of the Great Southern Hotel, Columbus, Ohio, Tuesday, May 10, 1904, President W. B. Carpenter, of Columbus, called the Homeopathic Medical Society of Ohio to order, stating that the hour had arrived for beginning the exercises incident to the Fortieth Annual session. There being present about sixty persons at the opening session.

Rev. James Albert Patterson, of Columbus, was called upon to lead the society in an opening prayer, after which President Carpenter said: "The physicians of Columbus are very glad to welcome the physicians of the State to this city. A year ago we had the honor of meeting the Chief Executive of Columbus, Mr. Jeffrey, who gave us a very hearty welcome. This year this same honorable gentleman had expected to be with us again to tell us why Columbus was still glad to have the State Homeopathic Society to meet within her borders, but at the last moment he found it impossible to be present, and so has sent as his delegate Mr. Keating, of the city law department, who will now address us.

WELCOMING REMARKS OF MR. KEATING.

You will doubtless be much disappointed in not having his Honor, the Mayor of Columbus, address you to-day, but at the very last moment matters of large import came up which obliged him to forego this pleasure, and to send me as his unworthy representative. I extend to you a most cordial welcome. Columbus is a great convention center and there is no class of men whom I am sure that it welcomes more cordially within its boundaries than it does its physicians; for yours is a noble work, gentlemen,—the alleviation of suffering and the smoothing of the way for the fast dissolving mortality. No doubt you are all well familiar with that old

story of the advice given by an old physician to his younger associates in the graduating class: "Keep 'em alive, gentlemen, keep 'em alive; dead men pay no bills." But you, as a brotherhood of professional gentlemen, are not actuated by such sordid motives. I find within your lines men the most kind, the most spirited, the most liberal, men who cheerfully sacrifice their own comfort, their own time, in following the plain path of duty for which you are so often unrecompensed. Columbus wants to become more of a medical center than it is. That is another reason why it is glad. We have here two large colleges and unusually large and well-equipped classes of students. We have here the central point for the State Board of Health, which is most efficient; and you all know of the existence of the State Board of Medical Registration and Examination centered at Columbus. And you know what good work these several boards and others have done in your behalf. Your papers and your discussion all tend to the uplifting of the individual practitioner, and through him necessarily his patrons and patients.

Mr. Keating continued for some minutes in this vein, telling several stories, and again inviting the profession to partake to the fullest of the hospitality of Columbus, and to return again next year if that should be in the plans of the organization. (Applause.)

RESPONSE TO THE "ADDRESS OF WELCOME."

BY THOMAS M. STEWART, M. D.

If we had any doubt in our minds as to our welcome to Columbus before Mr. Keating began his speech, I am sure that doubt has been dispelled. While an address of welcome by a representative of a city's government may be looked upon as a mere formality, yet it marks the esteem good citizens have for governmental rule, and the homage they desire to pay to those who for a time assume the burden of guiding the statecraft.

The Homœopathic Medical Society of Ohio has assembled in Columbus so many times that we feel somewhat at home; and upon this, as upon other occasions of our meetings, we feel particularly glad that Mayor Jeffrey sends us his greetings; because he has manifested in no uncertain way his sense of fair play, as well as faith in, that large body of physicians whom we represent in convention to-day.

We cannot give you facts and figures to show that we represent so much capital, or employ hundreds or thousands of workers, because we represent a profession, distinguished from commercial pursuits, in that we are laboring all the time to prevent, and to stamp out, the very diseases that furnish us employment. Our work is largely along quiet lines, and much of it is done with secondary thought to the financial element, the element so necessary to consider in the commercial world.

Therefore our work as represented in our program is one of thought force, from which we hope to derive the ideas that will enable us to do better work in the coming year, as well as the inspiration by which we shall achieve more brilliant results for the meetings of the future.

The good that may be done will not show upon the surface, it may not add directly to the growth of your beautiful city, or any of the other cities or towns of our glorious Buckeye State. But indirectly it may retain, for a somewhat longer time, the lives and influence of those who labor in the active affairs that constitute the life force of our varied institutions. The work these minds and bodies may do, their service in private or public life, are back of all their achievements, and in the doing of that work the physician is often the wise counsellor. This points to the fact that the diversity of interests in life is simply an illusion. The reality shows the unity at the center, the great binding force which makes us all workers in the evolution of a greater people, a greater nation, and a greater civilization.

We thank Mr. Keating, and through him, the chief executive of this beautiful city, for his kindly words of welcome.

The minutes of the Society being called for, Secretary Dr. Silbernagel stated that the same had been put into printed form and were now in the hands of the membership.

On motion the minutes as printed in transaction form were approved and accepted as the minutes of the last session of this Society.

The Secretary then presented his annual report as follows:

REPORT OF THE SECRETARY.

To the Homeopathic Medical Society of Ohio:

At the thirty-ninth annual session of the Society, held in Columbus one year ago, there was reported a membership of 222. These with the eleven who joined at that time make the present membership 233 without considering those who have fallen from the ranks.

The cost of the notices and programs for this meeting amounted to $20.25, and the cost of sending them to physicians, journals and newspapers $13.00. In addition to this the expenses of this office for stamps, postal cards, stationery, stenographic work, etc., was $23.41, vouchers for which are in the hands of the Treasurer.

Respectfully submitted,

C. E. SILBERNAGEL, *Secretary.*

Report accepted and referred to Publication Committee.

The President then appointed the following committees with oral instructions as to scope of their duties:

Supervisors of Election—R. O. Keiser, M. D., and C. F. Junkerman, M. D.

Committee on Credentials—Lincoln Phillips, M. D., Charles Hoyt, M. D., and H. D. Bishop, M. D.

The Committee on Publication had nothing to report except as to expense of publishing the transactions, which would appear in the report of the Treasurer.

The report of the Treasurer was next in order, but was passed temporarily in the absence of that official. Dr. Church arriving a little later, presented his report, as follows:

REPORT OF THE TREASURER.

T. T. Church, Treasurer, in account with the Homeopathic Medical Society of the State of Ohio.

Dr.

To balance May 12, 1903	$ 192.28
To cash received from fees and dues	343.00
	$ 535.28

Cr.

By Dr. Frank Kraft, as per bill	35.45
By The A. K. Tatem Label Co., as per bill	10.15
By N. L. Heaton, as per bill	6.75
By Chas. M. Cott, as per bill	9.25
By Dr. A. B. Nelles, as per bill	3.15
By Spahr & Glenn, as per bill	59.00
By The E. Liverpool Publishing Co., as per bill	212.25
By Postage	8.24
By Expressage	18.21
By Freight and drayage	.72
By Twine	.30
Balance	$ 171.81
	$ 535.28

Our last list of members contained 230 names, of which—

9 are honorary members;
34 reside in other States;
3 have a credit of three dollars;
93 have paid in full;
32 have paid to 1902;
1 owes a balance of four dollars;
1 owes a balance of five dollars;
35 have paid to 1901;
2 owe a balance of seven dollars;
3 have died since our last meeting, and
17 are to be dropped for the non-payment of dues.

230

I have received, and herewith present for your consideration, the resignation of Dr. J. H. Harvey, whose dues are paid to date.

Respectfully submitted,

T. T. CHURCH, *Treasurer.*

REPORT OF AUDITING COMMITTEE.

The Auditing Committee appointed by the President consisted of Drs. J. A. Mitchell, George S. Hodson and C. O. Munns, who in proper time and after careful auditing of the Treasurer's report, reported the same to be correct.

The Committee on Credentials announced that a list had been prepared and each member present was requested to sign the same.

On a call for Reports of Delegates from other Societies and Public Institutions, Dr. Stewart reported for Pulte College, saying that he could keep the Society busy for sometime listening to his report from that institution and reciting its good work; that they have been sending their graduates East to compete with those schools and to take some of the appointments in some of the Eastern hospitals. He also reported for the Cincinnati Lyceum, which meets every month; that with that Society and the Pulte Alumni they had entertained the Miami Valley Medical Society. He closed by extending an invitation to the Homeopathic Society of Ohio to meet at Cincinnati as soon as it found it in its heart to break away from Columbus.

Dr. Beckwith said Cincinnati had always been noted for its progress, and this year for its politics. He said he had spoken to Dr. Stewart at the dinner table, telling him that Cleveland wanted the next meeting of the State Society. Politically, Dr. Stewart is like his Boss Cox; he wants to cut Cleveland off. Dr. Beckwith stated that Cleveland had a college which stands the second in the United States with a fine corps of teachers and turning out fine graduates—21 at the recent commencement—with a large class in preparation for another year. The hospital is doing fine business with its rooms filled and looking around for further and still better facilities. The Cleveland Homeopathic Medical Society was also doing well with large attendance.

Dr. M. P. Hunt reported for the Legislative Committee, and Dr. R. B. House for Committee on Education.

These reports were received and referred to Publication Committee.

The Board of Censors at various times during the meetings reported the names of applicants for membership in this Society, which names having gone through the usual and proper course were put to vote and elected. The following are the names of those so elected at this fortieth session of this Society:

CENSORS' REPORT.

Buck, Charles R.....Cincinnati
Pulte Medical College, 1902.

Budde, Charles H..... Dayton
Medical College of Nurtzburg, Bavaria, 1880.

Burnham, J. E.....Prairie Depot
Cleveland Medical College, 1895.

Gaston, James E..... .....Wilmington
Cleveland University of Medicine and Surgery, 1896.

Humphrey, William A.....Toledo
Hahneman Medical College of Chicago, 1883.

Lyons, Matilda J..... ....Cadiz
University of Michigan, Homeopathic Department, 1887.

McCleary, J. R.....Marietta
Pulte Medical College, 1900.

Patterson, A. M..... .....Westerville
Cleveland Medical College 1895.

Peters, W.....Lancaster
Hahnemann Medical College of Chicago, 1885.

On motion the reading of the President's address was made a special order of business for 4:30 p. m.

Dr. D. H. Beckwith, Necrologist, then presented his report, which was referred to Publication Committee.

The President read a telegram of congratulations from the Indiana Institute, at the conclusion of which reading, on motion of Dr. Beckwith, the Secretary was requested to answer the telegram with the best wishes of our Society.

The special hour having arrived for the reading of the President's Address, Dr. J. H. Wilson, Vice President, took the chair while the President, Dr. W. B. Carpenter, presented his annual address.

The Chair appointed a committee on this address consisting of Drs. R. B. House, D. H. Beckwith and W. A. Dewey.

Reports from the Bureaus of Materia Medica, Sanitary Science and Surgery were presented at this session. The papers were discussed and referred to the Publication Committee.

Before putting the motion to adjourn to 8:30 a. m., the President called attention to the banquet which the Columbus physicians

had arranged for their visiting brethren in the Great Southern Hotel at 8:30 p. m.

EVENING SESSION.

Instead of the evening session a banquet was given by the Columbus physicians to the attending physicians. Dr. G. J. Jones, of Cleveland, was toastmaster, and the following toasts were responded to:

TOASTS.

Dr. Gaius J. Jones, Cleveland, toastmaster.

1. "The morning of a medical man's life. What should it be?" Royal S. Copeland, M. D., Ann Arbor, Mich.

2. "The medical man's mid-day. How to make the most of it." Maurice P. Hunt, M. D., Columbus.

3. "The twilight of a physician's day. Should he rest or continue to toil?" D. H. Beckwith, M. D., Cleveland.

4. "How soon will the demand compel an increase in the supply of graduates of Homeopathic schools?" C. E. Walton, M. D., Cincinnati.

5. "Whither is the medical profession drifting?" Thomas M. Stewart, M. D., Cincinnati.

6. "The physician's wife." De Witt G. Wilcox, M. D., Buffalo, N. Y.

7. "What is to be the limit of interstate medical legislation?" H. E. Beebe, M. D., Sidney.

8. "Is it profitable for a student who expects to practice Homeopathy to spend his first one or two years in an Allopathic school?" William A. Phillips, M. D., Cleveland.

Wednesday, May 11th, 1904.

SECOND DAY—MORNING SESSION.

On reassembling at 8:30 a. m., Dr. Baxter was called upon to address the Society on the work of the State Board of Medical Registration and Examination and gave a very interesting account of the work of this board.

Referred to Publication Committee.

Dr. Beckwith: You will all recall that in 1901 Dr. Walton offered a resolution that we meet four years in Columbus. We have been here now three sessions, in which the physicians of Columbus have taken much time and been at considerable outlay of money to make it pleasant for us. In conversation with many of the membership of this Society they think it is time that we relieve the Columbus physicians from the labor—of love though it be—of entertaining us again, and to permit other cities to give us a little attention. We also believe that the increase in membership would be greater by a change. I move you, therefore, that the resolution offered by Dr. Walton, May 15, 1901, be rescinded.

Dr. Walton: At the earnest request of Dr. Beckwith, I second the motion. I think our coming to Columbus has been a success, but we all feel that there should be a change.

Being put, the motion was unanimously carried and the resolution of May 15, 1901, was declared rescinded.

Dr. Beckwith: Now in behalf of the physicians of Cleveland, I wish to extend a cordial invitation to meet in Cleveland next year.

The President decided that this was new business and must wait for that order to arrive.

The special order of election having arrived, the ballot was declared closed and the result of the election announced as follows:

OFFICERS.

President.....J. H. Wilson, M. D., Bellefontaine
First Vice President.....Sara E. Fletcher, M. D., Columbus
Second Vice President.....J. A. Mitchell, M. D., Newark
Secretary.....C. E. Silbernagel, M. D., Columbus
Treasurer.....T. T. Church, M. D., Salem
Necrologist.....D. H. Beckwith, M. D., Cleveland

BOARD OF CENSORS.

C. A. Schulze, M. D.,.....Columbus
Gaius J. Jones, M. D.,.....Cleveland
H. E. Beebe, M. D.,.....Sidney
J. P. Hershberger, M. D.,.....Lancaster
J. W. Means, M. D.,.....Troy
C. E. Welch, M. D.,.....Nelsonville

Dr. Silbernagel being in the chair, the Committee on President's Address presented the following report:

REPORT OF COMMITTEE ON PRESIDENT'S ADDRESS.

After a careful reading of the scholarly and excellent address of our President, we take pleasure in commending his recommendation for a more thorough organization of the homeopathic profession throughout the State, and urge that medical clubs or societies be organized at all centers where sufficient numbers can be brought together to insure successful results.

We also commend the suggestion to furnish hospital and dispensary facilities so far as it may be possible for all persons who may prefer homeopathic treatment.

We recommend that all legislative matters as well as our interests relating to the establishment of a medical department in the State University be carefully supervised by our standing Committee on Legislation.

After a careful consideration of the recommendations to change Section 2 of the By-Laws by reducing the amount of the annual dues of this society, we respectfully submit that no change be made at this time relating to the annual dues, but we recommend that the initiation fee of one dollar be stricken out.

R. B. HOUSE, M. D.
D. H. BECKWITH, M. D.
W. A. DEWEY, M. D.

Moved and seconded that this report be received and its recommendations accepted and adopted. So ordered.

In order, however, to complete the report and its amendment, Dr. R. B. House moved that Section 2 of the By-Laws be amended by striking out the words "initiation fee shall be one dollar and."

Seconded and unanimously carried.

On motion of Dr. H. F. Biggar, Jr., and duly seconded, it was ordered that a committee be appointed by the Chair whose duties it shall be to secure increased membership to the State and local homeopathic societies, and whenever practical to organize local societies.

The President appointed on this committee: T. M. Stewart, M. D., C. E. Walton, M. D., R. B. House, M. D., T. T. Church, M. D., H. E. Beebe, M. D.

Dr. Biggar requested not to be appointed as a member of this committee.

A telegram was received from Dr. T. G. Barnhill regretting his inability to be present and sending his best wishes for the success of the meeting.

At this session the following bureaus reported: Gynecology, Ophthalmology and Otology, Laryngology and Rhinology, Neurology.

The papers were discussed and referred to Publication Committee.

Recess until 1:30 p. m.

SECOND DAY—AFTERNOON SESSION.

On reassembling, Dr. Baxter renewed the motion made earlier in the day by Dr. Beckwith inviting the Society to meet next year in Cleveland. This was seconded by Dr. G. J. Jones, and being put to vote was carried unanimously.

The President-elect then appointed the following physcians to serve the Society the following year:

BUREAU CHAIRMEN.

Sanitary Science.....R. B. Carter, M. D.
Materia Medica.....Frank Kraft, M. D.
Dermatology.....G. W. Spencer, M. D.
Surgery.....J. C. Wood, M. D.
Gynecology.....C. E. Sawyer, M. D.
Opthalmology and Otology.....T. M. Stewart, M. D.
Laryngology and Rhinology.....R. G. Reed, M. D.
Neurology.....J. E. Welliver, M. D.
Obstetrics.....A. W. Reddish, M. D.
Anatomy, Physiology and Pathology, Clark E. Hetherington, M. D.
Paediatrics.....Lincoln Phillips, M. D.
Clinical Medicine.....C. R. Coffeen, M. D.

DELEGATES TO OTHER SOCIETIES.

American Institute of Homeopathy—
H. D. Bishop, M. D., and J. H. Wilson, M. D.
Michigan State Society—
F. B. Monroe, M. D., and Guert E. Wilder, M. D.

Kentucky State Society—
S. R. Geiser, M. D., and A. L. McCormick, M. D.

Indiana State Society—
C. R. Coffeen, M. D., and H. B. Faulder, M. D.

EXECUTIVE COMMITTEE.

Drs. Harriet B. Chapman, O. A. Palmer, C. S. Ames, Frank Webster and J. H. Whitehead.

LEGISLATIVE COMMITTEE.

Drs. A. L. McCormick and H. H. Baxter—For three years.
Drs. M. P. Hunt and G. B. Haggart—For two years.
Drs. H. E. Beebe and W. B. Carpenter—For one year.

INTERSTATE COMMITTEE.

Dr. M. P. Hunt—Three years to serve.
Dr. T. A. McCann—One year to serve.

COMMITTEE ON EDUCATION.

E. R. Eggleston, M. D., Frank Kraft, M. D., George D. Grant, M. D.

COMMITTEE ON INCREASE OF MEMBERSHIP.

T. M. Stewart, M. D., C. E. Walton, M. D., R. B. House, M. D., T. T. Church, M. D., H. E. Beebe, M. D.

The following bureaus reported at the last session: Obstetrics, Anatomy, Physiology and Pathology, Paediatrics. The papers were discussed and referred for publication.

The routine work of the Society having been concluded, the Committee on Credentials reported that 86 persons had registered, 20 of whom were visitors; and that 108 attended the banquet.

On motion of Dr. Cook a vote of thanks was tendered the local physicians for entertaining the Society in such a delightful manner.

A vote of thanks was also extended to the President, Dr. Carpenter, and his efficient co-workers on the official staff, for their able administration; also to the hotel for its accommodations and courtesies; and to the press for its fair and generous notices of the meetings.

The Homeopathic Medical Society of Ohio, in its fortieth annual session, then adjourned to meet in Cleveland, the second Tuesday and Wednesday of May, 1905.

ALPHABETICAL REGISTER OF PHYSICIANS IN ATTENDANCE.

Akron—
Childs, O. D.
Kurt, Katherine.

Ann Arbor, Mich.—
Copeland, R. S.
Dewey, W. A.
Hinsdale, W. B.

Ashland—
Mohn, D. L.

Bellefontaine—
Wilson, J. H.

Buffalo, N. Y.—
Wilcox, Dewitt G.

Cardington—
White, F. R. Smith.

Chagrin Falls—
Cameron, G. D.

Chillicothe—
Hoyt, Charles.

Cincinnati—
Brickley, Laura C.
Buck, Charles R.
Geiser, S. R.
Hunt, Ella G.
Phillips, Lincoln.
Stewart, T. M.
Walton, C. E.

Cleveland—
Baxter, H. H.
Beckwith, D. H.
Biggar, H. F., Jr.
Bishop, H. D.
Jones, G. J.
Kraft, Frank.
Miller, William T.
Wood, J. C.

College Hill—
Kilgour, P. T.

Columbus—
Allen, Alice G.
Allen, O. S.
Barbee, B. I.
Bryant, Susannah L.
Carpenter, W. B.
Clemmer, J. W.
Connell, R. D.
Fletcher, Sara E.
Ireland, Charles L.
Jackson, L. A.
Keiser, R. O.
Leatherman, J. H.
Nelles, A. B.
Rether, C. H.
Rogers, G. W.
Schulze, C. A.
Sherman, S. M.
Silbernagel, C. E.
Waite, H. C.
Woods, G. W.

Dayton—
Welliver, J. E.

Delaware—
Hall, E. M.
Pulford, W. H.

Elyria—
Baldwin, H. D.

Hillsboro—
Hoyt, William.

Lancaster—
Hershberger, J. P.
Junkerman, C. F.
O'Grady, G. W.
Peters, W.

Leipsic—
Ruhl, H. C.

Marietta—
McCleary, J. R.

Marion—
Cheatham, Elizabeth C.
Sawyer, C. E.

Mt. Vernon—
Arndt, G. D.

Newark—
Baldwin, William M.
Hunt, H. E.
McClure, S. D.
Mitchell, J. A.
Palmer, I. N.

North Lewisburg—
Garwood, J. Stokes.

Oxford—
Munns, C. O.

Piqua—
Hetherington, Clark E.

Portsmouth—
Cooke, Clara E.

Prairie Depot—
Burnham, J. E.

Sidney—
Beebe, H. E.
Ferree, J. A.
Reddish, A. W.

Salem—
Church, T. T.

Springfield—
Grant, G. D.
Hadley, W. A. M.
House, R. B.
Miller, H. T.

Toledo—
Humphrey, W. A.
Zbinden, Christian.

Troy—
Means, J. W.

Washington C. H.—
Hodson, G. S.

Wilmington—
Gaston, J. E.
Wood, G. W.

Wellington—
Smith, A. B.

Wapakoneta—
Faulders, H. B.

Westerville—
Patterson, A. M.

Xenia—
Teegarden, William.

NECROLOGIST'S REPORT.

D. H. BECKWITH, M. D., CLEVELAND.

From birth to death is measured by years. It is a short period; some play their part, others fail to secure honors.

Comparatively few pass from the world in a triumph of glory; most men and women will pass quietly from this world, only to be remembered by their immediate friends; their names will soon be forgotten.

The beginning of man is the same to all, also the end; death is the great conqueror.

No one can tell what basis of intelligence we shall reach, or how we shall be judged.

We pay tribute to all our members that have gone to the great beyond. Each year takes some of this Society to their final resting place. This course will continue until the end of time—birth and death are natural consequences, therefore we are born and later shall die.

The Necrologist reports only three deaths of our members the past year:

Dr. H. B. Van Norman, of Cleveland.

Dr. F. W. Morley, of Sandusky.

Dr. James Dickson, of Canal Dover, of whom I have not been able to obtain any report.

Two months ago one of our former members (Dr. David B. Hale), who met with us for many years, by reason of failing health found it impossible to meet with us and tendered his resignation. He was a valuable man to the Society as well as to the Homeopathic profession. His son has taken up the work of his father, and I trust he may become a member of the State Society. He was 54 years of age. He was a graduate of the Eclectic school in Cincinnati in the class of 1869. He was a soldier during the Rebellion. At the close of the war was discharged with honors.

A young promising physician died a few months since from diphtheria, in Cleveland. Charles E. White, M. D.

The members of the American Institute that have died during the past year were Egbert Guernsey, who was one of the early pio-

neers of homeopathy, and a former contributor to medical journals.

C. S. Owens, of Wheaton, Ill., who perished at the Iroquois fire at Chicago.

F. N. Payne, of Boston, a prominent oculist.

H. M. Paine died at Atlanta where he had retired. He was formerly located at Albany, N. Y. He was one of the oldest members of the Institute and devoted much of his time and energy in procuring laws elevating the medical profession.

T. Y. Kinne, of Patterson, N. J., ex-President of the American Institute and one of the leading men of the profession.

Henry M. Dearborn, of New York, author of a treatise on Dermatology.

April 24, Dr. Franz H. Krebs, of Boston, who had been one of the leading physcians in that city for many years.

Pheobe J. B. Wait, New York.

Death has taken some of the early heroes the past year, but we have the satisfaction of knowing that there are left young men who can more than fill the places of the dead whose memory we trust will long remain with us.

Francis Wayland Morley, M. D., of Sandusky City, Ohio, was Vice President of the Homeopathic Medical Society of Ohio and officiated as the president of the session held in Sandusky, May 1900. C. E. Sawyer, president, being absent.

Dr. Morley was born at Tully, New York, January 17, 1861, and died July 4, 1903, aged 42 years, 5 months and 17 days. He was a son of Rev. and Mrs. Butler Morley.

Three weeks before his death he was attacked with infiammatory rheumatism. His death was caused by rheumatism of the brain, as diagnosed by his attending physicians.

His early education was obtained in the common schools, later he entered the Cleveland Homoepathic Hospital College, graduating March 1884. After receiving his diploma he located in Huron, Erie County, Ohio, where he soon had a large clientage.

His reputation as a successful practitioner influenced patients from other adjoining cities to consult him. He was recognized as one of the leading surgeons in Northern Ohio.

He married Miss Eloise E. Durker, of Oakland, Michigan, in the year 1884. The widow and one son and two daughters mourn the loss of husband and father.

In 1897 he was instructor in the Training School for Nurses at Dr. Sawyer's Sanatorium, in Marion, Ohio. The doctor took an active part in medical organization and often presented valuable papers.

In May, 1890, he joined the Ohio State Homeopathic Medical Society.

In June, 1890, he was elected a member of the American Institute of Homeopathy. Also a member of the Northwestern Ohio Homeopathic Medical Society. Member of the local Board of Pensions. Member of the Erie Commandery, No. 23, of Knight Templars.

On his death this society lost an active and energetic worker.

A tribute from the physicians of Sandusky who have been intimately acquainted with Dr. Morley for the past thirteen years is more impressive than all the encomiums the Necrologist could bestow upon him.

"THE LATE DR. MORLEY.

Resolutions of respect by the City Physicians.

Whereas, In His infinite wisdom our Heavenly Father has seen fit to remove from among us our friend and colleague, Doctor Francis Wayland Morley, be it

Resolved, By the physicians of the city in which he resided so long, that in the death of Doctor Morley, we as well as his patrons throughout the city and county, have suffered a great loss, and that it is but a just tribute to the memory of the departed to express in this manner our deep appreciation of his many excellent qualities of mind and heart and our high regard for his zealous and useful labors in the community.

To his loved ones in this hour of deepest sorrow we extend our heartfelt sympathy and the assurance of our ever kindly interest in their welfare.

Resolved, That a copy of these resolutions be presented to the family of our deceased friend and brother.

E. GILLARD,
C. A. SCHIMANSKY,
J. D. PARKER.

Adopted July 5, 1903."

At our annual gathering in 1893 among our number was an attentive listener. He was present at all the sessions; his white hair and dignified appearance indicated his threescore years. He took no active part in the discussions of the various papers that were read, but not a word escaped his observation. For twenty-eight years this attentive physician was a regular attendant at the State Society. He left these annual meetings with knowledge that made him a more skillful physician, therefore he claimed that his time and money was a good investment. At these meetings he met old and new friends that were striving after knowledge, and the best means to relieve the sick. Medical conventions were to him a source of rest and pleasure.

Horace B. Van Norman was born March 11, 1834, at Pine Hall, Middle Road, Ontario, Canada. At the age of 18 he left the farm to seek a place where he could obtain better educational advantages than he could obtain at home. He came to Ohio and enrolled his name at the Baldwin Institute as a student ready for all kinds of work in and about the college. For three years by his own labor he paid his tuition and other expenses. He found among the students Miss Jane Hoadly, who was a pupil in the class with him. It may be truly said of her that she made his life work a success. His graduation from the university did not take place until after a lapse of twenty years.

In 1861 he entered the office of Prof. T. P. Wilson as a student of medicine and graduated from the Cleveland Homeopathic College in 1864.

He soon located at Warrensville, and not finding a desirable location he went to Ashtabula, where by his industry and skill and perseverance he soon had a large clientage extending to many miles in the country.

I call to mind an incident that took place in 1868. I was called in consultation. The train left at 4 a. m. and I had to remain the night. He suggested that I see a few other patients with him, which were chronic cases. The country was traversed in various directions during the night, and I received the thanks of the country patients for my night visits.

It was a trait of character of Dr. Van Norman to take the suggestions of other physicians if they aided him in his mission of healing the sick.

In 1871 he came to Cleveland and located on the West Side, where he remained in active practice until a few days before his death, which took place on the morning of July 9, 1903.

In 1872 the Trustees of the Homeopathic College appointed him Lecturer on Hygiene, and he continued for several years to lecture at the college on various medical topics.

He has been President of the Alumni of the Medical College, President of the Alumni of the Baldwin University, and was a Trustee at the time of his death.

One year after his graduation he joined the State Medical Society and has often contributed valuable papers.

A member of the American Institute of Homeopathy since 1870, and was also a member of the Masonic, Odd Fellows and Royal Arcanum lodges.

In honor of his early work and the steadfast support he gave the institutions of his boyhood, a special memorial service was held at the Methodist Church in Berea, July 12, 1903, the President of the college and others speaking tributes to the memory of the dead doctor.

A strange coincidence: Dr. Van Norman and the late lamented Professor Nathaniel Schneider were born in Canada, left the farm at about 18 years of age, and came to the Baldwin Institute, educated themselves by their own work, attended lectures at the Cleveland Homeopathic College, and graduated the same year, and became members of this Society about the same date.

A family reunion was to have been held in Canada in July 1894 at the doctor's home. He had prepared a song for the occasion, by which one year ago I was awakened in this city by his singing with a voice soft and sweet for a man of his age. It so impressed me that I quote the two first verses:

"If I am dreaming, wake me not!
Let the tides of memory flow,
Bringing back each form and spot,
Fresh as fifty years ago;
Let me walk Toronto's streets
Just a merry lad again,
Though the boyhood chums I meet
Are these honest, gray-haired men.

"For I'm back in old Canada once more,
Here's where my heart is wont to turn,
'Tis my native land, the much-loved shore,
And her homelights in the harbor brightly burn,
I am breathing airs of very sweetness,
And in my soul is melody to-day,
For seasons God hath rounded with completeness,
For the fruits and flowers I've gathered by the way."

PRESIDENT'S ADDRESS.

W. B. CARPENTER, M. D., COLUMBUS.

Mr. Vice President, Ladies and Gentlemen, Members of the Homeopathic Medical Society of Ohio:

I embrace this first opportunity to formally express to this Society my appreciation of the honor which the members were pleased to confer upon me a year ago. The responsibilities of the office are always great, but they have been lessened by the loyal, unfailing support, the wise counsels, the cordial friendship that I have received constantly from all sections of the State; and in the closing hours of my administration, relying upon this same consideration, I desire to talk over with you some matters of great interest in the hope that there may be a distinct advance in our knowledge of our profession, and in our ability to carry its good to others.

First, then, let me say we live in a time when there is need for action, for *doing something*. Theory is all right, is necessary, but mere theory is but a waste of opportunity and never advanced any cause. Intelligent thought and fearless action bring results. We as a school do not have to fight as did our fathers for their very existence; the times have changed and other problems, at least no less necessary, must be met and solved. The "exigencies of modern life, higher education and general culture unite in demanding such a thorough understanding of ourselves and our work that there may be new laws and associations" when new conditions and surroundings obtain. How often in our gatherings do we felicitate ourselves over our goodly heritage, the law of Similia, do we clasp

hands and pat ourselves on the back over the claim that from Hahnemann we have received nature's perfect law of cure, and stop there. If that be so it is our business to know more of this law than Hahnemann did—we live many decades later. The law of progress and development will not permit us to keep our treasure carefully hidden away in a napkin; both we and our treasure would be lost. Come to think of it, it is probable that nearly every homeopathic physician is individually trying to make the most of himself and his opportunities. But the *individual* cannot produce much force or stir; we need *organization* and *unity of effort.* Some have been and are talking about unity of schools, but no conditions have arisen yet that render such a thing advisable or possible. We, ourselves, must organize. We need a Homeopathic Society or Club in every city, town, township, county or cross roads where two or three, or more, physicians can be assembled. Sectional societies, State and National bodies will follow and enlarge the work of these small centers. I would suggest that this Society consider the wisdom of the plan enacted elsewhere, by which members of these smaller bodies shall be members of the State Society upon the payment of certain dues, or the complying with certain other requirements, to be determined by a conference between such organizations.

To organization we owe what we are and have as a school; and to maintain what we have, and to succeed in the future in furthering and extending our interests, organized medical societies or clubs are even more necessary.

Organized effort ought also to take another form, that of establishing hospitals and dispensaries in every town of reasonable size. No doubt such an institution would have, in many instances, a very small beginning; but it would be a distinct advance and help, and would surely grow into a larger field of usefulness. Such institutions would not only be an evidence of the practical benevolence of our neighbors, and furnish a place for the more thorough, convenient and systematic care of our patients, but, what is still more important, would furnish the opportunity for practical demonstration of the truth and power of the system in which we so thoroughly believe. It is well enough to claim this and that, to tell those we meet of the superiority of our way of doing, to have popular meetings to rehearse our achievements, and show infallible statistics, to pre-

pare tracts and proper literature for public distribution; but in all our institutions of whatever kind and size we can demonstrate in a way that admits of no argument, the truth of our belief.

As a corollary to this it follows that we must all be greater students of our Materia Medica; we must do continuous, systematic work in the study of Homeopathic remedies so that the symptomatology of our drugs may not only be reliable and complete, but also be at our fingers' end. Thus can we lend lustre to the triumphs of surgery, force to the revelations of Bacteriology, *point* to the study of Pathology, and obtain the degree of "Master" of our calling, whether it be viewed as a science or an art.

Again, it should be our aim to secure as many recruits as possible to the study of Homeopathy. The Macedonian cry is abroad in our land for practitioners of our school, and the laborers are too few. Young men should be encouraged to secure a really good foundation education, and then address themselves to the study and practice of Homeopathic medicine. We read of the "passing of the preceptor." For one I hope that the changed methods of scholastic training will never succeed in effecting the removal of those so necessary to our growth. Every office should be a recruiting station first, a source of inspiration, encouragement and help ever afterward.

So far we have given consideration to professional co-operation, about which this further word is apropos. Let your professional associates know of your work and the results of your study through papers for medical societies and journals, and through discussion based on experience of others. It is quite the thing now to arrange for the outdoor treatment of pulmonary tuberculosis in properly constructed buildings or tents. Such arrangement is an evident help toward relief and recovery, and will be welcomed and advised by us all. But there is a form of tuberculosis, more amenable than the pulmonary variety, about which very little has been said. So I would call your attention to the fact that the "conditions of climate and general hygiene" that have made the sanatoriums for the consumptive so successful, would prove of even greater advantage to the numerous cases of surgical tuberculosis which you all know are mostly seen in the children's wards. Fresh air, sunlight, proper surroundings and proper Homeopathic medication will show them-

selves aids to recovery so effective that the best surgical care cannot suffice without them. Hence, the need for small neighborhood hospitals for this purpose also.

Speaking of hygiene reminds us that the attention of the State has been directed during the last winter to the general question of sanitation by the prevalence of typhoid fever in the larger cities, notably in the Capital City. From these recent experiences we are more sure that typhoid is a preventable disease and is due to defiling living water. It is now proposed to maintain large filtration plants for the supplying of the drinking water. Such plants are only costly makeshifts; they neither filter out the abomination nor attack the real source of infection. This whole question really is in the realm of political economy, and its problems cannot be solved without the united effort of the local and State hoards of health (these same boards not being political machines); and even then the complication and expense of the problems make it advisable and necessary for the general Government to take hold of them and through a Department of Health banish all these preventable diseases.

As lending emphasis to what was said a moment ago in regard to the need for more students and practitioners of Homeopathy, I desire to make note of the fact that in Ohio our school is not keeping place wih the others in relative numbers of practitioners, etc. It is not pleasing, yet necessary, to know that there are only about nine hundred physicians of our school now practicing in Ohio, although about twelve hundred have been registered; this shrinkage being caused by deaths, removals and abandonment of professional activity. You can easily see that our numbers are about the same as when the canvass was first made to determine our standing on the State Board. To say the least, we must be up and doing to retain our relative standing in the profession, and hence on the State Board. We surely need to *grow* and not merely to exist.

The report of the Legislative Committee will show you that very little was attempted, and nothing really accomplished in the way of changing the medical laws of the State during the recent session of the Legislature. There are continued efforts to induce the Trustees of the Ohio State University to establish a college of medicine as a part of their institution, the latest scheme being to take over an allopathic school as the Medical Department of the

State University. We have no doubt that our interests and rights in this matter will be watched and guarded by the Legislative Committee and other proper officers.

If you will turn to Section 1 of the By-Laws you will note that the initiation fee shall be one dollar, and the annual dues three dollars. I would respectfully suggest that effective steps be taken at this session to reduce the annual dues to a much less amount, probably one dollar. Considering the dues to our National Society, and other societies similar to our own, we are placing too much burden on our members. The dues were placed at the present figure to meet the expenses of paying for the Society Transactions; but if the Publication Committee were authorized to issue a volume of Transactions containing the record of business transacted, with the papers and reports incident thereto, and see that the Bureau papers were all published in our journals, that would willingly and gladly do so, then would every interest of our Society (expense and all) be more thoroughly conserved, and some burdens removed.

I shall not detain you at this time to listen to a review of any sort of the progress of this year. Marked progress in every branch of our science and art has been made. The journals, our best working literature, are full of evidences of this statement, and I am willing to believe that you all are familiar with these records. Permit me, though, to just refer to two lines along which decided progress has been made. A new light has been shed on the physiology of the ductless glands, as the result of the careful investigations of the last few years. These organs till recently supposed to be vestigial, or of little moment, now seem to be the chiefest in the physiological chemistry of cellular metabolism, tissue respiration and oxidation. The adrenals here play the chief part in all the oxidation processes of the body through the oxygen laden plasma. The anterior pituitary body is the governing center of these oxidation processes, and the thyroid by its iodine in organic combination is necessary for sustaining normal pituitary function. The posterior pituitary body is made the chief functional center of the nervous system, and assistant in maintaining cellular metabolism of all organs. The proteolytic ferment from the pancreas and spleen plays the leading part in all immunizing processes. These few words give the merest hint of

what may lead to a broader, deeper and larger understanding of the human economy.

In the neurological studies there has been considerable progress in the knowledge of structural organization of the nervous system; the better knowledge of function has led further up to the knowledge of intimate structure; the neuron doctrine is much better understood, especially as regards its repair after injury; the nature and transmission of nerve force by means of the electrochemical status of the ions seems to have been fully shown; the pathologic nature of acute myelitis is now known to follow vascular disease, and not precede it; more important superficial reflexes have been recognized and catalogued; and there is a growing tendency to combine nervous and mental diseases in study and in treatment, so that there may be more intelligent care of the mentally and morally afflicted. This, again, is a very fragmentary statement of the year's work in a specia line, still it will serve not only as a hint of what has been done, but be a stimulus to keep posted and even to be helpers in these rapidly progressing and changing departments of our professional studies.

Again, members of the State Society, I thank you, and request your hearty co-operation in every way toward making this meeting a success in interest and profit.

REPORT OF COMMITTEE ON MEDICAL EDUCATION.

GEORGE D. GRANT, M. D., SPRINGFIELD.

In view of the strenuous efforts on the part of our colleges to turn out a class of graduates that will be an object lesson to the public, and at the same time show the profession what they are able to do with students sent to them for a medical education, it is necessary that a careful selection be made by the physician first in the education of a student, and secondly in moral character. No matter what other qualifications a student may have, he is the better for a good solid education, and in as far as it is possible, they should have a first-class college course, and so raise the standard of a class in ability to learn, when brought into the complex method of today's teaching in the medical college.

Secondly, we most heartily recommend the university foundation for a college, and on such a basis as will place all our graduates on such a plane as will the more surely compel the recognition of a diploma as entitling a graduate of the university to practice medicine in any State in the Union. This is only to be accomplished by the doing away with rival colleges in the State, and the establishment of one great central school with teachers absolutely independent of friction, and who will give their whole time to the class room.

This will be a step in advance, but your committee urges the work toward that end.

E. R. EGGLESTON, M. D.
FRANK KRAFT, M. D.
GEORGE D. GRANT, M. D.

REPORT OF LEGISLATIVE COMMITTEE.

M. P. HUNT, M. D., COLUMBUS.

There is very little of importance to report at this meeting. The most important legislative enactment of the term just closed concerning medical matters was that of the bill establishing a tuberculosis hospital. A bill appropriating $70,000 for this purpose was passed by both houses—$35,000 available this year and $35,000 next year. The Governor cut out one year's appropriation, $35,000, leaving the other to start the institution. The matter of establishment is left, I believe, in the hands of the Tuberculosis Commission.

An attempt was made by the State Board of Medical Registration and Examination to pass a reciprocity bill. This did not succeed.

The question of a medical department in the Ohio State University is being agitated again. Something may come of it. An article in one of our medical journals within the past year gives the erroneous impression that medicine is already taught in the State University. A few years ago an attempt was made by the Board

of Trustees to establish such a department, but it "died in the born-in'," and no such establishment exists.

M. P. HUNT, M. D.
G. B. HAGGART, M. D.
H. E. BEEBE, M. D.
W. B. CARPENTER, M. D.
A. L. MCCORMICK, M. D.
J. H. WILSON, M. D.

Referred to Publication Committee.

REPORT OF STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION.

H. H. BAXTER, M. D., CLEVELAND.

According to the annual report about to be issued, I find that during the year there were three hundred and eight registration certificates issued, and one hundred and four upon examination, making a total of four hundred and twelve licenses issued during the year to medicine practitioners. Three licenses were issued to mid-wives, and seven to osteopaths, authorizing them to practice osteopathy, but not to administer medicines. These were all issued upon examination. Three applicants for registration were rejected, and twelve upon examination. Three certificates were revoked for cause. Eleven thousand two hundred and eight (11,208) licenses have been issued since the organization of the Board. During the last year the Board has instituted thirty-five prosecutions for illegal practice of medicine; of these eighteen were found guilty and fined; five were dismissed; ten are now pending. Two of those against whom warrants were issued left the State before they could be served, and will probably not return.

This represents only the routine work of the Board. Its real work cannot be expressed in figures.

One of the objects of the Board is to bring about a better understanding of its purposes, a better comprehension of the provisions and effects of the law on the part of the medical profession, and on the part of the people at large. I do not believe that any other profession is so much misunderstood, or encounters so much

hostility, as that of medicine. The attitude assumed by members of other professions, and by the public officers, toward the medical profession and toward the medical law is, to say the least, peculiar. The legal profession has a law very similar to the medical law. So also have the pharmacists, and the engineers and others. Very little difficulty is experienced in enforcing these laws. It is almost an unheard of thing for any one to attempt to practice law without first passing the examination and receiving a license. Any attempt to do so would be punished so quickly and surely as to effectually prevent a repetition of the offense. A case in illustration occurred recently. Parties in Columbus obtained a copy of the questions prepared for an examination in law. This was discovered in time and the offenders were promptly arrested and heavily fined. Had this occurred in connection with the medical examination, a hard legal fight would have resulted and probably the culprits finally discharged. We find great difficulty in getting the proper officials to do the duty which the law specially imposes upon them. The law makes it the duty of the prosecuting attorney to prosecute those charged with its infraction. While in many instances they do this willingly, in many other cases they practically refuse. One or two instances will serve to show this. In one of the counties a case was made against a practitioner for the illegal practice of medicine. The evidence was clear and distinct. The witnesses were summoned to appear before the Grand Jury, and were on hand at the proper time. They remained about the court house for all of one day, and were then dismissed. They never saw the Grand Jury; the evidence was never presented, and no indictment returned, all because the prosecuting attorney was not in sympathy with the law, and would do nothing to enforce it. In another instance the indictment was obtained, but the prosecuting attorney practically refused to put the case on trial. He confessed that the trial would not take more than two hours. The case ran along for over two years. The witnesses were scattered, their addresses lost, and the case finally nollied. Many other instances of the same nature might be cited. Public sentiment is a great aid in such matters, and if such a sentiment could be aroused to support the medical profession there would be much less difficulty in enforcing the law. The medical profession, as a whole, can assist very materially by helping to create such

a public sentiment, and at the same time produce a better feeling toward the medical profession generally.

Again, against no similar law is there such a vicious fight for its overthrow or nullification as against this law. During the session of the last Legislature several covert attacks were made upon this law. The first was in the form of an amendment exempting the graduates of 1904 from the examination. It is noticeable that the declared enemies of the law itself were those who most strenuously favored this bill. The next step was an amendment cutting down the fee to five dollars. This was introduced and favored by those who were openly opposed to any medical legislation. In this connection it is proper to explain the financial conditions of the Board. It is to be borne in mind that the Board derives nothing from the general treasury of the State. All of its expenses are paid from a special fund created by the registration and examination fees. The Board has no other income from any other source. At no time since the organization of the Board has the yearly income been sufficient to defray its expenses. It has been obliged to draw upon its reserve fund each year. As a result members of the Board have done a large amount of work for which they have received no compensation whatever. For the first time in the history of the Board the annual income this year will probably be sufficient to meet its expenses. Should the examination fee be reduced as proposed, the Board could continue but a very short time. Another amendment introduced provided that no more than four members of the Board should be of one political party. This was as vicious in its character as any of the others. The Board is not a political body. Politics plays no part in its proceedings. I do not think it has ever occurred to any member of the Board to inquire as to the political affiliation of its members. If they are all of one political party it is more by accident than design. Such a feature of its composition would make it political. Another amendment was introduced, which it is to be regretted could not have become a law. This was to enlarge the powers of the Board in the direction of reciprocity. The Board is at present handicapped in this direction. Ohio can accept the certificate of another State, only if issued after an examination. It was proposed to put this upon a broader and more liberal basis. The Board has gone as far in the matter of reci-

procity as the law will permit. A limited reciprocal relation has been established with a number of other States, and this will probably be increased during the coming year.

A committee was appointed in January to visit the various medical colleges of the State, for the purpose of inspection and for the information of the Board. Another purpose of this committee was to establish better understanding and a more friendly relationship with the colleges. We believe that a more perfect understanding of each will eliminate any unfriendly feeling that may have heretofore existed. This committee has visited every college in the State, and I believe that much good will result. It is the desire of the Board to work with the colleges and have them work with us.

BUREAU REPORTS

BUREAU OF SANITARY SCIENCE

G. B. HAGGART, M. D., Chairman - - - Alliance

1. *"Resume of the Work of the Year."*
2. *Our Drinking Water—What it should be—What we are getting."*

KATHERINE KURT, M. D. - - - - Akron

"Sanitation."

SANITATION.

BY KATHERINE KURT, M. D., AKRON.

To say to you that the word sanitation means to be sound, sane, healthy is needless, for you already know it. It is commonly accepted that an objectionable element, once out of sight, is beyond the reach of harm.

Clean everywhere, in food, in air, in house, in water, in soil, in body, should be a watchword with every doctor who by virtue of his office is a teacher as well as healer.

Two problems look the sanitarian in the face. These worked out and applied would add much to the sum of daily happiness and comfort.

First—Teaching people to keep clean.
Second—Method of disposal of waste substance.

As to the first, it is difficult, possibly, always to be pursued and never wholly achieved. Long since corporate authority has enacted sanitary laws and enforced them to the benefit of every one.

The chief trouble with city and village authorities lies in the low standard adopted and poorly enforced laws. This standard needs to be raised everywhere, in the country as well as in municipalities. To keep clean does not require superior skill, and they who fail to attain to the standard should be shown how, yes, required to get it.

It is generally thought that if highways and thoroughfares are kept clear in the warm season a community has accomplished as much as possible in a sanitary way.

To be clean is to purify and keep pure, street, alley and by-way, building and factory, basement and corner.

How often in passing along the down town streets are your nostrils offended by mal odor arising from basement windows or open space under the sidewalk? Here sweepings and other offal land and are allowed to remain, because considered cleaned away, while above in the building sits the merchant who would resent the assertion that he needs to clean his premises below. Tenants should be held responsible for purity of such places.

How can this higher standard be brought about? The ideal is not attained in anything.

Were I the municipal authority I would proceed to educate the people in rules of purity. I would enact laws to enforce my rules.

A municipality too large for management by one person I would divide into districts and appoint lieutenants who should be held responsible for the instruction and enforcement of laws. I would give to the people in their homes rules in simple printed language to be read and comprehended and kept in daily sight. They should pertain to food; to ventilation; to the use of lime as a puri-

fier; to the classification of waste material; destroying by fire everything combustible as far as possible on home premises without injury to other people; to the need of keeping the ground clean and free so that light, air and water may touch it everywhere.

To these general rules others should be added as might become necessary.

These rules, I would try to invest with the spirit of wholesomeness and interest in the citizen's welfare. My lieutenants should be required to see these rules enforced by inspection of premises, as far as necessary at regular intervals. The politician's hand should be beaten aside. He best qualified should be called to serve. This method diligently pursued would raise the standard of purity.

As to my second proposition—method of disposal of waste material or garbage.

Ever since my school days in college where I first studied chemistry I have been convinced that the destruction, by fire, of waste and effete material is most nearly sanitary and therefore best.

There I learned that vegetable organisms and animals are composed mainly of nitrogen, hydrogen, oxygen and carbon and that when the life is gone out this organism returns to the elements from which it was composed through the process of decomposition by heat and moisture, also that the same state is attained through dissolution by fire, without danger to life.

To me cremation or incineration of the deceased human body commends itself over the underground process.

Cremation of garbage does not commend itself because of the high expense of money attached to the methods followed heretofore.

Through communication with the President of the Board of Health of the city of Memphis, Tennessee, I learn that city has solved the problem of garbage cremation, by test, satisfactory to her citizens. Statements are here quoted from the president. The city destroys her garbage "on the spot," that is crematories are located in several places within the corporation.

In 1897 the city was visted with yellow fever; fifty severe cases developed.

Remembering the awful experience with this disease in 1878 the health authorities resorted "to every conceivable thing which

would improve the sanitary condition." Finally they resorted to cremation of garbage, instead of dumping it in the river, and in 1898 built four crematories so located in different parts of the city as to make the average haul of garbage somewhat less than three-fourths of a mile.

They have the method so well planned that "the cost of gathering, hauling and destroying garbage costs the city only two-thirds as much as when it was hauled and dumped in the Mississippi river."

At first thought one would conclude a garbage crematory operated in a closely inhabited community would prove a nuisance.

However, Dr. Heber Jones, President of the Board, declares he "can run a crematory in any part of the city of New York and if the neighbors did not see the garbage going into the crematory they would not know what was going on in the establishment." Their crematories are located in the most densely populated portion of the city and when in process of construction "people made direful prediction, threatened with injunction, made incendiary threats." "Within a month," says Dr. Jones, "after operation began all threats ceased, and since that time residences have been built within a stone's throw of the buildings and not a word of complaint is heard." The Doctor says "if there is one sound argument against the destruction of garbage by fire, I do not know it."

"We burn everything except ashes."

I have no description of the structures at hand, but they are said to be sanitary. "There is not one particle of odor escaping from the smoke stack. In the bottom of the smoke stack which is intensely hot—being heated with coke—gases are effectually destroyed." "With reference to odor in the crematory, I can take any of you into one and if you were blind-folded you would not suspect where you were, the draft from the hole being so strong that odor disappears immediately. It is sucked in, goes through the fiery furnace, up through the combustion chamber and is destroyed."

"You would be surprised at the small amount of coal it takes to run the crematories, constructed as they are. We have made many improvements on them since their original construction. We run the larger ones, which have a capacity from 50 to 60 tons a day on

a ton and one-half of slack coal per day." "If the garbage is wet this figure will be increased somewhat, but it will never exceed two tons."

"The crematories cool down between mid-night and morning, so early in the day more is required with little or none late in the day and evening."

"Ashes are kept separate and used for filling unpaved streets. Such material is useful. Our city engineer claims we save more than four thousand dollars a year by their use, which is more than it takes to run our crematories for the same period."

"Unquestionably, the proper plans for garbage disposal is to destroy it by fire, and I do not care what the size of the city, whether it be New York with its four millions of people, or Memphis with a little over one hundred thousand."

"If properly built crematories are used, and if properly managed and the cost of common slack coal does not exceed $1.50 per ton the garbage of any city can be cremated at a cost not to exceed 20 cents per ton. This I can demonstrate. It is by all odds the cheapest method, provided properly constructed crematories are used and intelligently operated and so located that the cost of hauling is reduced to a minimum."

In the summer, when the crematories run at full capacity, the cost per ton does not exceed 15 cents, and in the winter, when not run at full capacity, 20 cents.

We find it cheaper to run more crematories, even at half capacity than to haul garbage long distances.

In the summer when running at full capacity we destroy about 130 tons per day.

The cost of labor is about the same in winter as in summer. The amount of garbage in winter is about one-half that of the summer season, hence the proportional cost of incineration will be greater in winter.

It is safe to say the average cost of cremation of garbage in Memphis the year round is 18 cents per ton.

There is no reason why cremation of garbage in Ohio may not be done as well as in Memphis if the people will learn how to do it. I therefore advise that this society investigate the system fully and recommend its practical features to our cities and towns.

Dr. Beckwith: I want to compliment the author upon her excellent paper. Sanitation is one of the greatest subjects that we have before us in cities, towns and villages. The subject of cremation has been taken up for the examination and study of the medical profession for the last ten years. New York is very successful with crematories, although she doesn't cremate all her garbage—she sells lots of it for fertilizers. That is where much of the garbage should go. In the city of Cleveland we have 25 sanitary policemen who visit every cellar and every yard in every building in the city once or twice a month, the back yards also are taken care of. There are no odors from decaying stuffs in Cleveland that I know of; these sanitary policemen visit all these places and it is their duty to arrest any one permitting a nuisance, provided they do not follow his instructions.

Dr. Cameron: I understand that the tenants in the buildings should be held responsible for the garbage. It is therefore a little difficult to enforce these laws, for many times tenants are not people of property. It would be better to hold the owner of the property liable for the proper disposal of the garbage, than to try to hold the tenant, and the cost of that can be taxed against the property holder. That one point in practice will work out better if the cost is put upon the owner rather than upon the tenant.

Dr. Hoyt: I was glancing over the morning paper this morning when I happened to see the following:

SCHOOLBOY OF 1905.

(Life.)

Teacher—Sterilized Stephen, do you bring with you a disinfected certificate of birth, baptism and successful vaccination?

"Yes, ma'am."

"Have you had your lower left forearm inoculated with correct cholera serum?"

"Yes, ma'am."

"Have you had your vermiform appendix removed?"

"Yes, ma'am."

"Have you a Pasteurized certificate of immunity from croup, cold feet and cholera morbus?"

"Yes, ma'am."

"Do you promise for yourself, your heirs and assigns, for all ages, to use sterilized milk?"

"I do."

"Do you solemnly covenant to soak your slate in sulphur fumes?"

"I promise."

"Will abjure every companion that sniffles?"

"I abjure."

"Do you promise to use an antiseptic slate sponge and confine yourself to individual chewing gum?"

(Sadly) "Yes, ma'am."

"Then extract that one remaining milk tooth, tie a formaldehyde bag 'round your neck and make your will. Come tomorrow and you will be assigned an insulated seat in this sanitary schoolhouse."

Dr. Kurt: I do not mean to say the tenant should be held responsible for the proper disposal of garbage. If it is cremated by the municipality the cost will fall upon the tax payer.

All premises should be regularly inspected, inside and out, and the tenant, of any property whatever, should be required to keep it clean. I believe in compulsory cleanliness where not kept from motives spontaneous with the individual.

RESUME OF THE WORK OF THE YEAR.

BY G. B. HAGGART, M. D., CHAIRMAN, ALLIANCE.

It is usual I believe to open each Bureau with a short resume of the work of the year last past,—and as this bureau is one of the most important of any of the Society, I trust that the fortunately short remarks I shall offer will interest you and bring out a thorough discussion.

Sanitary science is one of the few recognized departments of medicine. Every State as well as every country has some sanitary laws. Every individual must needs be vitally interested in the practical workings of those laws.

How unfortunate it is for us that we cannot, like the German government, see the need of more stringent food laws as well as municipal regulations to control the output of our supplies, and to

stamp with the best evidence of sanitary condition everything offered for sale, be it food, water, residence or even clothing.

During the last year our State has battled with three classes of diseases brought about in three different ways, viz: variola,—through contagion, or the lack of proper quarantine; diphtheria,—through poor plumbing and close tenement living; typhoid fever,—through pollution of our water supply.

There have been three ways by which the State has endeavored to control the spread of these diseases. By public sanitation, by fumigation, and by medication.

In variola the sanitary precautions are the cleansing of public alleys and sewers and the institution of pest-houses. The fumigants have been largely formalin, sulphur and creolin. Medication has resolved itself into the only *homeopathic* specific there ever was,—vaccination.

In diphtheria the sanitation has largely consisted of isolation. Fumigation has not met with much direct use. Medication still proves to be most effectual, whether by serum treatment or the indicated remedy.

In enteric or typhoid fever, the sanitary precautions have been those of almost classical repute,—and isolation is rapidly forging its way to the front. Fumigation has not been used except in a general way later. Medication,—that old, well-tried, battle-scarred defender of three thousand years, is still more than maintaining its place in all professional and lay minds.

As then a general summary of the work for the year, I should heartily say, that medication has by all odds proven the most important ally we have had, and that we cannot say any more than usual this year,—that there are other things to assist us, but medicine is the best force we have ever safely employed. The State is working to good effect among the residents to get proper enlightenment and better prophylaxis. It has been a year marked by a campaign of education along the line of sanitary science.

OUR WATER SUPPLY; WHAT IT SHOULD BE—WHAT IT IS.

BY G. B. HAGGART, M.D., ALLIANCE.

First Thought.

Water ought to be the commonest thing in nature. Our bodies are composed of at least eighty per cent. of it, and it is nature's great diluent, the *physicist of the universe,* by bringing agents and elements in contact with each other.

It would seem that as savage man could so well supply himself with it,—camping and working near it, that the first thought of civilized man would be to secure an abundance of it, for his private social needs. What other great conductor to civility, in his economic needs would he allow himself to suffer for, from default? He needs room,—he takes it by means of war; he needs navigable rivers,—he gets them by stealthy politics; he needs gold, that product which has set the minds of all races on fire,—he pushes aside survey limits and obtains it; he needs even furs to keep him warm, and he carries on international litigations, without thought of expense, to get it even in meagre quantities.

But what of his drink with which he must wash down his nutriment, slake his continual thirst, bathe away the poisonous excreta of his furnace fires within and reduce his metabolic waste? Does he get it in reasonable amount, free from the poisons of the arts,—the contamination of the dying organic bodies over which it flows,—or does he even get it at any cost commensurate with its reasonable worth? Does he try to get it at all? Does he also, into whose hands the executive work to the end of so obtaining it stifle his willing conscience by the thought that while thousands of his fellow beings in the large cities are dying from the absence of it,—the need of water,—pure water,—that the time is not ripe, or the need for it not sufficiently patent?

A Second Thought.

What it should be.

Why such a question? What should *water* be? Better in the usual way the question is treated ask, "What should be water?" In some places the filter and the cauldron for boiling purposes will

have to ere long give way to the excelsior meat chopper and the coffee-mill.

What would the people of northern Michigan who have beautiful springs,—crystal fountains, truly, rock imbedded, call the vile stuff we pump into our houses?

What would the Swiss with their ice-cold currents, fresh from the mountain's side, glacier laden, call the material our muddy, stagnant streams supply?

What *do* the bacteriologists who are quibbling, not over one or two thousand bacteria in a cu. cm. of our water, but over *thousands of colonies* of the most virulent of bacteria, instead, think of it? What can they help but think of it?

It may be a serious question whether water can be too pure or not. The late Prof. Orton of this city, tried to convince the Society for the Advancement of Science, that distilled water,—absolutely pure and sterile, did not furnish the life giving elements. Did not contain the necessary salts of lime, soda, manganese, iron, the sulphides, etc. No doubt he was right, and it is better for their addition, but had we not better get them through our cereals, meats and fruits, than to take in so much filth as must need go along in their company in the usually supplied water of our large cities?

The idea that all types of the genus homo must in its lifetime "eat its peck of dirt" may be classical, but not appropriate.

What have we to say for ourselves? We spend enough to keep our streets reasonably clean, sometimes burn or purify our city wastes, and even see to it that our politicians do not drink bad whisky, but we pay enough and more than enough for our political warfares, holiday celebrations, and junketing tours to annually supply ourselves with even the poorest substitute for good, cleanly prepared water,—the artesian well.

I cannot foreshadow the future, but I wonder what effect a good drink of wholesome sterile water taken at regular intervals, for a year would have on the working results of one of our average badly maligned councilmen?

Perhaps we should have, corresponding with the cleaner quality of the circulating blood supplied to his brain, and tissue cells, a cleaner character of political actions, more altruistic work,

more intersections of our city streets decorated by statues of great men, better libraries,—at least a few art galleries, some better paid industries, as well as a better water supply to come.

All vices are viciously fed. So much for the point of view.

A Last Thought.

Are we to be the victims of our own negligence?

Have we no power within our borders save that of individual effort? Is not even that a great power when accurately and actively used? Look at the aqueducts of ancient Rome and tell me if you can think of a decadent civilization living through and in spite of such faults as our own,—they, too, without our present advantages, steam, electricity, and since discovered chemical activity. These ancient towns took their water supply from the hills and only by the power of gravitation forced it to baths and pools, and yet with all this disadvantage as we would now look at it, the people were better supplied, and with a purer quality of water than we, who boast of an intelligent civilization, and yet allow two of the diseases which thrive in the presence of dirt,—made possible by the lack of an adequate supply of water, to create amongst us, our greatest mortality. I refer, of course, to tuberculosis and enteric fever.

Fortunately for us we have a most zealous State Board of Health. Its work is most laudable in its beneficent results. Proud should be that mortal who has the ability to direct effectively this great work. The laurel wreath may well be accorded him, who as a member of the board of such a public trust can, and does do, such effective and all-pervading work.

Let us give the State in whatever section we are of it, our efforts to create an effective public sentiment in favor of pure water, —nothing except the purest is good enough. Condemn the crude well water supply. Resist all systems of settling basins, crude filtration, and other treatment of our city water, and try to protect our lake and river supply while we must use it. Hasten by our every effort the use of the artesian well and spring supply.

Pure water can be had. Its cleansing can be thoroughly done. Let our force of character attest that it can be had, and when it can be had *pure,* its cleansing will be *well done.*

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J. H. WILSON, M. D. - - - - - Bellefontaine
"Argentum Metallicum"

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"Alumina"

CLINICAL VERIFICATIONS.

BY C. F. JUNKERMAN, M. D., LANCASTER.

Case I. June 22, 1889, Mrs. E. B. S., age 32 yrs., tall, slender, dark hair and eyes, had been a victim of epileptoid convulsions for fifteen years, always coming on at or near time of menstrual periods at which time she suffered with intense pressure and bearing down pains as if everything would protrude from pelvis. She would either have limbs crossed or sit with them close together, and muscles in a state of rigidity to prevent apparent protrusion; was very sad, and much depressed on account of the continuance of convulsions, which in her former physician's opinion would cease after child-birth, which occurred first, eight years, and second, five years prior to above date with little or no relief; in fact, the absence of convulsions during pregnancy was the only mitigation, as the attacks grew more severe after each pregnancy. Sepia 12x was given with almost immediate cessation which proved to be of a permanent nature.

Case II. Miss C., age 8 yrs., oldest daughter of Case I, light hair, blue eyes, was from birth troubled with incontinence of urine. The peculiar and interesting features of this case was that when being bathed or even placing her hands in water she would lose complete control of urine in spite of her most strenuous efforts

to become master of this function. Otherwise she had perfect control night and day. The only symptoms or history of this case other than above mentioned was that the mother was similarly affected during her pregnancy with this child, but after delivery she suffered no further inconvenience with her urinary functions. Sulphur 30x was prescribed for the child and resulted in a complete cure.

Case III. July 24, 1889, Wm. S., age 37 yrs., light hair and light blue eyes, had been confined to house for about three months with the following symptoms: sharp tearing pains in region of right kidney extending to the bladder, hence to spermatic cord, the contractions of which drew the right testicle up and held it firmly against the inguinal ring. Violent urging to urinate with sharp cutting pain in urethra, at times the pains and contractions would become so intense that his jaws would set as in tetanus, and every muscle in his body seemed to be in a rigid state of contraction. This intense suffering at such times appeared to be the most severe it had been my lot to witness. This patient had employed in consultation and otherwise seven physicians, who had exhausted all their resources to palliate or restore the health, but without appreciable effect. He had been etherized, chloroformed, and given morphine so frequently and constantly that he declared that within the last twenty-four hours previous to my call he had received thirty-three hypodermic injections, which gave but slight, if any, temporary relief. He had taken no nourishment for twelve days. His family physician informed his wife and relatives that all earthly measures for his recovery had been tried and failed, hence they could prepare for his death within the next twenty-four hours. He was given berberis vulgaris 2nd, five pellets every fifteen minutes, and became perfectly quiet after taking the third dose, at which time he went to sleep and remained so for twenty-four hours, it being the first natural sleep he had had since the beginning of his sickness. On the third day after taking barberis he was unable to pass urine, and on introducing the catheter his bladder was found to be full of very fine sand, small calculi and much mucus which required several washings before it was entirely cleared, so to remain. This man made a rapid recovery and remains well and happy to date.

Case IV. October 4, 1900, Wm. J., age 32 yrs., light hair, blue eyes, large plethoric subject, was taken with severe pains in region

of right kidney, extending to bladder. Pains were so severe that he was twisting and turning from one side of the bed to the other, bathed in profuse perspiration. He had been subject to renal colic for some years, each attack confining him to the house for three or four days, and the only relief he had been able to obtain was from the use of morphine. He was given berberis vulgaris 2nd, eight drops in half glass of water, of which he took two spoonfuls every fifteen minutes. Within two hours he was relieved and he returned to his usual occupation in four hours from the beginning of the attack. The next day he presented me with a calculus he passed in about twenty-four hours after taking the berberis. (The calculus I have with me and will leave with the chairman of this bureau for inspection by any one who may so desire.)

Case V. Mrs. L. J., age 47 yrs., dark hair and eyes, weight before sickness 115 pounds, was taken January 25, 1904, with constant gnawing pains under lower inner angle of left scapula, extending through chest to about two inches below left nipple. Of the location, character and direction of these pains the patient was very positive in her statement. The peculiar gnawing pain starting under inner lower angle of left scapula and passing anterially through chest proved to be very difficult to cover with any of our well proven remedies, and as there were no other except such general symptoms as inability to sleep or lie down, loss of appetite, extreme anxiety and restlessness occasioned by the pain, my search for the appropriate homoeopathic remedy was long, but finally rewarded by finding under chenopodium glauci, severe pains in region of lower inner angle of left shoulder blade running into chest. The pains of chenopodium glauci, for the left shoulder blade are similar to the pains of chelidonium for the right shoulder blade. Not having the remedy in stock, it was procured after considerable delay from an eastern firm, but during this time my patient lost fifteen pounds in weight. This, in spite of the carefully selected remedies, which according to Burnett and Rademacher, have a specific action on the spleen, Bartlett's principles of diagnosis, Butler's diagnostics of internal medicine, Elliott and Ranny on nervous diseases all claim this disturbance to be of splenic origin. We got no relief until chenopodium glauci 3rd was prescribed three drops every hour until improvement was manifest,

which required but twelve hours. With the exception of a slight soreness she expressed herself as feeling quite well; this vanished in a few days after taking the remedy.

Dr. Stewart: This is the character of paper that ought to bring every homeopathic physician to his feet to bear witness of his own success in cases similar. I don't think there is any one here but who could not give testimony along the line of this excellent paper. We can't all engage in proving or reproving our remedies, but we can tell what success we have had with the old remedies. We are all looking for something better all the time, and I think we will some day get it. It is right along the line of Dr. Junkerman's paper that I want to repeat a case in my earlier practice. In this case I know it was the homeopathic remedy pure and simple that did the business. I can remember with a great deal of satisfaction a long while ago, Dr. Beckwith, that I was called to see a case of colic in an elderly gentleman, not Dr. Beckwith, and that it was a chamomilla case. He related much the same history that we heard reported by the essayist. He had been given morphine and all those usual things, and as I was the only physician in that vicinity I got the case. As I said I found it to be a chamomilla case, and inasmuch as all other remedies like morphine and other anodynes had been prescribed without result there was nothing for me to do but to look up the homeopathic similimum and give it. I knew it could do no harm and that was all the other things had done for him anyway. It was an old army officer, and he said homeopathy was all bosh and he didn't believe a homeopathic physician could do any more for him than the others. But I gave him the chamomilla, and what is more it cured the case. It gave him so much relief without anything else after about half an hour that he wanted to know what it was I had given him, and he wanted to get a gallon of it.

Dr. Junkerman: The cases I have reported were very interesting to me, not from the fact alone that most of them occurred in my early practice, as did Dr. Stewart, but they quite clearly demonstrate the positiveness and superiority of a prescription based on symptomatology, instead of pathology.

PLATINUM. PALLADIUM.

BY W. A. DEWEY, M. D., ANN ARBOR, MICH.

PREPARATION. *The Spongy Platinum Triturated.*

General Action.—Platinum finds no place among the therapeutics of the allopathic school. Our knowledge of its action is derived from provings by Stapf and Gross, two disciples of Hahnemann. It is pre-eminently a woman's remedy. Its centers of action are on the female sexual organs, brain and spine, depressing them. Before Hahnemann nobody had ever used platinum as a drug. Nobody could have supposed this drug was possessed of medicinal properties unless guided by the laws of dynamization and cure. We have said that it depresses the nerve centers. There is a strong tendency to paralysis and anaesthesia, localized numbness and coldness produced by the drug. The great splanchnic nerves, distributed in the abdomen, and in particular the nerves of the uterine system given off from the hypogastric plexus are especially affected by platinum. A lack of energy, a lack of electric tension of the nerves seems to be expressed by the symptoms. It has no special symptoms pointing to great hyperaemia, congestion or inflammation, hence no alterations in the pulse. Platinum does not directly affect the blood life, but it depresses and despotizes and weakens the nervous life. With this clue we will be able to understand its symptomatology. Here the mental symptoms are of the greatest importance.

Mental.—The keynote to the mental condition is self-exaltation and contempt for others. There is an arrogant proud feeling, contemptuous, pitiful looking down on others. Everything and everybody is beneath her. So she gets out of sorts with the whole world, everything seems too narrow, she gets restless, sad, life gets wearisome, the most joyful things depress her.

Now a very peculiar physical condition is apt to accompany this mental state. Objects actually look smaller than they are. On entering a room after a walk, everything looks small, the room looks gloomy and unpleasant. This condition may be found in hysterical patients, objects appear smaller than they really are with spasm of the eyelids. There is alternation of cheerfulness and sadness, laughing and weeping that is peculiar to hysteria, but platinum is especially appropriate in that form of hysteria in which the disposi-

tion to weep and fear of death which is thought to be at hand accompany. Another frequent trouble found in hysteria is the so-called clavus hysterious, a peculiar tense headache confined to a small spot. Platinum has this very marked cramp-like squeezing pain, compression, constriction about forehead and right temple. The pain increases and decreases gradually. Prosopalgia with a numb feeling in the malar bones as if the parts were between screws. Pain at the root of the nose as though squeezed in a vise and followed by tingling and numbness. A peculiarity of the platinum pains besides, is that they become worse by sitting and standing and better by walking. Another characteristic feature is the evening aggravation and the accompanying sensation of cold and chilliness, thus there is a feeling of coldness, creeping and numbness in the whole right side of the face.

Female Sexual Organs.—Hypersensitiveness is the great guiding symptom. The parts are excessively sensitive to touch, cannot bear the napkins usually applied. Constant titillation or tingling in the sexual organs, internally and externally. This may excite the unfortunate victim to such a degree as to produce that horrible disease, nymphomania. The ovaries are very sensitive and are the seat of the burning pains, menses too early, too profuse and consist of dark clotted blood. They are accompanied by spasms and by painful bearing down in the uterine region with chilliness and sensitiveness of parts. Chamomilla has dark menses, but the mental symptoms will easily distinguish. Metrorrhagia or menorrhagia with sensation as if the body were growing larger every day. Uterine hemorrhage, copious and often returning. In the treatment of uterine hemorrhage the color and consistence of the blood furnish the valuable characteristics of the remedy. In platinum it is very dark, thick and tarry, not so much coagulated, accompanied by dragging and pressing downwards and with this unnatural sensibility of the genital organs. The disturbances caused by platinum consist chiefly in certain spasmodic affections and pains, and too early appearance of the flow, but this does not result from congestive overloading of the uterus with blood as with crocus and belladonna, but from atony of the nerves and vessels of the uterus, whereby a condition resembling anaemia is induced which is indicated in the symptoms of the platinum prover, namely: pale, sunken

face, pale wretched aspect for several days, and also by the painful sensibility with almost constant internal chilliness and external objective coldness. There is weakness in the nape of the neck, pain in back and small of back, numbness in the coccyx. Very weary relaxed and prostrated. Platinum is one of our remedies for painful coitus, others being sepia, belladonna, creosote and apis.

Stools.—Constipation from inertia of the bowels. The stool is retarded, faeces scanty, hard, evacuated with difficulty, it adheres to the rectum and anus like soft clay or putty. A sticky stool. Constipation of emigrants and travellers, those who are constantly changing their food and water. Frequent unsuccessful attempts to pass stool. Painter's colic, pain in umbilical region, extending through to back, pressing and bearing down in abdomen, extending into pelvis. Platinum antidotes the bad effect of lead.

PALLADIUM.

PREPARATION.— *Triturations of the Metal.*

The mental symptoms of palladium are in many respects similar to those of platinum. There is much mental excitement, the patient is inclined to weep, is worse the day following an evening's entertainment. They imagine themeslves neglected and their pride is easily wounded. *Oversensitiveness to offense.* Attaches great importance to the good opinion of others which is the opposite to platinum.

Headache across the top of the head from ear to ear is a most characteristic symptom.

Face sallow, blue rings around eyes, nausea, constipation. Soreness of abdomen with downward pressure. *Knife-like pains* in the uterus, tired feeling in small of back, sore bruised feeling all over. *Heaviness as of lead* deep in the pelvis, worse from exertion and standing. Swelling of the right ovary, bearing down; jelly-like leucorrhoea. The *tiredness* is characteristic. Helonias has this also.

Dr. House: Dr. Dewey has made a very concise and clear presentation of these two drugs, and I am sure this society is under many obligations to him for such a fine delineation of these remedies. I have never made use of palladium, but the other remedy I have prescribed frequently, and I can add my verifications in a great

many cases to the symptoms Dr. Dewey has given. They have always proved true and the results have met the expectations every time when prescribed upon those conditions. I consider platina one of our good reliable remedies, one that we can prescribe with confidence in cases that have been presented, and one that is well worth the study and re-study of the homeopathic physician.

Dr. Stewart: It has been suggested that platina is primarily a woman's remedy, because she has a million things to annoy her; but, nevertheless, it may be a good remedy for men as well as women. It seems that we have had a demonstration of that not very far from this part of the room. Dr. Beckwith thinks I haven't had a chance to verify the remedy since the early years of my general practice—in those days when I used chamomilla. He evidently thinks I am a renegade and haven't practiced homeopathy. I want to say that I have had a number of cases sent to me by other physicians that needed platina, one of these not very many months ago. It was a case of eye-strain. It had lasted for a long while. I tried in every way to relieve the headache, but I couldn't do it; glasses wouldn't do it, and I finally did what any homeopathic physician would have done, inquired into the case, and found that by prescribing for the sexual and menstrual symptoms and giving platina I cured the headache.

Dr. Dewey: The remarks of the last speaker, especially the latter part of them, have answered any criticism I might have cared to make. It is too often the case that the specialist prescribes from a specialist standpoint almost wholly and doesn't do any good until he finally prescribes for the patient, then he will cure the headaches and the eye strains and all that sort of trouble. If Dr. Stewart had done that in the first place, as he should have done, he wouldn't have had to try glasses at all.

AURUM METALLICUM.

BY FRANK KRAFT, M. D., CLEVELAND.

Aurum metallicum, the copy set me, nilly willy, by the indefatigable and strenuous chairman of this section, is something with which I have only a little personal experience, either in the crude or attenuated form.

I remember that our own talented Dewey discussed a paper on aurum in the International Homeopathic Congress in London, in 1896, and that his reference to the 16 to 1 fallacy at that time and in that audience, fell as flat and profitless as a Russian joke would strike a modern Japanese space-writer. But that paper, "Aurum: Its Pathogenesy and Therapeutics," by the ever genial and interesting Washington Epps, of the London Homeopathic Hospital, was a rare production, and, I believe, the best summation of what is to be found in our Materia Medica upon this auriferous subject; and yet, at the conclusion of eighteen closely printed pages in the Transactions, the distinguished essayist says: "I must confess to some feeling of disappointment that the results of a search that has taken considerable of time are so small."

This, too, has been my own personal experience after nearly twenty years of practice; and a frequent reading of the symptoms as recorded in our books causes me to believe that there is very little to appeal to the average, every-day, busy practitioner in the symptoms recorded to help him with his ordinary cases.

In part proof of this opinion or statement let me quote to you, in a brief way, what the discussers said of this paper of Dr. Epps' at London; and when we are reminded that here were foregathered representative homeopaths from all parts of the world, the paucity of remark and suggestion will be the more appreciated:

Dr. Dewey, of America, found that "afraid of the slightest noise" was a characteristic symptom, and this was based on the overlying mental symptom.

Dr. Drzewiecki found that aurum cured an eruption on the body and also the ectropion of a Jewess.

Dr. Jagielski found poison symptoms in a patient who had the stumps of her teeth filled in and built up with gold.

Dr. Clinton found just the contrary in a patient coming to him from Boston. It did her good.

Dr. Villers remembered cases of poisoning in young medical men from wearing gold nose glasses.

Dr. Kroner had a case of heart trouble in a patient of 78.

And that was all!

If one studies the insane trend until presently he feels that he is hot on the spoor for some excellent symptoms—symptoms

that may be safely stowed away against such case falling into his practice, by reading carefully a little further, he finds himself up against a wall of disappointment in that the symptoms dematerialize completely, or take on a form to be better and more familiarly dealt with with other and more every-day remedies. Take the syphilitic line and mercury and the iodides loom up high and tall; this is true of the nose, throat, lungs and eye symptoms; so that I feel with Dr. Epps like voicing my disappointment at the poor array of creditable symptoms upon which to make an intelligent prescription.

Let me here interpolate what most of my colleagues know, that I cannot and do not practice homeopathy upon any one or two characteristic symptoms. I am 'bleeged to have a totality before I can touch the bottle's cork.

Here and there, in aurum, we find alleged characteristic symptoms, which, by frequent iteration, and frequent copying from an earlier into a later edition, and putting the symptom in black-faced type, have at length attached some validation to themselves. And upon these, some of my friends are able to prescribe and to proclaim their victory. But like the case of the "quadruped" births, or the two-tailed calf, these cures almost invariably happen over in the next county where I have never had an opportunity to investigate their essential truthfulness; or, as in some recent reports made, the author has such a deplorable reputation for truth and veracity in the community in which he lives and moves and has his being, that I wouldn't trust him any further than I could sling a meeting house by the steeple.

You see, of course, that I am astride of my usual hobby horse, the not-prescribing upon one or two symptoms however characteristic they may seem, but the rather adhering to the Hahnemannian dictum of prescribing upon the whole case—The totality of the symptoms.

The old school has at length discovered that there is some medicinal virtue in gold—notably in the gold cure. We find a number of remedies hawked in the open chemical market containing varying proportions of gold, and from which commercial companies we are each month in receipt of a hatful of blotters, or penholders, or inexhaustible pencils. But, with these much vaunted remedies,

as with all their other preparations, I am unable to find use for them, unless I assume the allopathic symptomatology, and go it blind.

I have not undertaken to write a thesis on aurum just because I happen not to know anything about it; but in what I have to say, I promise not to tire you, and possibly you may be able to glean a point or two which may repay you for your kindness and forebearance. I will plump myself upon the one and the only one of its many hundred reported symptoms that has ever served me, that of mentality, and leave all the others and singular for the discussers if they feel minded to take them up.

I quote now from the Epps paper:

The first effect of aurum would appear to be that of exaltation—"Serene, contented mood, he always wishes to converse with others;" "Considerable merriment and agreeable, comfortable feeling;" "Tremulous quivering of the nerves as with a joyous hope," and etc. This soon gives place to an exactly opposite condition, that of abject despair, as shown by such symptoms as, "Dispirited and desponding," he thinks that everything goes awkwardly with him, and nothing will succeed with him;" "Discouraged and at odds with himself;" "Crying and wailing; she thinks that she is irretrievably lost;" "Anxiousness, even a noise before the door makes him anxious." These symptoms of depression become more and more intense, until they become so overpowering that he becomes suicidal. "Melancholy, he imagines he is not fitted for the world, he therefore longs for death, of which he thinks with the most intense delight." With this the great restlessness in the day and sleeplessness and palpitation at night, nearly always present in persons with suicidal tendencies. This condition is shown in "He is driven to constant activity, and is sorry for his inaction, although he cannot do anything; he cannot work fast enough; he could not act so as to satisfy himself." Under sleep we have "Drowsiness during the day;" "Slumberous sleep with weakness of the head when sitting during the day;" "All night long, wide awake and without sleep, though without pains, and in the morning he still was not sleepy or exhausted;" "Early from four o'clock onward, he cannot sleep soundly any more; he throws himself uneasily from side to side, because he cannot remain long in any one position, and the hand on

which he lies soon gets tired;" "When at last he falls asleep he is disturbed with vivid or frightful dreams, in which he sobs or screams aloud."

This is the end of the quotation.

I will mention now my aurum case which I remember so distinctly, because it was in my early practice, when I had both time and inclination to study and philosophize on such few cases as came to me. A lady of 25 to 30 years of age, married, in good circumstances, without children, healthy in body and mind, so far as outward appearances went, came to me complaining of headaches, beginning in the morning, which felt like a bruised pain when studying, or reflecting, or reasoning, or trying to make plans, and most especially when she was writing or talking. These headaches, however, disappeared little by little when she gave over whatever mental work she was engaged in, and would be wholly gone by seven o'clock in the evening. There was a history of sleeplessness but no pain. I was a far more faithful prescriber, as I believed, in those earlier days than I fear I am to-day. I was pretty thoroughly wedded to the medical calculus, i. e. the mathematical repertory, with frequent ponderings over the unthinkable hypotheses which had been unloaded on me by enthusiastic but chiefly theoretical teachers and voluminious space writers (as I have since learned). I was in that delectable condition and frame of mind, when if the summing up of an hour's running down of half a dozen symptoms showed that calcarea carb. had 61 points, and clapporrhinum had 62, I would most assuredly have given the clapporrhinum—and high—in the full expectation that the patient would now get well, *tito tuto et jocunde.*

Well, I found after some careful studying of the headache symptoms that nux and sryonia—for sryonia was my *bete noir* even in those salad days—and pulsatilla ran high; silicea also came into the picture over the fence from an oblique angle; but none of these, nor all of them, given singly, and well potentized, administered high and low—as low as the thousandth—proved of any signal avail.

One night about ten o'clock I was hastily summoned to see the lady. I found that she had thrown herself before a fast moving train, and had been barely rescued in time to save being ground into

a shapeless and lifeless mass. Now, this was a most disagreeable revelation to me; a shattering blow to my vanity of correct prescription. What was there about these headaches that would lead to suicide, and why had I not discovered the trend? Was homeopathy a failure after all? Surely I had worked hard and conscientiously on this case; yet here was this pitiful failure to reach the case.

However, I began again with the examination and learned bit by bit that she had grown melancholy because of her barrenness; she had lain awake many nights thinking of it; she fancied that John didn't like her as he used to do formerly (foolish girl—as if all Johns the world over were not equally lacking in front-gate and moonlight spooning after a twelve-month or two); that he was growing cool and that sometimes he neglected to kiss her when he went away in the mornings; she knew he was getting tired of her; she was no longer the young and pretty girl which had attracted him; soon he would find some one else more young and more after his later taste; he must be getting tired of this burden at his house, this woman who was merely an item of expense, who could do nothing for him—not even bear him a child! and so the headaches began to come on apace, and with that came the brooding, each intensifying the other; after that came "the voice" condemning her as a pariah, an outcast from God's presence and favor, who, because of her many iniquities, would cause her to continue childless, and so ultimately lose her husband's rapidly waning respect.

I had no aurum with me, but I got some pretty quick, for I now remembered the insane symptom, and I also learned something from the husband which gave color to my belief—this time without the aid of the yard-stick repertory—that aurum would help if it did not cure. And it did. This woman is now the mother of a 16 year old boy and two girls, respectively 14 and 11.

And yet, Arndt, in a recent number of his Pacific Coast Journal of Homeopathy, said that the aurum suicidal tendency is a mere bluff; that these people are too cowardly to take their lives. In this case it was an actual and cleverly planned endeavor to shuffle off this mortal coil; and nothing but a providential interposition—if you believe in that—or the accidental re-walking of the track by the track walker saved her from being ground into an unrecognizable mass. It reminded me then, and it does to this day when I recall

the circumstances, in all its tragic possibilities, of the crowning scene of the old play "Under the Gas Light," which some of you other baldheads may remember.

Are we to argue from this one swallow that it was a full-blown spring? Are we safe to assume that all suicidal talk points to aurum? By no means. This is what I conclude; that if I had taken the full case and studied it independently of the fool algebraic repertory; that is to say, if I had found all the symptoms of the case and deliberated and weighed them in their relation each to all the others, instead of running down a headache which had no relation to anything else, I might have found the remedy. I certainly found the remedy easily enough after the fact; illustrating again the wonderful speech a fellow could have made if only the blamed things which occured to him on the staircase afterward had popped into his head at the time of speaking.

As I study the materia medica I try to fix in my mind some practical, everyday factor of the remedy in hand, in order the more easily to hold it ready for a hasty call. My memory was never of the tarbucket order, and it is getting less retentive as I approach the end of life's activities. Gold, to me, in medicine is indicative of gold in the crude. The getting of it in that crude, if legitimate, brings pleasure and happiness up to a certain point; after that it becomes a disease. The foolish chase after gold, as a something to hoard, results in morbidness, in disease, and possibly early destruction of mind as well as heart. I have not attained to that assumed elysium myself, but imagine, if you can, the horror of owning two hundred million dollars with nothing to wear but clothes; nothing to eat but food; no books to read, because without ambition, object or pith; nowhere to go but out because you have been there a dozen times, and if the money was not gained by masterful and tactful application of the thumbscrews to the trust-ground populace, but comes by inheritance from some fur-dealing ancestor, or the ferry-boat owner, to children who have nothing to do but devise newer and more dangerous fashions of inciting their blasé appetites—how long would it take, think you, before aurum would be indicated? We always think what a good time we would have if we had several million of dollars in our bank account; and, still, when we come to simmer it down the "good time" would be based almost wholly and

solely upon feeding the appetites and passions of the body to dangerous excess; for we already have everything else in normal quantities.

The one word, therefore, which to me would typify this remedy, is the French word *ennui*. But please do not jump at the conclusion that there is nothing in aurum except this, for that wouldn't be true. There is much more to the remedy; it has been my misfortune that I am unable to apply it. That's all. I would put it in this way—it being eminently proper for the inhabitor of a parish practice, to conclude his sermonette with a glowing moral application: if you have a rich young person of either sex who has been pampered and coddled and given everything the world possesses before he or she was 25 years old, has hit the booze-bottle not wisely but far too strenuously, and then comes to you with some genital disease, mild or grave, and a fearfully depressed mind, look well to your aurum.

Dr. Wm. Baldwin: I am reminded that about 15 or 20 years ago of having had a case in a certain family. I was attending the wife and other members of the family for some other disease, and while so engaged in that family the domestic in the family, a young German girl, wanted to talk to me. She was the very picture of robustness, blooming cheeks, and energetic and every indication of health. As I was about to leave the house one time, she said to me, "I am not sick, but I want to see you because I have a peculiar thing ailing now, what that is, I don't know, except that I want to commit suicide." I looked at her and saw she was in dead earnest. "Now why do you want to commit suicide?" She answered, "I have no reason on earth." "How do you think of ending your life?" "I think most of jumping out of the window." I said, "Well, just wait a minute and let me give you a dose of medicine." I opened my case and gave her a dose of aurum. I interrogated her a few days afterwards concerning that feeling and she told me that that feeling had entirely gone from her. She is now married and mother of a family. I have seen and talked with her since, and she has never had anything like that feeling since that one dose of aurum.

ARGENTUM METALLICUM.

BY J. H. WILSON, M. D., BELLEFONTAINE.

There is no better way to understand a drug thoroughly and practically than to study it by comparison with other similar drugs. We find physicians differing in their methods of study, some depending on the memorizing of symptoms, especially the key-note symptoms, while a great many study from a purely pathological standpoint and endeavor to apply the drugs on a pathological basis, and others make the application by comparison of similar acting drugs, and I may say by exclusion as well, depending upon the peculiar symptom of the disease regardless of the pathology. While all of these methods have a certain value in making a selection of the proper drug, and no one method can be as successfully used alone as in combination with the others, the method of comparison has simplified the study of Materia Medica to me more than any other.

Our worthy chairman asked me to write a paper for this Bureau and assigned to me argentum metallicum as the subject. I can only hope to bring before you some of the more prominent features of this remedy, and make a few comparisons with other drug symptoms which are similar. If in so doing I succeed in making it easier for some one to make the proper selection for his prescription at the bed side I will be amply repaid for my trouble.

You will find this drug has a special action upon the cartilages all through the body, and upon tissues which have a feeble circulation, and will be found indicated in deep seated insidious complaints, which come on without warning many times, manifesting themselves in general weakness, with mental weakness, loss of memory and confusion of the mind, this condition preceding some insidious, deep-seated trouble, such as tuberculosis, epilepsy, etc.

Under head symptoms, we have vertigo, especially when looking down from a height or looking at running water, or any object passing rapidly, left-sided headache, which seems deep seated, confusion of mind, mental depression, tired, worn out feeling, prostration, all aggravated by mental work, just such a condition as you will find in brain fag in the overworked business man or student. Gelsemium has many similar symptoms, weakness, prostration, wants to lie down and be quiet, don't even want any one around, he

feels too tired to be talked to, but this is owing to muscular weakness and exhaustion, while argentum is from brain exhaustion, and they come from entirely different causes. The argentum affects the intellectual mind and not the centers that control the affections as in aurum.

Under eyes, we have some prominent symptoms, but not so often indicated as argentum nitricum. The troubles are likely to be deep seated, chronic troubles, scrofulous in nature, chronic redness of margins of the lids, pustules on edges of lids. Abundant purulent discharge, lids everted, the tarsal cartilages liable to be affected. With this condition we are not liable to have much pain.

In the nitricum we have many similar symptoms, but they are inflammatory in character and more painful. Graphites has many symptoms of margins of lids similar to argentum, but not likely to be deep seated like metal, and more liable to have chronic skin troubles in connection.

In the throat we have swelling in region of the submaxillary glands, swallowing difficult as from internal swelling, throat feels raw and sore during expiration, coughing or swallowing. This condition may extend into the larynx, where we get the hoarseness, especially in professional singers and speakers, raw spot over bifurcation of trachea, cough with expectoration looking like boiled starch. This symptom of boiled starch expectoration seems characteristic; you will find it wherever the mucous membranes are affected, in catarrh a discharge from the mucous membrane is seen resembling boiled starch. In this throat trouble patient will sometimes have a continual short cough which is very annoying, and will wind up with one or two hard coughs, when there will be lump of mucus thrown from the throat looking like boiled starch. This will give relief for short time, when the same thing is repeated; these cough and throat symptoms are more likely to come with or precede deep seated diseases as in tubercular troubles.

Aurum Triphyllum has swelling of submaxillary glands, with sore throat and hoarseness in singers and speakers, but has more constriction and burning. The discharge from the mucous surface more excoriating, and does not have the expectoration like argentum. Phosphorus is frequently indicated in these conditions; hoarseness, cough aggravated from talking, and in the evening, and

from changing warm to cold room. In catarrhal troubles of the metal we have not only the mucous membranes affected but may have the cartilages and bones involved, especially in tubercular constitutions.

We find under this metal, hunger a prominent symptom, excessive appetites even after a full meal; there is also considerable flatulence, but not so much as under the nitricum, and like china, does not get relief from belching, carbo veg. the opposite.

There is frequent desire to urinate, with profuse discharge of sweetish urine and worse at night. This will lead you to think of it in diabetes, apis mel. has profuse discharge of urine, but not sweetish, and generally comes in connection with dropsical troubles.

Under female sexual organs the left ovary is the most affected. If you will notice this is more of a left-sided remedy than right. Argentum Nit. seems to give the preference to the right.

In this short paper I have endeavored to bring to your notice some of the prominent symptoms of this valuable metal and show where they differ from a few other drugs, and wish to call your attention to the fact that it is not only the difference in symptoms but the character of the disease must be taken into consideration as well.

Dr. Beebe: This paper is truly a homeopathic materia medica paper, and is one that would easily be known from an old school paper on the same subject. Having been intimately associated with Dr. Wilson professionally for thirty years, I can say truly that he is a practical homeopath and knows how to make a homeopathic prescription. Dr. Wilson's success as a prescriber has been largely because of his close application to the study of the materia medica from a comparative standpoint. He absorbs the symptomatology of a homeopathic remedy totally. He learned that under the instruction of T. F. Allen, and we all know what T. F. Allen's writings consist of. We know his success as a teacher, and his writings, as well as his teachings, were largely along the line of comparative materia medica. T. F. Allen's works, our own Farrington's, and, of course, Gross—who was an older writer and teacher—were the three teachers from whom Dr. Wilson imbibed his knowledge of comparative materia medica, and I feel that when he makes an assertion

regarding a remedy he is not only adding a bit of actual personal professional experience but that he has made a study of the subject. I have much confidence in anything that Dr. Wilson furnishes on materia medica.

Dr. Wilson: I will say in concluding the discussion that I had prepared a paper on the argentums, but I got notice of the meeting last Saturday and found that I had been placed on the Bureau for argentum metallicum, and Dr. Rosenberger for argentum nitricum. So I had to go all over my work again and bring the subject down to the one remedy. I hope Dr. Rosenberger is here to give us something on the nitricum end of argentum.

ALUMINA.

BY A. S. ROSENBERGER, M. D., COVINGTON.

Pure Clay. Among the leading conditions corresponding to this drug is dryness involving both the skin and mucous membrane. The patient has a premature old look. The functions of the body are performed in a manner resulting in a numbness of the limbs and really of the whole body. The gait is unsteady, or such as you will find in locomoter ataxia. The digestion is like all the movements of the body, slow and resulting in constipation. The books say no stool until there is a large accumulation in the rectum, and then though the stool may be soft it is expelled with difficulty.

We find it suited to diseases of old people and infants. The mental symptoms are very prominent. The patient is timid with apprehensiveness and peevish fear of losing the mind or of death, tendency to suicide, yet she abhors the idea. The sight of blood on a knife seems to bring on the thought of suicide. This symptom was verified in a lady during her climacteric. She insisted on her husband getting all of the knives and his razor and locking them up at night, fearing that she might get them and kill herself during the night.

The memory is much impaired, seems to be unable to remember what she wants to say in a conversation, confusion of mind, uses the wrong word in conversation. Vertigo, inability to walk in the dark. Locomoter ataxia, must have eyes open. It is a very valuable remedy in this disease. It will relieve the tearing pains in

the thighs, when sitting or lying down, and when they are worse at night. The nates go to sleep when sitting, with great heaviness of limbs. The patient can hardly walk; has a staggering gait. Pain, cramps in the calves and soles of the feet. When this picture is present, attended by the peculiar mental symptoms, in short, when the symptoms agree, you can expect (and you will not be disappointed), results with this remedy.

I have a case of advanced locomoter ataxia in which I always relieve the distressing symptoms with this remedy. The 30th, potency acts very nicely in his case.

This case has the mental symptoms very fully developed. The mind has that confused state. Seems to be unable to arrive at a definite decision, judgment is much impaired. One other mental condition is very marked, he is led to doubt the reality of things with which he has been very familiar, even his own identity is in doubt; thinks he is someone else or that he is insane. Gets in a great hurry, everything seems to be moving too slow; the delays worry him so much. The time of aggravation is in the morning after waking. Like lachesis, the remedy is full of paralytic conditions and symptoms which proceed from the spine.

It may, and seems to be at first, a weakness of the parts involved, and is improved by rest, but it gradually increases until we have it general. There is at times great difficulty in swallowing. Then difficulty or slowness in action of the bladder. The patient will sit or stand a long time, and no amount of straining on his part does a particle of good. There is an unsatisfied feeling in the urethra after urinating, compelling an amount of straining in order to get rid of a drop or two that may be retained in the urethra. The rectal symptoms have been already referred to. We have this as a result of the paralytic condition of the remedy already referred to. We must differentiate in the rectal symptoms between this and many remedies that have difficulty in expelling stool, or as the books have it, inactivity of the rectum. Hepar sulphur, has inactivity of the rectum very marked, but when we look at the mental symptoms of the remedy we see a great contrast. An impulsive desire to suicide or to kill someone else.

If the patient should be a barber, he can hardly restrain from cutting the man's throat, with his razor, whom he is shaving. The

mother leaves her child with the nurse, for she is afraid she will kill it. Ferocious disposition, hyper sensitiveness to pain, easily irritated, very hasty in speech, a very chilly remedy. In nux mos. we have a very sleepy patient. Cannot sit down to do anything without going to sleep, exceeding dry mouth, a disposition to faint when standing a long time in a close, warm room. China is another remedy. But we soon find plenty of distinguishing symptoms in them all if we study the test carefully, but this is necessary above everything else.

These are the ways and means of the remedies expressing themselves, and if we are familiar with our materia medica we soon learn to understand what it says to us.

The remedy is full of catarrhal conditions, the symptoms agreeing. From all mucous surfaces there is thick yellow discharges from eyes, nose and throat. Nose is full of crusts of dry mucus. The opening of nostrils is closed with crusty formations. Always expectorating, or constantly blowing the nose. Catarrhs of old people, of long standing, a great disposition to take cold. This would be a very apparent condition, a thin person being poorly nourished, circulation disturbed by the sluggish disposition of all the organs, and yet the patient cannot bear the cold air, nor a very warm room; wants a medium temperature.

The same catarrhal conditions extend down through the oesophagus, so that we find it sensitive and attended with difficulty owing to the sensitiveness of the mucous membrane, and in the second place from the tendency to a paralytic condition of the oesophagus. The patient expresses it that they feel the food all the way down to the stomach, which we never do in health. This catarrhal condition extends through the entire digestive track so that often we have the soft stool, and much mucous passing after the stool.

In the paralytic condition it is very gradual in its appearance. At times it seems that by putting the will for a certain length of time upon certain muscles, they will be called into action, and perform their functions. Everything is slowed down. The conductivity of the nerves is impaired so that the prick of a pin upon the extremity is not felt for a second or so afterwards. This continues until his senses are impaired in this way, until it really means a benumbing of the consciousness and appears to be a mental sluggishness.

The skin symptoms of alumina are a very important part of its symptomatology. We have intolerable itching on getting warm in bed (something like sulphur). The patient scratches until he bleeds. This we must consider, for the patient scratches until the skin is raw and we have a scaly surface, but originally we have itching without any eruption; but with the itching and bleeding we get some relief of the itching.

We have thickening and indurations and ulcers with indurations at the base of the ulcers. This is a result of the sluggish, lazy condition both of the skin and mucous membrane and a very marked condition of the remedy.

We have purulent ophthalmia, chronic sore eyes and nasal polypus most liable on left side. A disposition in the remedy is to produce minute growths, indurations and infiltrations. Lupus or cancer of nose, scirrhus of tongue, soreness and bleeding of gums, offensive saliva, and burning in mouth and throat. It will antidote the poisons or cure colic produced by working in paint. I have been able to entirely relieve a case of colic in a house painter with this remedy, the other symptoms agreeing.

There is a tendency of this remedy to localize itself upon mucous membranes, hence catarrhs everywhere from the nose all the way through the alimentary tract. A very deep antiseptic remedy. The patient needing this remedy and receiving it will not see the immediate effect on the local part, but the patient will feel better, though the catarrh will show little or no improvement, yet this, too, will be improving all the while, and in time the local symptoms will yield. In this it is similar to the weakness or paralysis produced by plumbum.

From the effect of the remedy upon mucous surfaces we should see at once that upon the rectum and anus we would have all kinds of trouble with a thickened and indurated mucous membrane. We have fissures, it is an outgrowth of the effect of the remedy upon the economy, favoring the formation of fissures. We see that all the functions of the body are slow, sluggish, resulting in stasis of the blood in the capillaries.

Nitric acid and graphites are remedies to be studied in this connection. See what they have done for the patient. We have the same condition upon the mucous membrane of the vagina, leucor-

rhoea copious and acrid, inflaming the parts with which it comes in contact. The mucous membrane is patulous and thickened, all the pelvic organs are liable to the same catarrhal condition, with heaviness and weight in pelvis as if organs would fall out, all worse after menstruation.

It is a remedy for cough. The chest troubles will bear a very careful research. The cough is worse on waking in the morning; it is sometimes a long attack of it. Sometimes she coughs until she has to vomit, passes urine involuntarily. There is little if any cough during the day. There is a sensation as if the uvula was long, a sensation of tickling in the throat. A remedy to be thought of by singers and public speakers, when the voice gives out or becomes feeble and they cough with the feeling as if something was hanging in the throat. This symptom I recently verified in a lady who sang in the church choir. She insisted that there was a piece of skin hanging loose in her throat. Alumina C. C. relieved her promptly. You need to study rhus tox. along with these cases carefully, but as in all rhus tox. cases they seem to do very well if they keep the parts in motion, but rest puts them out of use at once.

Phosphorus, you will remember, has a similar hoarseness, but after the phosphorus patient thoroughly clears the throat of the mucus in the throat they can do very good work as long as they keep at it. The skin is dry, sweat is almost unknown, yet the patient is tired, worn out, etc., yet does not sweat, as the calcarea carb. patient, who sweats profusely. Chronic dryness of skin, additional cover increasing the itching, resulting in fissures at orifices from its dryness.

MATERIA MEDICA MELANGE.

BY C. A. SCHULZE, M. D., COLUMBUS.

Silica. Very often one overlooks seemingly insignificant symptoms. To an allopath they seem trivial and unimportant. To a homeopath they may mean everything—a cure. We must look to the odd and unusual symptoms in reviewing our cases. They are the ones that set us on the right track. Such are found under silica. The patient will either voluntarily or upon questioning say "Doctor, I notice that when I have a passage from my bowels the fecal matter will come out part way and then slip back again." By

following up the other symptoms of the patient you will surely find them covered by silica.

Baryta Carb. A remedy that takes away business from the surgeon, in my estimation, is a good thing for the patient, if not for the surgeon. When you find small, movable, fatty tumors under the skin you'll usually remove them by giving baryta carb. Be persistent and you will be rewarded.

Colchicin. You may oftentimes be puzzled as to what to give to quiet the intense pain of rheumatism. You may be tempted to give one of the alkaloids of opium, or a coal tar derivative. I would advise you to try colchicin 2x before so doing. I think you will not have to resort to anything else. Put about four grains into one-half glass of water, give teaspoonful every hour until you get relief, or lengthen the interval of the dose whenever you get the griping effect in the bowels.

Natrum Sulph. Oftentimes there will be bad results remaining after an injury to the head. You may have given arnica, hypericum, opium, aconite or ferrum phos., and still the bad effects are there. It may show some mental derangement and puzzle you what to do farther. In such cases think of natrum sulph., and, happily for the patient, you will soon see an improvement and cure.

Bacilinum. In troublesome coughs which do not yield to your seemingly well-selected remedy, whether due to tuberculosis or not, do not forget bacilinum. The keynote is weakness and exhaustion. This remedy works better in the 100 or 200 potency.

Psorinum. It may at the same time be your lot to be baffled in knowing what to do for foetid foot sweats. If after, or before, trying mercurius or silica you will look up and give psorinum high, you will be rewarded for your efforts. The keynote is foul smell or odor.

Ferrum Phos. We possess a potent, powerful remedy in combating acute, active inflammatory conditions. It is ferrum phos. For incipient colds it is worth its weight in gold. If, on exposure, you will give your patient a dose every hour for four hours, your cold symptoms will have disappeared in a very short time. Try it if you have not already done so.

Spiritus Glaudium Quercus. The alcoholic is to be pitied. Anything we can do to cure such an one, or take away the craving for spiritous liquors, is a boon. We have such a remedy. It is spiritus glaudium quercus. It should be administered in from ten to fifteen drop doses three times a day. It may be taken in water or milk. If dropsy and liver trouble is present it will be all the more sure to help your patient. The treatment must be kept up for three or four months. I have had the pleasure of curing a number of patients with this remedy.

Ledum Palustre. The season of the year is coming on when insect bites and stings will be common. Their bad effects can be obviated by the administration of ledum pal. internally and locally. It is one of our best remedies in this trouble.

Hypericum. Very often after injuries the patient complains of neuralgic pains or numbness. If the nerves have been injured, there is only one remedy to be thought of, and that is hypericum. I have seen the bad effects of such injuries, of months and years standing, disappear in a short time after the giving of the above drug.

Mygale Lasiodura. In chorea where there is twitching of the facial muscles on one side, or irregular, convulsive movements of one side of the body, which cease during sleep, but return on awakening in the morning, be sure to give mygale las. You will be highly gratified at the results.

Gnaphalium. You may run across a case of lumbago that you will find will not respond to your ordinary remedies like bryonia rhus and calcarea carb. If you have numbness in the lower part of the back, and a sensation of weight in the pelvis with amelioration on motion, you will find gnaphalium will cure your case.

Xanthoxyllum. You may often be in a quandary as to what to give in amenorrhoea. If your patient has ovarian pains which run along the course of the genito-crural nerve, and are very severe, with agonizing bearing down, you will quickly relieve your patient by giving xanthoxyllum.

Lemna Minor. We may often be at fault to know what to do for post nasal catarrh. If you find loss of the sense of smell and a putrid taste in the mouth, especially on rising in the morning, dropping down of mucus from the post nasal region, you will be

gratified by the remedial action of lemna minor. It is also said to be good for nasal polypi especially when accompanying above conditions.

Dioscorea Villosa. If we are able to avert a felon, we may indeed be called blessed. If, when the pains are sharp and agonizing, or on the beginning of pricking pains felt in the fingers or thumb, you will give dioscorea vil., you will almost always stop the further progress of the inflammation, at any rate bear this remedy in mind.

Magnetis Polus Australis. A very painful and troublesome malady to handle is ingrown toenails. I have given quick relief to the pain by giving magnetis polus australis, a dose about every one or two hours.

Kali Sulph. You may have a case of wandering or shifting rheumatism. Pulsatilla may seem indicated, but by trying it you do not get results. Now if you will look up kali sulph. very closely you will likely find the symptoms covered by it. It is a first cousin to puls., and has many symptoms in common with it.

Teucrium Marum Verum. A very troublesome affection is nasal polypus. Most physicians resort to the snare for its cure. It must have a suitable soil to grow on. Teuc. m. ver. changes the soil and deprives it of its nourishment. By giving it you will often be pleased by its rapid action in removing the cause and the polypus.

Iris Versicolar. There are headaches and headaches. Amongst them all, the bilious headache is the most annoying. Such a headache sours one's life more than any other. I said sour. That is one of the keynotes for the remedy. Extremely sour stomach, vomiting of very sour, burning fluid, great burning distress in epigastrium. There is a dull throbbing in the right side of the forehead, shooting pains in temples, all associated with nausea. Give iris ver. 30x or higher, and you will quickly relieve your headache and cure your gastro-hepatic derangement.

Dr. Means: I was not present when this bureau was opened, but I understand every member is present. I want to compliment the chairman on the success of this bureau, because materia medica has not had the recognition in this Society of late years that it merits. If we would study our materia medica more and talk amalgamation less, the idea that is becoming prevalent, that we will some

day in the near future, unite in one grand medical school, and that school be allopathic, would be forever banished from our minds. The old school knows but little about materia medica and the application of drugs in the cure of disease. Outside of surgery, chemistry and bacteriology the allopathic school of medicine is a century behind Hahnemann's idea, and for us to go over to them would be like turning the wheels of progress backwards. Go on, give no quarter, and our benighted brethren will some day see the star of hope in the east, that will enlighten them and cause them to flock to our standard.

Dr. Beckwith: I have not attended as many meetings of this Society as my good friend, Dr. Beebe, but I have been attending them for the last thirty years and also the American Institute, but I must say for this bureau that they have given us some of the finest papers I have ever listened to; the most homeopathy and the best subjects we have ever had in this Society.

Dr. Schulze in closing his Bureau said that he had tried to get the very best writers with the best of topics. He was pleased at the compliments showered upon the bureau, and he believed that a careful study of the papers when published would show that they are really masterpieces.

BUREAU OF SURGERY

A Symposium on Diseases of the Gall Bladder and Gall Ducts

H. D. BISHOP, M. D., Chairman - - - - Cleveland
"Etiology and Pathology"

W. A. HUMPHREY, M. D. - - - - - Toledo
"Symptoms and Diagnosis."

G. J. JONES, M. D. - - - - - Cleveland
"Treatment—Medical."

DE WITT G. WILCOX, M. D. - - - Buffalo, N. Y.
"Treatment—Surgical."

GENERAL ETIOLOGY AND PATHOLOGY OF DISEASES OF THE BILE PASSAGES.

BY HUDSON D. BISHOP, M. D., CLEVELAND.

Introduction.

In planning the work of this Bureau, it seemed to me that benefit would result from a comprehensive presentation of a study of diseases of the bile passages. The liver, through its internal and external secretion, is of more importance than any other gland of the body, and until recent years many of the pathologic conditions to which it is subject have been imperfectly understood. Our present information concerning it is by no means complete, yet it has rapidly increased within the last decade, and the principles of treatment have been accordingly changed.

General Etiology.

Diseases of the bile passages originate for the most part in some form of inflammation of the mucosa, this inflammation being caused either by some injurious material originating in or coming through the liver itself; or by injurious substances which have gained entrance into the bile passages from the intestine.

The former are of clinical importance, only, in connection with diseases of the parenchyma of the liver; the latter form the chief etiologic factor in the diseases under consideration.

The full recognition of this important etiological fact has had much to do with present day methods of treatment of the dis-

eases of these tissues. Of the method of invasion, whether through the general blood current or by direct invasion through the ducts from the intestine, there is and has been much difference of opinion, but experimental and clinical evidence is overwhelmingly in favor of the latter contention. No matter what the source of the invading micro-organisms, all authorities agree upon the following propositions: That normal bile is sterile, and under normal conditions, i. e., when there is a free and unobstructed flow of healthy bile, infectious micro-organisms do not gain entrance into the bile passages, or if they do gain entrance, the resisting powers of the tissues prevent their growth and development. However, when the conditions exist which are favorable to the development of an infectious inflammation in any part of the body, then it is that we have the beginning of some form of disease.

The most frequent of these conditions which are favorable to the development of an infectious inflammation which may exist in the bile passages is a partial or complete failure of the flushing of the biliary passages with bile, from a deficiency of bile, from a mechanical obstruction to the outflow of bile or from a loss of peristalsis of the vessel walls. A contributory condition which seems to favor infection even more than is ordinarily the case is the existence of a general lowering of the nutrition of the body with a consequent failure of its resisting power as is the case in old age and after exhausting diseases.

The invading micro-organism, when it meets with these favorable conditions, produces all grades of inflammation, characteristic of mucous surfaces, ranging from an increase of the normal secretion with proliferation of epithelial cells to suppuration and ulceration. The regularity with which these results are produced is by no means constant, the degree of injury depending wholly upon the conditions present. The infection may be of a very mild degree for some time, being finally overcome by the resisting powers of the body, or it may suddenly increase in violence, taking on all of the characteristics of a virulent infection.

Taking up in detail, the principal diseases of the bile passages, we have to consider the following:

1. *Disturbances in the Caliber of the Bile Passages.* There may be simply a narrowing of the caliber from a cholangitis or a

complete occlusion from gall stones or a phlegmonous cholangitis. Whatever the degree of narrowing or occlusion there is a mechanical obstruction to the outward flow of bile with increased tension and dilatation of the passages above the constriction. When this condition exists, either permanently or for a long time, the bile ducts become dilated, whatever inflammation is present is intensified and finally, hypertrophy or atrophy of the liver itself may result.

2. *Cholangitis.* Simple catarrh of the bile passages is undoubtedly most often caused by conditions other than infection, such as gastro-intestinal disturbances, caused by dietary indiscretions and irritation from biliary concretions. Such a catarrhal condition is, however, always an invitation to the entrance of infection and sooner or later there is added to the simple catarrhal inflammation the exciting cause of an infection, which may or may not become actively virulent. Suppurative cholangitis is always the result of an infection, either primary or secondary as just described. The infective micro-organism is usually the bacillus coli in combination with the staphylococcus aureus or albus. It is a frequent complication of the more severe infectious diseases, particularly typhoid fever and occasionally pneumonia.

3. *Cholecystitis.* While the gall badder is subject to the same etiological factors as the other biliary passages, yet the fact that it is more often the seat of the development of gall stones, adds to its predisposition to inflammatory disease. What is true of the role played by infection in the other bile passages, is even more true in the gall bladder from the fact that the conditions favorable to infection are more prevalent here than in the other passages. A slight degree of inflammation is sufficient to close the small opening from the gall bladder, and when this is completely or even partly closed a rapid change takes place in the contents of the sac, from admixture of broken-down epithelium and products of germ growth. Beginning in the mucosa, the inflammation extends through it, involving the connective tissue structures of the bladder walls, and finally to the peritoneal covering. The final result as far as the structure of the gall bladder is concerned is that of all chronic inflammation, atrophy.

This is the so-called fibrinous inflammation of the gall bladder, and is the most common course of the disease. Suppurative and phlegmonous inflammation may result as a consequence of a violent infection or mechanical injury to the walls from large calculi.

4. *Cholelithiasis.* The frequency of gall stones is a matter of considerable variance according to the statistics of different observers. It ranges from 6 per cent to 29 per cent in autopsies of male and female subjects and averages about 15 per cent in female subjects alone. Cholecystitis and cholelithiasis are so closely associated in their etiology that a discussion of one involves the other. Clinical and experimental data have shown that to produce a concretion two things are necessary; a cholecystitis or cholangitis must exist, and with it, either caused by it or by some other cause there must exist a stasis in the flow of bile. The chief conditions in which these elements are present are the diseases of the bile passages described, but a marked contributing cause either to the production of these diseases or to the condition of cholelithiasis is the mechanical obstruction produced by tight lacing and pregnancy. This explains to a large extent the greater frequency of gall stones in women.

The changes which take place within the gall bladder incident to the formation of gall stones are probably as follows: A cholecystitis exists which is produced by microbic infection. As a result of this inflammation of the mucous membrane of the gall bladder there is a degeneration of epithelial cells followed by desquamation and repair of the injured tissues. These desquamated epithelial cells undergo fatty degeneration and within them are formed large and small droplets of fat, which as they leave the cell conglomerate and form little balls of fat. These balls of fat form the neuclei of the gall stones, and if stasis of bile is present or occurs, layers of cholesterin are rapidly deposited and the stone is formed. (Hoppe-Sayler).

The number of stones which may be formed is almost without limit and depends upon the capacity of the gall bladder and bile passages. Seven thousand eight hundred and two separate stones have been found in a single case. The most frequent location for their formation is the gall bladder, less often, the bile ducts and bile passages.

The effect of the presence of the calculi within the bile passages and particularly so within the gall bladder is ultimately that of atrophy of the part. Leading up to this condition there are the conditions of mucous membrane and connective tissues which are characteristic of infective inflammation and mechanical injury. These are ulceration, formation of sacculated areas, diverticulae, abscess formation and even perforation.

The pathological changes incident to the repair of the injured tissues, offer the ideal condition for the development of carcinoma, and this fact should always be considered in the study of obscure cases of liver disease.

DISCUSSION.

Dr. Connell: In listening to Dr. Jones' paper, I think I will have to take exceptions to some part of his recommended treatment, especially in reference to the handling of gall stones. They all seem to start with the hypodermic injections of morphine reinforced with atropine. Now I have been in practice some thirty odd years, and I have handled gall stones after gall stones, and I have handled them without one use of morphine, and I have followed physicians that have injected their patients full of morphine, giving it either hypodermically or by way of the stomach; but in most cases you could find the trace of the needle all over the body. It is a trying place in which to place the physician. The patient is suffering and the relief is not always all that we are trying to get, and the physicians are not willing to stop and consider their materia medica as they would in other cases of disease and get the proper similimum, but they rush either to morphine or a surgical operation. But when I handle one of these cases, and I have handled a good many of them, they receive nothing but medical treatment, and homeopathic treatment at that. If we don't do this, are we any better than the old school? Can we expect any better results than the old school? If we use our homeopathic remedies, do we not invariably get better results than the old school? I say most emphatically, yes! And if I was giving a young man advice today in the matter of gall stones it would be to study his case as he would a case of typhoid fever or any other condition to which he was called, and give the indicated remedy. Throw away the hypodermic, for it cures nothing, while the homeopathic remedy does cure,

as we all know. I have cured one case with veratrum album, another with dioscorea, another with chelidonium, and you will find lots of symptoms of sulphur in these cases. Again, in these flabby cases you will want calcarea carb., and then there is belladonna given not lower than the third, and not oftener than once an hour, as well as nux and other remedies. As this speaker (Dr. Jones) is one of the professors of one of our colleges—which in many instances are aping after the old school and causing our boys to leave homeopathy for the old school—I think he should have given us thoroughly honest homeopathic treatment from a homeopathic standpoint. In addition to my homeopathic treatment I use lots of olive oil—have used gallons of it—and have had fine results by ordinary remedies in different cases.

Dr. H. T. Miller: The last speaker has mentioned a number of remedies that have served him well, and as a young man I do not feel inclined to dispute him. But in an experience of sixteen years, five of which were in surgical work with gall stones—in all that time the best remedies have been turpentine and carduus. I was recently called to a case which had been given the usual remedies, the pains continued even after having been given a grain and a half of morphine. Operation revealed two ounces of gall stones and pus. What would your homeopathic remedy have done for you there? It wouldn't have done a bit of good. The diagnosis had been appendicitis—I really hadn't thought of gall stones—if I had had any doubt at all it would have been in the direction of an ovarian tumor. But operation revealed the gall stones that had been there about two years. Do you think olive oil plus all the other remedies could have cured that case? I think not. I congratulate Dr. Wilcox on his able paper. It will do more good for homeopathy than such wild remarks as we have just listened to.

Dr. Wood: It certainly seems too bad to let this excellent series of papers pass into the proceedings without a thorough discussion. I was not present to hear Dr. Bishop's paper, but I know Dr. Bishop well enough to know that he went thoroughly into the etiology and pathology of the subject under discussion. I heard Dr. Humphrey's paper on "the symptoms and diagnosis," and he certainly has given us an exceedingly clear and precise paper dealing with this phase of the subject. It likewise did me good to hear

Dr. Jones' paper on "the medical treatment of gall stones." He did not treat his audience as though he were talking to a kindergarten school. He assumed that we knew something of the homeopathic treatment of gall stones, and he dealt directly and practically with the subject in hand. Dr. Wilcox, as usual, gave us a clear and classic statement of the surgical side of the subject. I do not think that anyone could put in so few words more information pertaining to gall bladder surgery. Gall bladder surgery is one of the live issues of today. We should deal with the subject from a practical standpoint. It is not one to be dealt with sentimentally or superficially. If there is a medical treatment that is better than surgical, let the gentlemen who have such knowledge give it to us without impassioned oratory. In short, we should deal with this as with all scientific subjects in the spirit of true scientists.

Even a most cursory review of the literature of gall bladder surgery will show that we have made great strides during the last five years. The per cent of cures by surgical measures is infinitely larger than it was ten years ago. We would certainly be derelict in our duty to our patients did we not give them the very best chance to get well that modern science can afford. I think that we are indebted to our chairman, Dr. Bishop, for creating so excellent a symposium on gall bladder surgery as he has. The series of papers which have been presented make a valuable contribution to the literature of gall bladder surgery.

Dr. Humphrey: I don't know that I have anything to say so far as the treatment medically is concerned, the symptoms and diagnosis of the disease, that upon which I directed my study has not been questioned by the society. As you all know it is not always possible to differentiate the different diseases of the gall ducts and gall bladder. It is the persistence of the symptoms that attracts our attention, and it is their persistence that causes us to infer the one or the other disease. I want to say this in the discussion of this matter, viz: that it is for us as physicians to enquire into the case, to inspect every part of the body, in order that we may get at the true cause, to study the treatment and cure and all those things that go to make a perfect picture of the disease. We are to discuss not only the medical side but the surgical side also. Dr. Wilcox has told us in the beginning that we should come to the surgical

side only when we had exhausted the medical side. I am very much pleased with this thought. I have tried all the means recommended and one more. I have succeeded in relieving a certain class of these cases in which the jaundice is not persistent nor prominent by flushing the gall tract, the gall ducts and gall bladder with heroic doses of podophyllum. I have also succeeded in curing some of my cases according to the Hughes method, which is calcarea and china high. In a number of cases I have had satisfactory results with this treatment, but I will say to you frankly that I used morphine during the attacks. I can't say that in any case the morphine worked to the detriment of the patient. I have succeeded in curing more cases with podophyllum in heroic doses—all they could stand two or three times a week for three or four weeks, and I have never seen but one of these cases have a return. In one case relieved by this remedy, it was followed by biliary colic and I had to follow it some time with other remedies.

We should remember that we may have biliary colic without gall stones, and if we cut down for them we will not always get them. Last year in discussing this subject in the North-Western Society at Toledo, Dr. Biggar broached the thought of using hydrastis, especially if they have a catarrhal origin. We must also remember that even the presence of gall stones will be tolerated by a gall duct after a period of time just as any other tissue becomes tolerant of the presence of an object that is foreign.

Dr. Jones: I have I presume lectured to as many students as anyone else in the room. I have signed the diplomas of probably fifteen hundred. I have been as conscientious I believe in teaching as any one I know of, and I have taught them just what I knew to be absolutely right. When I started out in practice I had some such an idea as Dr. Connell has, and I remember one case as well as though it were yesterday. I had quite a little practice in a town some nine miles away. I was called there to see a man who was suffering from what I considered gall stone colic. He had intense pain. I looked the case over, because he was a man who had been using stimulants pretty freely. I prescribed nux vomica, and remained a short time to watch its effect. He was slightly relieved and then I started home. I do not believe I had reached my home before he sent for his old physician, who gave him a strong dose of

opium—there were no hypodermic syringes then. Dr. Connell was somewhat inconsistent, for if he had succeeded in relieving every case by the homeopathic remedy there would be no use for surgery or a surgical operation, and if it is true that in some of his cases he did not relieve them with the homeopathic remedy then he must have reached out for something else. Certainly he must have preferred morphine to a surgical operation. I believe that in this assemblage that if all spoke truly that very few beside Dr. Connell would allow himself to suffer many hours from gall stone colic without asking someone to give him a hypodermic injection of morphine. Certainly I would not. When this tube contracts forcibly upon a jagged stone there is danger of rupture at any time; then an operation must be very quickly done. Morphine is one of the means for saving the patient's life. There is one point that has not been touched upon, and which I consider of considerable importance. It has been stated that we are prone to have cases when no gall stones are found. I have had two or three instances where we had such symptoms and found no gall stones of any considerable size; but we found instead biliary sand, a fine powder which was passed, and after that came the relief. One gentleman from Pennsylvania came to me who had his case diagnosed as carcinoma. He had sharp attacks of pain followed by jaundice. After a most careful examination I found, or rather he found, that he had passed off as much as a drachm of this biliary sand, and by systematic medical treatment and diet he was cured and has not suffered for years from anything of this kind. It requires considerable diagnostic ability to differentiate this class of cases from the true gall stone. In one instance I had the product examined by several chemists and only one was able to decide what it was. He claimed that it was xanthin, a product of the liver.

Dr. Wilcox: Only the most exaggerated cases will come to the surgeon, and I think this is especially true of gall stone disease. I know very well that the cases upon which I have operated have been cases which have passed through the hands of our very best homeopathic physicians, some of whom have practiced thirty and some even as high as fifty years, but they recognized that their treatment was of no avail and that something radical must be done, and the mechanical conditions disclosed would have convinced any

man on the face of the earth that medicines, however intelligently applied, could not relieve the distinctly mechanical condition. I believe it is the duty of every homeopathic physician or anyone else to relieve his patient, and if he finds that the homeopathic remedy will not do it, then he must resort to something that will. If morphine will do it, then well and good; if it is an operation, then surely an operation should be done. These mechanical cases cannot be relieved except by morphine. In a case of gall stone colic where the pain is excruciating, morphine is properly indicated. In many of these cases it requires about ten or fifteen minutes for a small gall stone to pass into the duct, and morphine is the remedy that will tide him over that agonizing passage. I have no doubt that the homeopathic remedy does relieve in many of these cases, especially such as have been spoken of by Dr. Humphrey and Dr. Jones; but in these mechanical conditions you will not reach the trouble with the homeopathic remedy.

Dr. Jones: How large a gall stone do the members know as having passed through the gall duct? I have a stone at my office which measured when passed five-eighths of an inch in diameter, and the patient recovered. She lived for ten or twelve years afterward.

Dr. Connell: I treated one case after it had been morphined and morphined, and by washing the stones that were passed I found one that was an inch in diameter, and quite a number of stones from that size on down.

Dr. Biggar, Jr.: Answering Dr. Jones' question, I would say that it would be most difficult to pass a stone five-eighths of an inch in diameter through the common duct. I think we have no means of knowing how long it takes to form a stone in the cystic duct or in the intestine by pathologic action. But these large stones referred to by Dr. Connell may have been formed in the intestines or gall bladder and cause pains simulating gall stone colic.

Dr. Jones: This woman was sick for three months, and her skin was of the color of black walnut; she had seen doctors enough to diagnose her case, and they all agreed that it was a gall stone condition. True, it might have ulcerated into the intestine, but

there was nothing to indicate that. It is not strange that such a stone should pass the common duct while it was still intact, for I have seen this duct when it measured over an inch in diameter.

SYMPTOMS AND DIAGNOSIS OF DISEASES OF THE GALL BLADDER.

BY W. A. HUMPHREY, M. D., TOLEDO.

CATARRHAL CHOLANGITIS.

Symptoms.—This condition is usually secondary to gastro-duodenal catarrh, to pressure from without or to local spreading infections. Again, it may be primarily infectious. These facts should be borne in mind in making a diagnosis, although we may have many of the common symptoms present. There may be present neither pain nor distress any more than is due to dyspepsia with languor. Jaundice is usually present in varying degree, and there may or may not be hepatic tenderness.

Fever is not a constant symptom, yet we may have a moderate temperature. Stools are clay colored, and the urine contains bile pigment. The pulse may be normal, but the rule is that the pulse is slow, sinking to forty or even twenty a minute.

The liver is slightly enlarged in some instances. In others the enlargement is quite marked. The duration is from four to eight weeks. The stools should be watched carefully, as in them we shall find the first evidences of subsidence of the swelling, or removal of the obstruction.

Diagnosis.—The diagnosis is usually not difficult. Jaundice occurring in young, healthy persons with absence of emaciation or evidence of cirrhosis or cancer and moderate in degree, usually points to catarrhal inflammation as the causation. Absence of pain and the negative results of physical examination, together with the maintenance of nutrition, help to confirm the opinion.

Cases which continue over two or three months should excite suspicion that it is more than simple catarrh. Many cases are the results of typhoid, pneumococcus or other infection. Differentiation should be made from syphilis, tuberculosis, cirrhosis, cancer and other conditions.

We should consider Weil's disease very carefully when the symptoms are severe. In the latter, the symptoms are very abrupt in their onset, with chill and fever of remittent type, severe pains in the back and limbs, with headache and light jaundice only. There are no preceding languor or gastric symptoms. The liver and spleen are swollen. Albumen is usually present, and sometimes hematuria. All these are in quite marked contrast to the insidious onset of simple catarrhal jaundice.

Suppurative Cholangitis is a secondary affection and simulates hepatic abscess, pyelophlebitis, syphilis of the liver, cancer or Weil's disease. The diagnosis is based upon its slow development and the presence of infection of the ducts or gall bladder, foreign bodies as gall stones, or existence of general infection. Jaundice may be absent entirely. The fever is that of general infection, hectic in type. The liver is enlarged moderately and is tender. There is a tender area in the region of the twelfth dorsal vertebra near the middle line. (Boas).

The blood shows leucocytosis, and when there is intermittent fever the examination establishes the absence of malaria. These facts not only establish the diagnosis, but the differential diagnosis as well.

CHOLECYSTITIS.

Acute Cholecystitis usually gives rise to distension of the gall bladder, with either serous or purulent fluid. This accumulation depends upon the closure of the cystic duct, as a result of inflammatory swelling, and the pouring out of an inflammatory exudate more or less rich in cellular elements of the blood, and the epithelium of the gall bladder, depending upon the activity of the process. (Stockton). Much evidence has been accumulated to show that cholecystitis in the majority of instances is due to bacterial invasion, whose presence brings about the disturbance of the lining membrane of the gall bladder. There are also certain predisposing factors, such as age, sex, indolence, gluttony and constipation, which should be borne in mind. Stout, inactive, constipated women at or before middle life are more subject to this condition than younger, active individuals. The close association of cholecystitis and gall stones, both as to etiology and clinical history, is such that it is not always possible to differentiate them.

Cholecystitis is almost always a secondary affection. It may or may not be associated with cholangitis. The affection is accompanied by local and constitutional phenomena. There are present increased tension and rigidity of the soft parts in the vicinity.

The gall bladder may protrude below the liver and may be palpated below the margin of the right lobe of the liver. Oftentimes there is present angiocholitis, in which case there will be present more or less pericholecystitis with adhesions.

The region is tender and painful, with more or less prominence according to the amount of tension and swelling. Pain is rarely absent and often very severe. It is generally continuous, with additional paroxysms of severe pain, like biliary colic. Fever, chills, rigors, etc., attended by marked remissions and sweating, vomiting and tympanitis, and at times jaundice. Leucocytosis is present, the white cell count rising 25,000 or 30,000 even when pus is not present. The patient is very ill, and dissolution threatens. Many terminate fatally, while others subside to recur repeatedly in the form of sub-acute or chronic cholecystitis. When the disease has reached this stage, the symptoms vary somewhat from those recited in the acute form. The severe pain and tenderness referred to the locality of the gall bladder are less, and the fever, gastric disturbance and symptoms in general less than in the acute form, yet there is present enough local disturbance to direct attention to the diseased condition.

The liver sometimes returns to normal size, but is usually slightly enlarged, especially in the region of the gall bladder. Adhesions frequently form, and are a source of pain to the patient. Local enlargement of the liver occurs where the inflammation continues. The gall bladder itself may shrink and be so small as to be concealed, while again it may take on the other extreme and enlarge and the walls become alternated.

The adhesions may give rise to symptoms which are of special diagnostic value. When they extend to the abdominal wall, there is a sense of tension or pain when the patient assumes the upright position. When they attach to the pyloris or duodenum, we often have disturbances of digestion occurring sometime after eating. Again the symptoms are vague, involving any or all of the digestive tract, such as auto-intoxication, constipation, diarrhoea, etc.

Diagnosis can often be made by exclusion only. An intercurrent attack of biliary colic will be of material assistance in the diagnosis, and will also help to establish the presence of gall stones.

In fact, it is impossible to tell in any given case whether the cholecystitis exists with or without gall stones, but they are pretty sure to appear if the cholecystitis continues for any length of time.

Chronic irritation of the gall bladder from mild inflammation, varied by exacerbation of the same, furnishes some valuable aids to diagnosis, viz: Subicteric condition of the skin and conjunctivae often transient, with sensation of weight or even pain or tenderness at the junction of the ninth rib with the cartilage, or at the point of the twelfth right intercostal nerve one inch from the spine, (Boas sign). Or some patient may go along for years suffering from auto-intoxication with bad breath, slight rise of temperature and urinary disturbance, and not having any very distinctive sign, no diagnosis is made.

If the patent has had typhoid fever at any time, no matter if a dozen years or more intervene, and we have this train of obscure symptoms, or even a part of them, we are justified in looking carefully to the gall bladder and ducts for the seat of trouble, for it has been conclusively shown over and over again that typhoid is the great antecedent of gall bladder disease.

Many of the cases of so-called relapse from typhoid are but development of cholecystitis, or it may accompany typhoid, manifesting its presence by an altered range of temperature, and an increase of the other symptoms, and sometimes by the presence of jaundice. Musser's latest statistics show that forty per cent of the cases of cholecystitis were preceded by typhoid fever.

INFECTIONS, ULCERATIVE AND CROUPOUS INFLAMMATION OF THE GALL BLADDER AND DUCTS.

Any or all of these conditions may exist as an accompaniment of one of the infective fevers, gall stones, etc., or secondary to infective conditions in other parts of the body.

Often the condition is not recognized during life, or there may be present only irregular fever with rigors.

If, after an attack of hepatic colic, fever of an irregular type, chilly sensations or sharp rigors occur, and prostration ensues, inde-

pendently of any paludal affection, we may suspect ulcerative inflammation of the bile ducts. Jaundice is present, which deepens, hepatic pains are marked, and a fixed local pain in the right hypochondrium is complained of. If the gall bladder is involved, enlargement of that viscus is observed. As the inflammation progresses, symptoms of perihepatitis and local or general hepatitis occur. There is pain also in the epigastrium. Vomiting often occurs. Hemorrhage from the stomach or bowels occurs also, and diarrhoea frequently develops. Budd believes many recover. This depends upon the course in which the pus burrows. If by chance it burrows toward the stomach or duodenum, and by lucky chance finds an entrance into one of these, recovery may take place. Or if it come to the surface, it may be safely evacuated. Or if none of these fortunate results occur, the patient may develop a typhoid condition, the fever continues, gastro-intestinal digestion gives way, cholaemia occurs, and death results from perforation or exhaustion.

If the cholecystitis be due to a foreign body, such as gall stones, the lodging of one of these in the common duct is often accompanied by a peculiar intermittent fever, the so-called intermittent fever of Charcot. (Musser). Diagnosis of this form of infection is very uncertain in the latent form. Pain in the hepatic region with enlargement, and tenderness on pressure, irregular chills and fever with jaundice in one who has had an attack of gall stones, are strong factors in making up an opinion. Prognosis is grave.

Differential Diagnosis.—When syphilis is suspected, we may be able to get the antecedent history, or specific treatment may help to clear up the diagnosis.

Infectious endocarditis may simulate this condition from the presence of hepatic congestion with septic fever, jaundice, etc., but endocarditis of itself is usually secondary, hence a careful analysis of the case will be a help in settling the question.

From multiple hepatic abscess, we are not always able to distinguish this condition, but in multiple abscess, the liver is large while in cholecystitis the gall bladder is large. Later ascites, diarrhoea and vomiting of blood may accompany the hepatic abscess.

In abscess of the liver, the signs are rather posterior than anterior. It is a very rare disease, is very slow in developing and is not painful.

Subdiaphragmatic abscess has a history of slow development with both abdominal and thoracic symptoms. Exploratory puncture posteriorly will be of assistance. Pleurisy and pneumonia ought not to be confounded with this malady.

CHOLELITHIASIS.

Gall stones usually produce no symptoms. Kehr believes that symptoms occur in only five per cent of cases.

The great majority of gall stones form in the gall bladder and remain there, producing absolutely no disturbance to their possessor. If they are of lesser diameter than the lumen of the ducts, they may pass harmlessly into the bowel without producing any symptoms. Others are too large to enter the cystic duct, consequently remain harmlessly in the gall bladder.

It is the moderate sized calculi, those that can enter the ducts and yet cannot pass readily, that make their presence known, and their consequences dreaded. When there are prodromal symptoms of cholelithiasis, they are identical with those produced by cholangitis and cholecystitis, viz: languor, dyspepsia, disturbance of the bowel, and the train of symptoms attendant upon whichever local condition exists.

Gall stones continually present in the gall bladder act as other foreign bodies, and do eventually damage the mucous membrane and predispose that viscus to cholecystitis and its train of symptoms. If a patient whose gall bladder contains calculi should have an attack of typhoid, the chances of infection are very much increased, and we should be on the alert for the symptoms of cholecystitis during and ever after the attack.

The neurasthenic with his multiple symptoms pointing to anything and everything, may possess the one tell-tale symptom, viz: dragging pains in the side, which will lead to the causation in the gall bladder, the relief of which will dispel the whole syndrome.

The symptoms produced by calculi are usually due to their presence in the ducts, and the muscular effort to force them onward to the bowel, when we have pain with shock, jaundice and fever.

Jaundice occurs when the stone lies in the direct route from the liver to the bowel, i. e., either in the hepatic or the common ducts. After an attack of colic, jaundice usually appears within twenty-four hours. The stools will be marked by the absence of bile in them. If the stone pass the bowel, the jaundice will slowly disappear. The cholangitis set up by the traumatism of the duct may cause swelling and temporary occlusion, which accounts for the slowness with which the jaundice disappears.

In case of permanent impaction, the jaundice becomes intense, and death ensues from cholaemia. Icterus varies in a given case, and may be entirely absent from time to time. In such cases, the obstruction is partly relieved from time to time by the irregular form of the stone which permits of partial flow of bile, or the stone lies free in the diverticulum of Vater. Or the variation may be due to the "ball valve" action of the stone, or remittance of the swelling of the mucous membrane of the ducts. Pain is more or less constant, as is also colic. The constant pain is of the gnawing or dragging variety. Its presence is good evidence of calculi in the ducts. This variety is due to inflammation from the infective cholecystitis or cholangitis. Tenderness of the liver is a frequent accompaniment of this dragging pain.

Biliary Colic is usually sudden and severe and often attended with shock, which may be fatal, as in three cases reported by Murchison. The pain varies from minute to minute, owing to the peristalsis. It is nearly always accompanied by vomiting, which is severe and may persist after the stone has escaped into the bowel. Cold extremities, sweating and general depression are present. After persistent pain for an uncertain period, the pain ceases, owing to escape into the bowel, or the dropping back into the gall bladder. The termination is not always of this character. The symptoms sometimes become remittent, the calculus remaining in the duct for years.

In the "ball valve" type of the disease, in which the stone lies freely in the ampulla of Vater, the pain may be periodical, slight or even absent, and the condition shows itself more by jaundice and fever than by pain.

Fever.—Gall stones alone in the gall bladder will not produce pain in uncomplicated cases. When an attack of biliary colic occurs

there is usually rise of temperature, even when the extremities are cold. It is claimed to be reflex, but it is probably due to infection. It is accompanied by rigors and sweating, and is of an irregular type. Charcot called attention to this type of fever, and it usually goes by his name. It is not always present, even when there is stenosis, Osler having reported two when it was absent.

Finding biliary calculi in the stool is conclusive evidence of their presence.

Diagnosis.—It is not possible to make a diagnosis in most cases, since they present no symptoms. It is necessary to get a careful history of every obscure case, and to weigh all the facts carefully, and as a last resort to make exploratory incision. The X-ray is not reliable owing to the fact that cholesterin concretions are permeable to the ray. Local tenderness at two points may often suggest gall stones, viz: (a) Midway between the ninth costal cartilage and the umbilicus, and (b) immediately to the right of the eleventh and twelfth dorsal spines. (Boas point).

When the symptoms are marked, the diagnosis is simple. Differential diagnosis should be established from intercostal neuralgia, gastralgia, ulcer of the stomach and duodenum, appendicitis, hepatalgia, pancreatic calculi and tumors, renal colic, movable kidney, tumors of the gall bladder, and biliary passages, suppurative cholangitis and malaria.

Intercostal neuralgia may be excluded by absence of jaundice and fever, and by the presence of tenderness along the course of certain nerves, although it may accompany gall stones in rare instances.

Gastralgia usually occurs in early life, while gall stones rarely occur before middle life. The pain is more to the left and is usually relieved by food, and there is no jaundice.

Gastric ulcer is aggravated by food, and the vomited matter contains blood.

Hepatalgia is rare; its existence is denied by many.

Pancreatic calculi are difficult to differentiate, although the pain is usually to the left of median line. Jaundice is rare. Glycosuria is apt to be present, the dejections contain fatty acids, and an excess of undigested muscle fibre.

In appendicitis the pain is usually below the level of the umbilicus, and there is swelling and dullness there. Leucocytosis is present, which will not be true in gall stones, unless associated with inflammatory complications.

The pain of renal colic usually originates in the loin, is lower down, and radiates toward the genitals, and there are usually present urinary symptoms.

Movable kidney is often very difficult to differentiate from gall stones; experienced clinicians mistake one for the other frequently. They do exist together sometimes.

Floating kidney may drag or press upon the gall duct so as to produce jaundice. If we are able to replace the kidney, and the manipulation is followed soon afterward by profuse flow of urine, the diagnosis is clear, but all cases of movable kidney are not attended by twisting of the ureter or pressure upon it, hence we may not get this symptom, or we may have a very much enlarged and displaced gall bladder which will be exceedingly puzzling to the diagnostician.

Many new growths and tumors cannot be diagnosed from cholelithiasis; they often co-exist. Rapid emaciation, jaundice, slight variable fever, with distended gall bladder point to cancer.

In cholelithiasis, the gall bladder usually is smaller, owing to the cholecystitis.

Malaria can be differentiated by blood examination.

The situation of the calculus is of great importance. Calculi in the gall badder can sometimes be palpated. The sensation is "like the grasping of a bag of hazelnuts," says Murchison. Care should be exercised, lest one should rupture the viscus or set up inflammation, which would aggravate the condition.

When the hepatic ducts are invaded by small calculi, they usually pass directly into the bowel without symptoms, but when a calculus lodges in the hepatic duct, pain, fever and jaundice will be present without enlargement of the gall bladder.

A calculus in the cystic duct is attended with pain, but with jaundice only rarely.

When the common duct is the seat of the lodgment, the symptoms already detailed will be present, viz: the tender area on a line between the ninth costal cartilage and the umbilicus continues or

occasional jaundice, according as the impaction is complete or incomplete, with absence of enlargement of the gall bladder, enlargement of the spleen, absence of ascites, jaundice, etc.

CHRONIC OBSTRUCTION OF THE DUCTS BY GALL STONES.

If the cystic duct be the seat of chronic obstruction, the gall bladder becomes hypertrophied to a variable degree, reaching in rare instances to the pelvis, and has been mistaken for ovarian cyst. The contents are invariably of a thin mucoid nature, which is mixed with bile for a time, but in case of complete obstruction, the bile is entirely replaced by a clear fluid, neutral or akaline in reaction. The physical diagnosis of this condition furnishes the only reliable method of differentiation.

Atrophy is usually preceded by this condition, and when extensive cannot be diagnosed except by exploratory incision. Many of the obscure effects of gall stones cannot be detected during life. For instance, perforation and fistulae. Obstruction of the bowels from gall stones presents the usual symptoms of this condition, the discovery of the calculi in the intestine being the only method of diagnosis. This cause of obstruction should be borne in mind, because it is by no means rare. Fitz found twenty-three cases out of 295 due to this source.

Stenosis presents the symptoms common to cholangitis. The diagnosis depends upon recognizing the cause if possible. When it is due to external causes such as cancer or other tumors, we may be able to arrive at a correct diagnosis by careful exclusion.

Another and most important remote effect of gall stones and diseases of the ducts is biliary cirrhosis of the liver. This condition is important here, because its presence may assist us in arriving at a conclusion as to the condition of the gall ducts. Weber defines it as "any cirrhosis of the liver originating from disease of the biliary ducts or obstruction of the outflow of bile." It occurs with or without gall stones, and sometimes without obstruction of the common duct. In a given case in which we find a resemblance to "hobnail" liver, which has a history of any of the gall bladder diseases, we may reasonably attribute it to this cause, after excluding syphilis, tuberculosis and cirrhosis due to alcoholism. The latter has its origin in the blood

vessels, while biliary cirrhosis has its origin in the hepatic ducts. The physical symptoms are much the same, except that biliary cirrhosis is usually accompanied by enlargement which is fairly uniform, and the surface is granular to the feel. It is not the coarse "hobnail" irregularity of ordinary cirrhosis. This, coupled with a former history of chronic jaundice and symptoms of cholecystitis or cholelithiasis gives us a reasonable basis for diagnosis.

There is still another class of these cases occurring in the young, due in all probability to chronic ascending cholangitis, which was first described by Hanot, whose name the disease still bears. Rolleston has disputed this theory, claiming that the condition is a descending cholangitis originating in the radicles of the hepatic ducts. Both are no doubt correct. When we have the ascending variety, we are concerned as relating to the subject under discussion. Much the same symptoms prevail as are described above, with the result that the child becomes dwarfed if he lives long enough. This condition often exists in whole families abroad, but is very rare in this country.

THE TREATMENT OF GALL STONES OTHER THAN SURGICAL.

BY GAIUS J. JONES, M. D., CLEVELAND.

Preliminary to taking up the treatment I desire to say that in my opinion gall stones are much more common than is generally supposed, even by the profession, and I also believe that the majority of cases recover without treatment. In former years nearly all cases of severe pain in the abdomen not accompanied by any prominent local condition which would account for it were treated as cases of colic, and usually the patient would consider that the trouble was due to some error of diet, or over-exercise. In proof of this statement I desire to quote a few cases.

Mrs. F., aged forty, called me to attend her on account of a very severe pain from which she was suffering. This pain was in the region of the gall bladder, extending through to the back and accompanied by nausea and vomiting. The pain was paroxysmal and lancinating, and I noticed that there was some appearance of jaundice. Both she and her husband told me that this attack was

similar to other attacks which she had been subject to for twenty years, coming on every few months, and passing away, leaving her somewhat debilitated, but otherwise in reasonable health. The physician whom she had employed during these years was a man of prominence in the city, and generally considered a careful diagnostician. He had never hinted that she might have gall stones, but had treated the case as one of gastralgia, the treatment consisting of a hypodermic injection of morphia, and some slight treatment, following for two or three days, with directions in regard to diet.

I suggested to both the patient and her husband that I believed the case was one of gall stones, and that I desired the husband to make a search for them the following day, and to continue the search for two or three days. The second day he found two gall stones, measuring more than three-eights of an inch in diameter. This patient has been under my treatment since that time, about eight years, and has had possibly on an average of two attacks a year. Some of the attacks were mild, but a few quite severe. It has been now a year since the last attack.

Another case, Mrs. P., aged at that time about sixty, called me about ten years ago. Her early history was similar to that of the case of Mrs. F., she having had on an average two or three attacks during the year for ten or fifteen years. The same symptoms were present—the lancinating pain in the epigastrium and right hypochondrium, extending through to the back, with nausea and vomiting, and finally sudden relief. Gall stones were found to be present in this case after a proper search was made. Prior to my visit she had been treated, as did the other physician in the case of Mrs. F., for gastralgia, and due, as he and they supposed, to an error of diet, and she had become very abstemious on account of the fear of these paroxysms. I have looked after her since that time, and she has had during the first three or four years about that many attacks, but in the last six years she has not suffered in that way at all.

Mrs. G., aged thirty-five, called me five years ago during the absence from the city of her family physician. She presented the characteristic symptoms of gall stones, and had been treated in a manner similar to the treatment in the other two cases, and she had dieted herself so carefully on account of the idea which had been conveyed to her by her physician, that these attacks were due

to errors of diet, that she had lost about one-third of her weight, and she was, in consequence, extremely reduced in strength. I had her husband make a search for the next two days, and he found three gall stones. Upon the return of her physician she told him that my diagnosis was that of gall stones, and he answered that that was impossible, as she had not the prominent indications of that trouble. She answered, "No matter about that—I have the gall stones here," and handed a small vial containing the stones to the doctor, who immediately said that that was sufficient proof, and that he evidently had been mistaken in the case for these several years.

Much can be done for these cases outside of drug therapeutics. The condition of the mind has very much to do with the treatment of gall stones. The old idea that the liver had much to do with the mental state has undoubtedly much truth in it, and anyone who is possessed of a violent temper, or is inclined to fits of melancholy, is much more liable to this disease than others; consequently in the treatment of such cases patients should be directed to avoid all such troubles, and to control themselves and live, as far as possible, contented and happy lives. One case which I watched very carefully for years, never suffered from an attack of gall stones while she was away on her summer vacation, but would have one or two attacks during the winter while she remained at home.

From the symptoms which I have noticed in all these cases I have come to the conclusion that duodenitis is a very common accompaniment—in other words, the inflammation which is excited by the traversing of the gall duct by the gall stones extends to the duodenum, and in consequence we get a catarrhal inflammation, and frequently an extension of this inflammation to the muscular coat, and possibly to the serous layer, and as a result of this we get atony of this portion of the bowel, or a loss of peristaltic power, with a consequent tendency to the accumulation of the product which should pass readily downward. Partial stenosis of the pylorus may be produced in this way by an extension of the inflammation upward until the various changes which precede that condition are brought about. Following that come dilatation of the stomach, with all its consequences, so that the treatment of a case of gall stones must include the treatment of a catarrhal inflamma-

tion of the various bile ducts and of the duodenum as well, and possibly of the pylorus. This should be borne in mind constantly when the diet for such cases is prescribed.

The diet in such cases should be of such a character that it will not irritate the duodenum as it passes downward. No particles of indigestible matter should be allowed to enter the stomach. All food should be properly cooked and thoroughly softened by some process before it is allowed to be taken. During the time of the attack very little food should be taken by the mouth. If the attack is long continued, or if there is very severe irritation of the duodenum and stomach, I would advise rectal feeding until such time as the patient would be able to take liquid food. After the attack the food shoud be chiefly of a liquid character for some days, and then the cereals should be allowed, and as soon as the patient is able to take food in considerable quantities my advice is that they be quite well fed. They should take a liberal quantity of fluid—at least three pints of fluid should be taken within twenty-four hours. This should be distilled water, or some other fluid that is free from all solid particles. I advise such cases to take at least a half-pint of water upon rising in the morning and the same upon retiring at night.

Medical Treatment.—The treatment is to relieve the attack as soon as possible, and as the stomach is usually disturbed, I usually prefer hypodermic injections. It is entirely useless to give medicine by the mouth when there is considerable gastric disturbance. Ordinarily the hypodermic injection of a fourth-grain of morphia, combined with 1-150 of a grain of atropine will relieve the patient for perhaps three hours. I would not repeat it in less than three hours, and would probably lessen the dose then. Sometimes it has to be given for several days, until the stone is passed. You will understand that the pain may stop and the stone remain in the duct. By keeping quiet, the peristalsis may be stopped and the pain discontinued. It is a difficult process to dilate the duct until large enough to allow these stones to pass. It has to be gradually enlarged until this occurs. The lower extremity is the most difficult point of distension; frequently it does not allow the calculus to pass, and it may remain there for months or years. Inflammation may occur there in consequence of the presence of the stone, which will

make its exit more difficult still. A poultice of slippery elm, best applied over the epigastrium and right hypochondria, will give some relief. There will be some fever, as a rule, for which aconite will be the remedy. I have considerable confidence in the use of china as a preventive of the formation of gall stones. I have used it considerably. Following aconite, if there is a regular intermitting fever, china would certainly be well indicated. In some cases with a tendency to perspiration without relief, mercurius would be indicated. This remedy is supposed to aid in the formation of bile, and the liver will return to its normal condition, but it more probably returns by curing the catarrhal condition. For the jaundice, which is frequently obstinate, I have found leptandra to be effectual. This resembles mercurius much in its action.

Colocynth has proven a remedy of great value to me in these cases, not only during the period of attack, warding off the pain in some cases, but for the continous irritation of the duodenum following such an attack. I frequently give this in the third attenuation four times daily for many weeks, and most of the cases under my charge at the present time who are subject to these attacks, have on hand a vial of the third of colocynth, which is given upon the first indication of a return of the trouble.

Bryonia will prove valuable in many cases after the attack when there are sharp lancinating pains aggravated by the least motion.

Nux vomica, when there is constipation with urging to stools, is especially valuable after the person has taken many vegetable cathartics or for those who have been addicted to the use of alcoholic stimulants or tobacco.

SURGICAL TREATMENT OF GALL STONES.

BY DEWITT G. WILCOX, M. D., BUFFALO, N. Y.

Lest the surgeon be arraigned on the charge of too hasty resort to the knife when medication and hygiene will suffice, I will preface my remarks by saying: In all cases of persistent or recurrent gall stone colic, with or without icterus, or in all cases of marked icterus, unaccompanied by pain, the knife should be used only after the failure of internal medication together with the most approved

hygienic living. But in making such a provision I should desire to emphasize my belief that no physician has a right to persist in his medication treatment of such cases, unless he early succeeds in materially mitigating the severity of the attacks and lessens their frequency. To so persist means, in the vast majority of instances, to either jeopardize the life of the patient or to condemn him to the life of periodic suffering which dispels all the joy of living. Therefore, while the knife is not to be taken up too readily, neither should it be withheld a moment after a fair trial has been given less severe measures.

Much has been written in the attempt to classify the cases of gall stone disease suitable for operation. To my mind such classification is of little benefit. If there is but one gall stone and it has found lodgment somewhere in the biliary tract and neither nature nor remedies will dislodge it, then the surgeon must go after it, and it makes little difference where it is lodged, for the surgeon has shown himself capable of reaching it no matter where located.

Again, if the patient continues to have frequent and severe attacks of pain, to the extent that life is rendered miserable or the health fails, then again must the surgeon become the constable and arrest the offender, which thus far has avoided apprehension. Hence, my classification will be this: to operate all cases of disease of the gall bladder or ducts (where an operation is at all warrantable) when other treatment has failed, and when the health of the patient is jeopardized even slightly.

Having thus settled the question of when to operate, we must next consider how to operate, and here a classification becomes helpful, because all diseases of the biliary tract are not alike as to their pathology. A single large stone incarcerated in the common duct shows distinctly different symptoms from a number of small stones collected in the gall bladder. It is in the former that icterus is usually present, owing to the more or less complete obstruction to the outflow of the bile, and because of that fact, these cases are far more dangerous to life than other biliary diseases, the danger depending entirely upon the degree of obstruction. Hence a patient with biliary colic, presenting signs of icterus with cholemia, is a dangerously sick patient and will not allow very much time to be lost in experimental medication. Frequently the obstructing stone

is so situated in the common duct, that it will float upward and allow the imprisoned bile to escape on either side and thus relieve the intensity of the cholemia; but a spasmodic contraction of the fibres of the common duct will soon drive the calculus into the narrow canal and more cholaemia follows. It is here that the judgment of the family physician is put to a severe test, for he should recognize fully that patients whose systems are saturated with bile, do not go through the ordeal of an anaesthetic and an operation at all well, and if their lives are to be saved the knife must be used early.

There are three distinct ways of treating the gall bladder surgically:

First, to remove it entire; cholecystectomy.

Second, to incise it, drain it, and close it again; cholecystotomy.

Third, to incise it, drain it, and attach it to the abdominal wall, allowing a fistulous opening to remain for the purpose of evacuating the bladder for such time as may be necessary; cholecystostomy.

At present the weight of surgical opinion seems in favor of removal (cholecystectomy); yet my personal experience with incision and drainage has been so satisfactory that I am rather loth to advocate the more radical operation. There are, however, certain indications, which render cholecystectomy absolutely necessary, and when such conditions are encountered, the surgeon has but little latitude of choice.

The conditions calling for the removal of the gall bladder are, great hypertrophy of its walls with threatened gangrene, new growths or any indication of neoplasm of that organ. A very badly contracted gall bladder with thickened walls and damaged mucous membrane, is an exceedingly difficult organ to drain and the risk of imperfect drainage may be greater than the risk of removal, hence in such conditions removal may be best. Incision and drainage without attachment to the abdominal walls, are indicated in those cases of simple gall stones, without visible evidence of infection or chronic changes incompatible with complete restoration of functions.

This latter condition is by far the most common in patients who have sought surgical relief early, before the gall bladder has undergone irreparable repair and where the patient's general health has not been reduced by occlusion of the common duct with the resulting cholaemia.

The third manner of treating the gall bladder, incising, draining and attaching to the abdominal wall (cholecystostomy) is required in those cases where the organ is too badly damaged to trust it in again performing its functions for fear of breaking down, but where the patient's general health and power of resistence is so much below par as to render a radical operation hazardous; in fact, I should limit the employment of this method of dealing with the gall bladder almost exclusively to that class of cases wherein the physical conditions of the gall bladder were such as to demand its removal and yet the patient's strength would not warrant the prolonged operation requisite to its removal.

Just a few words as to the method of operating; by elevating the patient's shoulders and placing a four-inch sand bag under the angles of the scapula, the operation is greatly facilitated. The best incision is the one known as Bevan's, which starts at a point just below the border of the last true rib (so as to escape entrance into the pleural cavity) and passes downward parallel to the outer border of the right rectus muscle.

This incision can be made long or short, according to the requirements. There is less objection in making a long incision in this part of the abdominal wall than elsewhere, because of the lessened danger of a hernia, hence it is best to make an incision sufficiently long to allow ample opportunity for doing the work rapidly and well. After reaching the gall bladder it will be well to bear in mind a few anatomical points. The fundus of the gall bladder approaches the abdominal wall near the end of the ninth rib. It is from two to three inches long. The cystic duct is from one-half to two and one-half inches long, averaging a little over an inch. The common duct varies between one and a half and five inches, averaging about three inches in length, and having a circumference of twenty millimeters, but is so narrowed by the vale of Heister that in only about ten per cent of cases will an ordinary silver probe pass. Just before the common duct enters the intestine it expands to form the ampulla of Vater, receiving at this point the pancreatic duct. Lying above and posterior to the cystic duct is the cystic artery; to the left of the common duct is the hepatic artery, and between and behind these two is the portal vein. The gall bladder itself is quite loosely attached to the under surface of the liver by areolar tissue, and covered by a reflection of the peritoneum.

The liver should be drawn upward by a wide retractor, whose blade is protected by a gauze pad, to prevent injury to that viscus. This retractor should be held by an assistant standing near the head of the patient; with the liver well out of the way and the patient's shoulders so elevated that the light falls directly upon the gall bladder, there is little difficulty in reaching and examining the entire biliary tract.

If the operation of cholecystotomy, simple incising, has been decided upon, then that organ is seized with volsellum forceps, drawn to the surface of the abdominal incision, protected well, opened, its contents entirely removed, whether they may consist of little or big gall stones, mucus, bile, cholesterine or diseased membrane; the ducts are then carefully explored by passing either a finger or sound through the cystic hepatic and common ducts. If no gall stones are found in the ducts, then the gall bladder is thoroughly washed, dried and closely stitched, after the manner of closing an intestinal incision. The abdominal cavity is then dried, not flushed, and the incision closed without drainage.

Cholecystostomy is performed in much the same way plus the stitching of the edges of the aponeurosis to the abdominal incision. The gall bladder is then loosely packed with gauze and this is changed daily or oftener as required. If the resulting fistula does not close of itself in six weeks or two months, it is best to freshen the edges of the wound and sew up the opening. I have never had any difficulty with such fistulae, all of them closing spontaneously, save one, which required the second and third operation 'ere it closed, but it has since remained closed without causing any difficulty. The possibility of such fistulae is what makes the operation of cholecystostomy unpopular, but even though such a fistula may result and refuse to heal, the patient is alive and in far better condition than when he had the frequent attacks of gall stone colic or was at death's door with toxic cholaemia. Personally I have known of biliary fistula which failed to heal.

The method of removing the gall bladder is as follows: After walling off the abdominal contents with strips of gauze, the peritoneum, connecting the gall bladder and liver, is incised around the entire base and neck of the gall bladder or wherever these two organs are attached. It then becomes an easy matter to separate

one from the other by blunt dissection, preferably done by the index finger. The cystic duct is severed by making an incision through the peritoneum parallel with the duct, stripping off such peritoneum for a little distance from the juncture of the duct with the gall bladder. The duct is then tightly ligated and severed, the stump being touched with pure carbolic acid and then buried by folding and stitching the redundant peritoneum over the stump, much as the stump of the appendix is buried. The most important part of the operation is to secure absolute closure of the cystic duct and complete burial of the stump, for a slight leakage of bile into the free abdominal cavity means a fatality. After the gall bladder is removed, the flaps of peritoneum remaining on the liver, where the gall bladder rested, should be drawn together and stitched, to avoid any raw surfaces being left. In all of these operations I think drying preferable to flushing the abdominal cavity.

We now come to the consideration of another class of cases, which while they are far more serious are fortunately less frequent, namely, those wherein there is an impacted stone in some one of the ducts. If the stone has lodged in the cystic duct, it can be removed without difficulty through the gall bladder by the method just mentioned. In fact, nearly all cases of calculi in the gall bladder present obstruction of the cystic duct, hence these can scarce be considered as a class by themselves. Lodgment in the hepatic duct is quite rare. I have never seen such a case, but a few have been recorded. In such cases the calculus can be reached either through the gall badder or by incising the hepatic duct and removing the stone.

Lodgment in the common duct is a much more frequent occurrence. Mao Robson says that about 67 per cent of cases of obstruction of the common duct occur at the duodenal extremity; about 18 per cent at the upper or hepatic extremity; and 15 per cent at the middle portion of the duct.

Up to this point the operation for the removal of gall stones has been comparatively easy and safe, but the moment we attack the common duct, we pass over the line of safety into the region of danger. It is rare that the surgeon is called upon to make a more difficult or dangerous operation than that of choledochotomy, which is an incision into the common duct, the removal of a calculus and the successful closure of the rent through which the stone was re-

moved. The calculus has succeeded in passing the sentinel at the outlet of the gall bladder and has pushed on into the cystic duct. Here it has made its ready escape and fled into the common duct, but has been arrested at the gateway of the duodenum by the small sphincter muscle situated there. Let us notice what effect this passage and interruption of the stone has had upon the patient. She (three out of five such cases are women) has been conscious of the migration of the calculus since it left the gall bladder. It, being a large stone, has caused much distress while in the cystic duct, there being present vomiting, dull ache and other reflex symptoms just mentioned. As soon as the stone entered the common duct the agonizing gall stone colic began, which is caused by the contracting efforts of that duct to force the stone onward, together with the roughened edges of the calculus scraping alone the sides. This attack is long or short, according to the time required in completing the journey through the duct. Usually the stone is forced to the duodenal extremity of the tube and there stops, but the great pain does not cease then, because the duct is still making great efforts to rid itself of the offending concretion and so keeps up its contracting spasms. In a few hours these contracting fibres tire and relax; then comes a respite from suffering, but as the call comes for more bile in the intestines, the gall bladder is stimulated, bile flows into the common duct, contraction begins and the pain returns. This process is repeated at intervals of six, twenty-four and forty-eight hours, the pain usually coming on at certain hours with considerable regularity. In a few days the patient becomes jaundiced, because there is interruption to the outflow of the bile. The surprise is that the jaundice does not come on earlier and become deeper, but that is explained by reason of the gall stone floating up and away from the duodenal outlet during the period of quiescence, thus allowing quite a free escape of bile. Indeed, were this not the case, a fatal cholaemia would ensue very rapidly. How are we to distinguish these recurring attacks, just mentioned, from acute attacks due to the passage of separate individual stones? Very easily: the latter come with no regularity, are usually shorter in duration, and when the pain ceases the patient is perfectly well. There is no dull ache, nausea or vomiting following the pain as in the former. Moreover, in the case of impacted stone, each recur-

ring attack is more severe until it is ushered in with marked chill, followed by high temperature and rapid pulse. But a distinctly distinguishing symptom in this condition is the gradually increasing jaundice with clay-colored stools.

Our patient has now come to the point where she is seriously ill. She has days, possibly weeks, in which she has no pain. She even clears up of her jaundice, because of the valve-like action of the stone in the common duct, but it is sure to come on again, the jaundice grows deeper, exhaustion is more marked, vomiting frequent and stools clay colored; every new attack runs the temperature a little higher, reaching 104 degrees. What is going to be the outcome? What can be the outcome when eight or ten ounces of so poisonous a substance as bile are forced into the general circulation every twenty-four hours? Inevitable death, and it is positively foreshadowed by the foregoing symptoms. A patient may last from three to eight months in the condition described, and every day nature will be crying out piteously for relief.

There are two difficulties in the operation of choledochotomy: first, to find the stone, as the outlet of the common duct is in the lesser peritoneal cavity, behind the stomach and pylorus, deeply imbedded in its surroundings by connective tissue, omentum, peritoneum and intestinal adhesions. The second difficulty is the insertion of the sutures to close the rent, through which the stone has been removed. This is best done by passing the sutures, after the Lembert method, before the stone is removed, for the moment the stone is delivered, the overstretched walls of the tube collapse instantly, bile pours out of the incision, presenting almost insurmountable difficulties to a proper closing of the opening. By passing the sutures first, the stone fixes the duct and keeps it distended. The loops of the sutures are pulled up out of the way, the incision is made between the sutures, the stone delivered, and then the tightening of the suture closes the incision at once.

However, before closing the incision into the duct, the surgeon should make sure that the duct is open, both into the intestine and back into the cystic duct. As it is almost impossible to avoid a slight leakage from the duct incision, it is better to pack around tube with gauze and then leave drainage; otherwise the leakage and diffusion of bile is almost sure to cause trouble.

It is gratifying to learn how much is being accomplished along surgical lines for the relief of this class of sufferers. Few diseases of a chronic type cause more excruciating agony to the patient than gall stone colic, and any reasonably safe method which promises not only relief but a fairly sure guarantee against return is worthy of our most careful consideration. I am convinced that gall stone surgery soon will stand on the same plane of rational treatment as is ovariotomy and hysterectomy, and that in a short time there will be placed to its credit the relief of thousands of otherwise incurable sufferers.

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"Dysmenorrhoea"

M. P. HUNT, M. D. - - - - - Columbus
"Ectopic Pregnancy."

DYSMENORRHOEA.

BY C. E. SAWYER, M. D., MARION.

Normal menstruation is a natural physiological function, wholly free from any discomfort. The menses should arrive and depart at regularly stated periods without pain or distress, and woman should be as unconscious, except for physical manifestations, of the menstrual cycle as she is of the secretion of urine, the digestion of food or the automatic operation of the heart. And any departure from this natural condition, so far as dysmenorrhoea is concerned, depends upon one of two states of the human economy. First, some real organic change within the generative system itself, or second, upon some general constitutional incompetency. Either of these causes may operate singly or combinedly, and for this reason it becomes vastly important that we look with the greatest care into the causes of dysmenorrhoea when considering the matter of treatment.

By so doing we learn that the possibilities in the treatment of dysmenorrhoea oftentimes go beyond the mere fact of local disorder—it has to do with disturbed physiological function which neither begins nor ends with the generative system, but affects as well the whole human economy.

Dysmenorrhoea is in the majority of instances a disturbance of the general nervous system, and to be treated successfully must be regarded as such. Therefore the old classification, obstructive, congenital, neuralgic, membraneous, etc., do not signify much; they have to do rather with manifestations than conditions; they are effects, not causes; symptoms, not disease.

This being true, it is necessary that the line of treatment adopted should be broader than this classification contemplates. On this assumption it is necessary to go farther and deeper than simple retrenchment against the occurrence of pain and suffering during the cycle. To ferret out the causes and really cure dysmenorrhoea, we must go into the family history, personal idiosyncrasies, individual habits and surroundings, and lead up step by step to the present disturbance. Want of care in investigation of causes will leave many a case to continue but temporarily relieved, if relieved at all, when it should be cured and cured permanently.

To simplify the subject, I shall in my discussion regard dysmenorrheoa as due either to local organic change in some of the organs of the generative system, or as the result of some general constitutional disorder. Among the former we may have sclerosis of the ovaries, inflammation of the tubes, displacements of the uterus, fibrous growths or stenosis of the cervical canal. Fortunately these are all conditions which may be readily diagnosed by careful physical examinations, and no doctor, no matter how good his guessing propensities, or however great his intuitive foresight, should ever fail in any case of dysmenorrhoea to make a careful thorough examination, and if any of the above named physical conditions do exist ordinarily, nothing but surgical interference will suffice, and no method short of radical surgical means will cure. There are remedies which may even in these cases mitigate the suffering, there are means which may relieve the trouble temporarily, but so far as cure is concerned, they are only makeshifts and should be so labeled.

If it is a sclerosed ovary that is causing the trouble, take it out; it is already worse than dead, and consequently worse than useless. If it is an inflamed and thickened tube which will not yield to carefully indicated treatment, after a reasonable time, remove it; it is only a menace to life and should be eradicated. If it is a fibroid growth, much may oftentimes be accomplished by internal medication, and the local applications of electric means. In this connection as a medicinal remedy, I would call your attention to iodide of lime, given in five grain doses three times a day. Within the past year I have treated successfully three cases of dysmenorrhoea due to fibroid growths to complete recovery by the combined use of the violet ray applied externally and the iodide of lime given internally. In each of these cases the distress at each menstrual period was so agonizing as to put the patients in bed for at least two days out of twenty-eight.

In cases where medicinal and other means are not sufficient there should be no hesitancy in surgical procedure; enucleation of the tumor is usually easily accomplished, this, too, without compromising any of the organs. This is a field in which gynecological surgery has won many laurels because it saves rather than destroys. In the event of mal-position being the cause of dysmenorrhoea, the needs are self-evident, nothing but overcoming this will be sufficient to the end, and whatever operation or treatment accomplishes this best will be most serviceable.

If a patient has real stenosis of the uterine canal, there is but one sensible thing to do; that is to anaesthetize her and dilate the canal freely, fully, thoroughly, only desisting when all resistance has been overcome. Temporizing in this matter is worse than useless. I would remind you that a small sound passed within the uterus is always accompanied with more or less danger, while complete dilatation is absolutely harmless. Stenosis is generally regarded as a very common cause of painful menstruation, but my own observation disproves this. If all things else are equal, if the constitutional forces are acting properly, the normal menstrual discharge requires but a small opening for its outlet and a pinhole os does not by any means always indicate obstruction to flow and consequent pain. Such physical appearances are misleading, and it is in this particular class of cases that extreme care in diagnosis is neces-

sary, and without this care the gynecologist's reputation may be compromized, for if he promises cure by dilatation alone, his promise may never be realized.

This is one of the cases in which there is some general constitutional deficiency, and this brings us to the consideration of the second class of cases, viz: the one in which general constitutional forces are at fault and for which the treatment to be employed must be general, more persistent, less heroic and more continuous than in cases where surgical interference is indicated.

To illustrate the class of cases to which I now refer I would remind you of the numerous cases of young women who come to every gynecologist for relief from this affliction, the history of many of which is imperfect and the cause vague. Local examination reveals no specific cause. The uterus may be normal in position, size, shape and form, the cervical canal reasonably patulous, the tubes and ovaries practically normal, and yet the pain at the menstrual period is extremely distressing. This is what I denominate the trying case of dysmenorrhoea. Trying because of a lack of significant symptoms, trying because the patient is not always agreeable to the persistency of effort in its overcoming, trying because it is difficult to impress the patient and those related with the importance of the correction of habits of life and modes of living. In the majority of this class of cases we find two prevailing conditions, one a highly organized, over-sensitive nervous system, the other a marked disposition to rapid congealing of the blood and of congestion of all tissues. As a result of these shortcomings, it will be found that there is an imperfect condition of elimination going on within the body at all times. Examination of the urine will show high specific gravity, scanty flow with deposits of urates and phosphates in abundance. As a result of this there is going on within the system, a condition of auto-intoxication and all infection, no matter what its source, disturbs the nervous system pre-eminently.

With this condition existing constantly, with the elimination forces loaded to their capacity, the menstrual cycle brings not only extra duty to the nervous mechanism but likewise extra responsibility to the eliminative forces, and without help to carry on these extra demands, pain is a consequence, a consequence, too, which can only be overcome by constitutional forces operating in a proper

direction. These are the cases which have to be studied from a general standpoint. They are the ones in which matters of diet, general habits of life and modes of living have to be taken into consideration. They need to be taught the importance of general physical improvement, they must be instructed in matters of diet, they must be led to know that sweets, that stimulants, that highly seasoned foods and that a nitrogenous diet is hurtful and consequently they must be restricted in these particulars. These cases need plenty of outdoor exercise. They should be taught to breathe deeply, to be regular in their habits of bowel and bladder movement, to live as much as possible in the open air. These are the cases that should be restricted in social demands, in mental requirements and physical waste; unless these conditions are taken into account the indicated remedy will be ineffectual and the results unfavorable.

A young woman presenting these constitutional conditions should be instructed explicitly in her mode of living. She should be told of the necessity of keeping all of the eliminative organs active, the body should be bathed frequently and rubbed briskly with a flesh brush. She should drink freely of pure water and take plenty of outdoor exercise. In other words, anything and everything that will bring about the most perfect condition of elimination and assimilation must be employed.

I have purposely omitted drugs and their use because I take it that every physician knows when these are indicated and how to prescribe them, but I do know that every physician does not realize the importance of thoroughness in examination, care in diagnosis and the necessity of urging surgery when indicated, and the correction of faulty habits of living, and it is to emphasize these particular points that I find excuse for this paper.

DISCUSSION.

Dr. William Baldwin: It seems to me the Doctor's paper lays too much stress on the surgical measures in these cases. For thirty years I have had the best of success in treating such cases, and I don't think I have had to resort to more than a temporary dilatation with a steel dilator. I take the homeopathic indications always in consideration and treat my cases homeopathically for all the symptoms presented. In fact I have such success that I have had a great many patients from other States. I wish I could say I had as much

success in other diseases and ailments. I find it quite impossible to make a complete diagnosis without the steel sound. For instance, you will find in some cases that the womb has dropped slightly and makes a kink, or ante, or retroflection, so that neither the menstrual blood nor the sound can pass, so it strikes the posterior uterine wall. But with the steel sound you can manipulate it until you have it in place and the sound will gently find its own way to the fundus of the womb by its own weight, and makes about one-sixteenth of an inch opening. If we go to work and open it a quarter or a half inch we bring about an unfortunate condition that will give us trouble. I have been treating dysmenorrhoea in this way for over thirty years. Cures almost 100 per cent.

Dr. Arndt: The tendency of specialists is to forget that the part of the body they are concerned with is really related to the rest of the body; and that its well being is still in a large degree in the keeping of a central nervous system, which relates it to the rest of the body, and which makes it bear its part in the general joy or sorrow. Any treatment of local disturbance that does not take into account this central nervous mechanism falls far short of completeness. Peripheral manifestations are of use, but are very often misleading unless they correspond to central conditions. They should serve to call our attention to the real trouble. In the great majority of cases of dysmenorrhoea we will find on examining the nerve centers that the lower portion of the cord will be sensitive—twelfth dorsal, second and fifth lumbar. A permanent cure is practically out of the question unless these centers are relieved of the trouble existing there. The indicated remedy acts through the nervous system, and when we succeed in finding the real remedy there is nothing left to be desired. But very few are fortunate enough to often find that satisfaction, and mechanical and chemical aids are necessary to help perform the cure. I wish to recommend the careful examination of the spine in these cases, and the use of vibratory treatment for tender centers.

Dr. Fletcher: I want to express my appreciation of the paper and of the hygienic treatment of dysmenorrheoa advised by the writer. I also want to say that in electricity I have found a great adjuvant. In young girls I find that by placing the negative pole over the sacrum and the positive over the uterus

one can often relieve this condition of dysmenorrhoea, combining this treatment with proper exercise and food. In other cases where we have stenosis by using a dilator with the negative pole in the cervix you can often overcome that painful condition without the use of surgical measures. You can use the graduated sound in dilating and get very good results through the intelligent use of the continuous current.

Dr. Biggar, Jr.: Dr. Sawyer impressed me with his original measures. I want to speak of one feature that has given great relief, and that is the exercise of fencing. By fencing you get a development of the pelvic muscles and pelvic structures that strengthens the ligaments to support in correct position the displaced organ. I can't see how stimulating the sacral nerve centers in the spine will relieve a mechanical retro-displacement, for the retroverted uterus is the cause of the nervous condition and not the effect, therefore correct the mechanical defect and relieve the tension on the sacral nerves and then tone up the nervous system. Sounds should be most carefully used. They are at times dangerous. I have seen hyperaemic organs punctured from the use of sounds by careful operators. We have all of our sounds and dilators made with a shoulder two and three quarter inches from the tip, so as to obviate any accidents. There was one case of a woman not pregnant but whose womb was large and congested and the sound in the hands of a skillful physician penetrated the wall, necessitating a laparotomy for peritonitis.

Dr. Munn asked if Dr. Sawyer curetted in all cases of membraneous dysmenorrhoea.

Dr. Sawyer: I do not.

Dr. Beebe: Dr. Biggar spoke of the use of sounds with shoulders to them. I believe that to be a very fine thought. He spoke of the danger of perforating the womb, and here I agree with him again. I have had the accident of penetrating the wall of the uterus with a sound, fortunately without bad results. The first time that happened was when Dr. Wilson of Bellefontaine was with me. We were much alarmed, but the patient got along very well. I have done it a half-dozen times since, still I wouldn't recommend it as a safe surgical procedure.

Dr. Arndt, answering a question as to the length of time for treatment with the vibrator, said that depended entirely upon what is wanted to be done. For stimulation, five to ten seconds; for inhibition, from twenty to forty seconds with hard pressure. I think the matter of diet could be trusted to the disposition of the patient. If the body is normal and functions are active, especially that of the stomach, then I think the diet need give us no concern.

Dr. William Baldwin: The diet has much to do in results in these cases. Keep the stomach sweet and we can accomplish wonders. My attention was forcibly drawn to this by a young lady who stated that when she wanted to go to a dance she would drink vinegar to first stop her sickness, if "on," at that time. This impressed me very much, and acting on that suggestion in the treatment of dysmenorrhoea or amenorrhoea, I always see that by proper diet, i. e., using soda biscuits instead of fermented bread, and no butter except in cooking, avoiding all acids and acid fruits, using meats and vegetables, I delight myself and patients with results of the action of the indicated remedy. If the above suggestions are disregarded, I am always sure of defeat.

Dr. Sawyer: I find that I failed in one purpose of my paper, in that I did not make clear that there are cases for treatment by mechanical means, and that there are other cases that cannot be helped except by operative means. I directed my attention chiefly to the surgical cases in order to emphasize the necessity of using surgical means to effect their relief, and I think by reference to the cases cited it will be shown that there is not one of them but that does require surgical procedure. When the condition of dysmenorrhoea is due to a nervous cause; when mal-nutrition is the basis of the disturbance, then means should be applied in accordance with the demands of the case. Again, each case of dysmenorrhoea is a law unto itself and must be so regarded, else we will continue to have many failures which might otherwise be recorded as cures. Dr. Beebe would have us think that it is a common thing for the up-to-date doctor in sounding the uterus to go through into the abdominal cavity, but I would advise against this course of procedure. Of course it may be possible among Beebe's patients to persist in this course of treatment without danger. I think this is entirely due to the fact that they come from Sidney.

ECTOPIC PREGNANCY.

BY M. P. HUNT, M. D., COLUMBUS.

Pregnancy Outside the Uterus. Extra-Uterine Pregnancy. Tubal Pregnancy. Interstitial Pregnancy.

Normal fertilization of the ovum takes place in the outer portion of the fallopian tube, the ampulla. The fertilized ovum then travels down the tube to the uterine cavity, where it becomes implanted to await further development. In ectopic gestation this physiological action fails to take place. From some cause or other, probably a malformation of the tube or diseased condition of its mucosa, the movement of the fertilized ovum toward its natural temporary home is interfered with, and it immediately seeks another and becomes implanted somewhere along this canal, either within that portion of the tube which passes through the uterine wall (interstitial pregnancy), or in the narrow, constricted portion, the caliber of which will allow the passage of a common bristle, called the isthmus (isthmian pregnancy). Or, in that portion of larger caliber which will allow the passage of the uterine sound, called the ampulla (ampullar pregnancy).

That variety of ectopic pregnancy called interstitial is not of frequent occurrence; or, if so, it is overlooked, as the ovum in most cases becomes, very soon, detached, and pushes its way into the uterine cavity, where it may go on to full term and be delivered normally, or, if anything untoward should occur, it is treated and terminates as an abortion, never having been correctly diagnosed.

In the second variety, when the implantation is in the narrow portion of the tube, we have a different proposition; the danger of rupture is very great, as the gestation sac is thin and the tubal wall is thin. This variety can only stand the pressure a few weeks at the farthest. Probably the most frequent variety is the third, or ampullar. This will stand for development much longer, as the caliber is larger. At the distal extremity it may include the ovary or the abdominal cavity in its attachment, as the fimbriated end is patulous and a slight hemorrhage or even contraction on the part of the tube between the attachment of the ovum and the uterus will cause an abortion of the tube—that is, the fimbriated extremity dilates and allows the mass to escape into the abdominal cavity.

The isthmic or ampullar varieties may rupture into the abdominal cavity through the walls of the tube (abdominal pregnancy), or between the folds of the broad ligament (intra-ligamentous pregnancy), and further development of the ovum may take place in either case if the placenta or embryo is not too seriously damaged. The placenta may attach itself to any part of the abdominal cavity; intestines, ovaries, uterus, bladder or abdomen, peritoneum, and circulation be immediately continued. The embryo usually dies. If it goes on to full term, it must be relieved artificially from its position. If, on early rupture or tubal abortion, the fetus is thrown into the abdominal cavity, it soon becomes absorbed, and in a few days nothing is found of it. Old embryos arrested in their growth either become mummified, macerated, or calcified.

The uterus in ectopic pregnancy becomes hypertrophied and the mucous membrane is changed into a decidua, as in normal pregnancy. This decidua is shed at the time of rupture, abortion, or when the embryo dies from any cause. The uterus, as a whole, in ectopic pregnancy becomes about the size of a womb in the third or fourth month of normal pregnancy. If the tubal pregnancy should go on to full term, the enlargement will not increase, but will remain stationary; as soon as the decidua is thrown off from rupture or abortion or death of the fetus, it gradually becomes smaller as involution goes on.

The symptoms vary according to the stage. In the early stage only the ordinary symptoms of pregnancy are likely to be observed; cessation of menses, nausea, and changes in the breasts. There is the enlarged uterus with softened cervix, and purplish appearance of the mucous membranes of the vagina and cervix; all symptoms of normal pregnancy. However, there can always be felt, to one side or the other of the uterus, a soft and movable tumor which should immediately arouse suspicion. When rupture takes place, however, the scene changes and that very rapidly. The pain comes on suddenly, is sharp and agonizing, and referred to one side or the other in the pelvis. Almost at once there is a bloody discharge from the uterus. The patient shows symptoms of profound shock from internal hemorrhage; she frequently falls to the floor, and in a large proportion of the cases, fatal collapse from pain and hemorrhage will occur in a few hours. In some cases the symptoms will

not be so severe; the rupture may be only partial, and the hemorrhage not so great, but in a few hours, or perhaps days, the rupture will extend with another attack of greater severity. Then there follow general abdominal tenderness and subsequently symptoms of peritonitis. In tubal abortion the symptoms are somewhat modified and may easily deceive the patient and physician as to the nature of the illness. The ovum becomes detached from its bed in the ampulla, or near the distal end of the tube, by hemorrhages which have occurred previously, and the dilatation is caused by clots forming from those hemorrhages. It is dropped into the abdominal cavity in a mass, clots, ovum and all, to be walled off or absorbed. There will be felt a tender, boggy mass and later symptoms of localized peritonitis. If the rupture occurs between the folds of the broad ligament, the pain is paroxysmal, likely to recur, and varied as to its severity. The symptoms of collapse are not so severe because the hemorrhage is not so great, owing to the pressure given in front and behind by the layers of the broad ligament, causing a rapid formation of clot and consequently checking the hemorrhage.

In this variety of ectopic pregnancy there is often found rare continued vitality and development of the fetus. If this occurs, then there is a secondary rupture into the peritoneal cavity with symptoms as outlined above. Few foetuses survive the fourth month; if one does, the subsequent symptoms are those of intra-uterine pregnancy with the modification which would obtain under the altered conditions.

Diagnosis.—In diagnosing ectopic pregnancy, the fact that there may be coexisting with this condition an intra-uterine pregnancy should not be lost sight of.

Ectopic pregnancy is most found in those women who have some pre-existing pelvic trouble. Diagnosis before rupture or tubal abortion is not at all easy. The main reason for this is that the patient is rarely ill enough to seek advice; she feels, and her physician also, that it is the "same old thing," and an examination is not made. However, the symptoms of pregnancy are there and the history of the case together with an enlargement of the uterus and tumor on one side or other of the uterus; this tumor may be so movable that it will have the appearance, or touch, of a cystic

ovary and may be so diagnosed; or, if in the narrow portion of the tube, it may have the feel of a pus tube and mislead in that way, but by keeping in view all the time the symptoms of pregnancy—cessation of menses, nausea, and changes in the breasts—an approximate diagnosis should be made in almost every case; excepting, perhaps, the interstitial variety. When primary intraperitoneal rupture takes place, with the pain and symptoms of internal hemorrhage and escape of shreds of decidual membrane from the uterus, there is no very good excuse when a diagnosis is not readily made. And it must necessarily be made from the symptoms, for bimanual examination will aid but little, on account of the pain and generally bad condition of the patient. When the rupture is between the folds of the broad ligament, the pain is variable and paroxysmal, and the shock, or symptoms of hemorrhage, less severe because the volume of effused blood is limited by the resistance afforded by the folds of the broad ligament. If this form of rupture takes place very early in the stage of pregnancy, the symptoms may be so slight as to escape notice, the mass being absorbed without ever being discovered. But if the secondary rupture takes place, then the symptoms are more marked, for it is now into the peritoneal cavity, and we have the same condition as above outlined: severe pain, collapse from hemorrhage, etc. If the ovum survives, another series of diagnostic indications is manifest, making its appearance after the fourth month. The general indications of pregnancy are present and remain characteristic as development of the fetus advances. There is absence of menstruation, changes in the breasts, vulva, and uterus, abdominal enlargement, movements of the fetus and placental souffle. Palpation of the fetus is easily made on account of the thinness of the abdominal wall. This latter is not to be depended upon, however, as a diagnostic point, for occasionally the uterine wall is so thin and attenuated that it may give the impression of nothing between the fetus and abdominal wall.

When the term of pregnancy is completed and spurious labor comes on, the diagnosis is easily made. The pains are well defined, contractile, gradually increasing in duration and severity, recurring at intervals and gradually subsiding; after spurious labor and the consequent death of the fetus, marked changes are observed, both as regards the fetal and maternal structures. The placental circu-

lation continues for some time after this change takes place. The abdomen decreases in size, fetal movements cease, and the uterus undergoes involution. In some cases the sac and fetus break down into a gangrenous, suppurative mass, with general septic symptoms of a severe type. Pus may find outlets through the abdominal wall, rectum, vigina, or bladder, and the debris of the macerated fetus follow through those openings. Or the fetus may undergo mummification, or calcification, and thus the patient escapes the septic symptoms.

Treatment.—Before surgery made such rapid strides it was considered good treatment to arrest the development of the ovum and promote absorption. Strychnine to the toxic degree, hypodermic injections of ergot, and puncture of the cyst. More recently the injection of morphine into the sac, and later the application of electricity. These methods are now all of them obsolete. As will be seen by the above description of ectopic pregnancy, a certain number of cases will recover by the expectant treatment, and this under the most adverse circumstances. By far the larger number will recover by prompt surgical treatment. It is shown that the mortality of those not treated surgically is over eighty-five per cent, and of those treated surgically, six per cent. The operation before rupture consists of an abdominal section, removal of the tube, and immediate closure of the wound. A simple operation on a patient in good condition, is free from shock or hemorrhage and without any septic or inflammatory lesions.

When rupture has occurred into the peritoneal cavity an immediate operation is necessary to save a life. It is an emergency to arrest hemorrhage and is just as justifiable as to tie an artery in any part of the body for the same purpose. When the peritoneum is incised, blood clots present themselves and must be rapidly turned out until the bleeding point is reached and clamped. The operator may then be more deliberate, clean out the cavity thoroughly and tie off the tube. Irrigation with hot saline solution will be of benefit to the patient as a stimulant and will also help in making the toilet or closing the wound, which may be done without drainage. If some time has elapsed between the rupture and operation, the danger of sepsis being greater, and nature having thrown around the mass a protecting wall, it will be better to make

the incision through Douglas' cul-de-sac, clean out the clots and arrange for drainage in that way, than to run the risk of infecting the peritoneum by an abdominal incision. Often these cases are overlooked until the mass becomes in verity a pelvic abscess, which may be emptied in the same way.

The operation in advanced ectopic pregnancy will vary in accordance with the condition of the fetus, whether living or dead. When the child is alive the operation should be done without waiting for the spurious pains. When the child is extracted the sac should be stitched to the abdominal wall and the wound dressed open until disintegration of the placenta has taken place, relying on drainage and antiseptic treatment until the mass is discharged. After spurious pains and the death of the fetus it is better to wait for some weeks before operating. The circulation through the placenta will remain active for some time after the death of the fetus, and while it is so it is impossible to remove it en masse on account of the hemorrhage. After several weeks the placental thrombi become organized, then it can be enucleated without danger from hemorrhage. The danger to life, when ectopic pregnancy has gone beyond the fourth or fifth month, is very great, and this is due to the placenta rather than the fetus.

DISCUSSION.

Dr. DeWitt G. Wilcox: This is an exceedingly interesting subject and I want to present one phase of it by relating a case which shows some of the legal aspects of tubal pregnancy.

About a year ago one of our prominent general practitioners called me in consultation over a supposed case of tubal pregnancy. The patient was a young woman of about twenty-five years of age, married three years, never been pregnant. She had consulted this physician about a month prior, because she regarded herself pregnant; he agreed with her and she employed him to care for her at her confinement. About a week prior to my seeing her she had sent for her physician suddenly, because she was flowing and having pain. He feared a miscarriage and enjoined rest. The hemorrhage continuing next day he placed her in charge of a nurse. Patient then began to have severe pain over right ovary; so severe physician gave her morphine. Upon the third day physician examined her and found a membrane protruding from the os. This he removed

and upon a close examination of the same, he found it not a placenta but a well marked decidua. He then made a careful examination, found the uterus too small for a three months pregnancy, the os but slightly open, not at all patulcus. He also found a well-defined lump upon the right of the uterus at the location of the tube. This lump was very sensitive and was the place to which she referred all her pain. He concluded she had a tubal pregnancy. That night her pain was even more severe, demanding morphine. I saw her the following evening, obtained history as above. Patient thought she was about three months pregnant. Had missed two menstrual periods; found she had all the usual symptoms of pregnancy, save an enlarged uterus; this was but little larger than normal. Found the large tube readily and could feel it pulsate.

Patient, husband and nurse were all sure there had been nothing which escaped from the uterus save the membrane mentioned; this the nurse had not preserved.

It seemed to me one of the clearest histories of tubal pregnancy which I had ever found. I so diagnosed it and recommended operation. Patient was operated next day, found blood clots in the right pelvis, tube unruptured, but the fimbriated extremity wide open and patulous, from which blood was oozing. I regarded it then as a tubal abortion, but could not find the fetus. This was not at all unusual, as in but a small percent of cases is the fetus found. I cleansed the abdomen, squeezed out the tube and left it undisturbed. I then curetted the uterus to be sure that it was empty. I found it so, there being but a few shreds of membrane. The patient made an excellent recovery, returning home from the hospital in five weeks.

When I presented my bill, the husband said, "Doctor, I have made up my mind not to pay this bill, because I have been led to believe that my wife did not have a tubal abortion but simply had a miscarriage, and that you and my family physician were mistaken in your diagnosis." I then consulted his physician and we agreed to sue him for our respective bills. We gave him another interview and went over the history of his wife's case minutely, comparing it with the records of cases mentioned in our best text books, but he was obdurate, as some quack physician had made him believe that we had operated unnecessarily.

We therefore placed the matter in the hands of our attorney, and it is on the docket for the next term of court. His attorney has made a number of offers to compromise the matter by a partial settlement, but we have refused to compromise one cent.

The grounds upon which he seems to base his position is this: When the family physician left the operating room immediately after the operation, the husband asked him as to the result. The physician replied, "She is all right, but we did not find all that we were looking for," he having reference entirely to the fetus; not meaning that there was the least doubt as to the fact she had a tubal pregnancy. The husband related that conversation to a so-called physician, whose record with the profession is not good, and this physician immediately set to work to make the husband believe that our diagnosis was at fault and the operation unnecessary. Undoubtedly the point to be settled in court will be this: Is the presence of a fetus in extra-uterine pregnancy necessary to establish a diagnosis. I find from reading and enquiring from other physicians that the fetus is found in but fifty per cent of cases.

Dr. Wood: I think that in early rupture of tubal pregnancy there are very few instances where the fetus is discovered, particularly if the rupture takes place into the fold of one or the other broad ligament, constituting the co-called extra-peritoneal hematocele. The fetus in very early pregnancy is quickly digested by the peritoneum if it escapes into that cavity. In a very large percent of pelvic hematocele, the cause is a ruptured ectopic pregnancy cyst. However, occasionally we meet with instances of hematocele due to other causes. A striking instance of this kind recently passed under my observation, which I reported in the Medical Counselor, and which will appear in its next issue, (June). The patient was a woman who had an exceedingly tender mass in the posterior cul-de-sac which I took to be a retroverted uterus. She had besides the supposed retroflexion, lacerations of both the cervix and the peritoneum. She objected to having the uterus fixed in front. I therefore anaesthetized her for the purpose of repairing the lacerations. Under anaesthesia I felt something during the bimanual examination give way, the sensation under the finger for all the world being like that of a retroflexed fundus slipping from the hollow of the sacrum. After doing the orificial work, I was rather suspicious

of her condition and therefore opened the abdomen. Much to my surprise I found the abdomen full of blood, which proceeded from a ruptured ovarian haematoma. My patient would quickly have bled to death had I not opened the abdomen and secured the bleeding point. The diseased ovary was of course removed and the bleeding point secured. The patient made an untoward recovery, but the case shows in a striking manner that we may have hematocele from causes other than ectopic pregnancy. The lesson is that in all instances where we suspect internal hemorrhage, the abdomen should be speedily opened.

I do not believe that Dr. Wilcox will experience any trouble when his case comes to trial in getting almost any number of the most eminent surgeons in the country to testify in his behalf.

INJURIES OF THE CERVIX CALLING FOR SURGICAL INTERFERENCE.

BY JAMES C. WOOD, A. M., M. D., CLEVELAND.

When Dr. Emmet first advocated trachelorrhaphy as a legitimate surgical procedure in certain injuries of the cervix, he builded better than he knew. He recommended the procedure for those forms of laceration that are attended with eversion, abrasion and deposition of the cicatricial tissue. He recognized the part played by cervical rents in the production of sub-involution, menorrhagia and reflex symptoms. Later on, he recognized the importance of cervical irritation and scar tissue as causative factors in the production of malignancy.

Those of you who were doing surgical work when Dr. Emmet first announced trachelorrhaphy as a legitimate and beneficent operation can well remember the furore which this announcement created. Many were the arguments pro and con regarding the subject. A certain class of men, as is always the case, advocated trachelorrhaphy as a cure-all and innumerable operations were performed that never should have been performed. Another class of men, ever conservative, disapproved of the procedure in no less emphatic language. The latter gentlemen based their arguments largely upon the unsuccessful operations performed by men ill-fitted to assume the responsibilities of surgery, and who ignored

entirely the counter-indications which Dr. Emmet tried so hard to impress upon the profession. Such counter-indications were peri-uterine fixation with infiltration, inflammatory diseases of the uterine adnexa, etc. Many cases of sub-acute and chronic pelvic inflammation were re-excited by the efforts to repair the existing lacerations.

The status of trachelorrhaphy today is very different from what it was twenty or twenty-five years ago. In the first place, the technique has become so simplified that a skilled surgeon ought to do the operation in from five to fifteen minutes. Secondly, we know much more of the causation of cancer than we did twenty years ago. At least we know that cancer of the uterus first occurs, in a very large per cent, in the cervix; and that 95 per cent of cervical cancers follow in the train of childbirth. While then we may still be in doubt as regards the exact nature of cancer, we do know much pertaining to the circumstances under which it arises. Finally, abdominal surgery has reached such a degree of perfection that the counter-indications which Dr. Emmet put forth, no longer prevail, inasmuch as the practical surgeon will not hesitate to open the abdomen and do whatever work may be necessary therein, after completing the plastic work upon the cervix and the pelvic floor. Then, too, we know much more of the modus operandi of the reflexes than we did twenty years ago. Therefore, trachelorrhaphy is performed much oftener than it was then, and rarely is it uselessly performed if we have present any of the several conditions enumerated.

I no not mean to infer that every woman who has a cervical tear needs to have it repaired. Were this statement to hold good, almost every woman who has had a child would have to submit to operation. As a matter of fact, the larger per cent of tears of slight degree do not call for surgical interference. On the other hand, when there is sub-involution with menorrhagia, relaxation of the pelvic floor and rectal lesions, the cervical rent should be repaired when the other conditions enumerated are cared for. Or in the neurotic where there are reflex symptoms implicating the back, the intestines, the stomach, the mammary glands, or other parts of the body, the cervical rent should be repaired. The technique is so simple as to make the danger almost nil in reasonably favorable cases.

Sub-involution with menorrhagia, retro-displacement of the uterus with varying degrees of procidentia, relaxation of the pelvic floor, and lesions of the clitoris and the rectum, can safely be cared for at one sitting, after which the abdomen can be opened and whatever work may be called for done, providing of course no counter-indications prevail. After the abdomen is opened lesions of the appendages can be dealt with, the uterus fixed in front, and should the appendix-vermiformis be inflamed, this can be removed at the same sitting. I think that I get more satisfactory results from all around surgical work of this kind than do I get from any other class of surgery.

To summarize:

1. Trachelorrhaphy in skilled hands is practically free from danger.

2. In all instances where the uterus is enlarged, the cervix everted, and there is hardness about the cervix, trachelorrhaphy should be performed.

3. In all nervous diseases occurring in women, cervical work may be necessary to overcome symptoms remote from the cervix, In these cases even a slight amount of cicatricial tissue in the cervix should be removed and the rent closed.

4. The laity should be instructed regarding the relationship existing between cervical tears and malignancy. In all instances where a cervical catarrh is perpetuated because of the laceration, trachelorrhaphy, with other necessary work, should be done.

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

C. O. MUNNS, M. D., Chairman - - - - Oxford
"Keimol in Suppurative Otitis Media."

ROYAL S. COPELAND, M. D. - - - Ann Arbor, Mich.
"The Practitioner and the Abnormal Eye."

T. M. STEWART, M. D. - - - - - Cincinnati
"Cerevisine in Purulent Conditions."

W. A. PHILLIPS, M. D. - - - - - Cleveland
"Injuries of the Eye Ball."

THE PRACTITIONER AND THE ABNORMAL EYE.

BY ROYAL S. COPELAND, M. D., ANN ARBOR, MICH.

A common way of scolding is to abuse the offending party over the shoulders of a more intimate associate. In order to reach the practitioner, then, I propose to speak somewhat in detail of the failure of my own specialty in the most important feature of its usefulness, namely, the therapeutic treatment of the abnormal eye. In diagnosis, direct and differential, instrumental and by inspection; in treatment, depending upon local medication and manual dexterity, there can be but words of praise. It is in the therapeutic field alone that criticism can be offered.

Homeopathy in Ophthalmology.

Theoretically, homeopathy bears the same relation to ophthalmology that it does to surgery and gynaecology. In each of these fields it should be as conspicuous as it is in neurology, or in the treatment of disease attacking the heart, lung, stomach or kidney. Practically, in the surgical specialties, homeopathy is frequently overlooked entirely, or, at least, relegated to an unimportant position. This statement is, of course, simply a matter of opinion, but it is a conclusion based upon observation and, perhaps, experience.

Disease is a something hard to describe. It meant one thing to the physician of yesterday; it means another thing to us; it may, and probably will, mean something else to the practitioner of tomorrow. But, whether the definition accepted be the birth of last year, or next year, it must be general enough to cover every tissue of the body and specific enough to describe abnormal conditions in

any single organ. Therefore, disease is disease, whether it attack the lung or the ovary, the kidney or the eye. Homeopathy, then, which is a science of therapeutics, bears the same relation to the specialty that it does to general medicine. Hence, it follows that homeopathy must have the same importance in ophthalmology that it has in the cure of gastric disturbances. Indeed, if we consider the organs included in the last comparison, homeopathy should be a *more* important adjunct in the treatment of ocular disease, because the accessibility and observableness of the eye add to the subjective manifestation of the lesion a wealth of objective signs. In compiling the totality of symptoms and selecting the similimum the ophthamologist, certainly, has greatly the advantage over the stomach specialist.

Granted that this conclusion is true, why does the ophthalmologist neglect the important functions of the internal remedy? In my opinion there are several reasons. For the purposes of this discussion it may not be amiss to consider a few of these.

Errors of Refraction.

The first is the frequency of functional and even organic disease of the eye and the many manifestations of functional nervous derangement due to errors of refraction. The mental processes of the ophthalmologist differ from those of the general practitioner. I do not mean to imply that the Michigan ophthalmologist possesses in any degree an intellectual advantage over the general practitioner of this State. One has but to read the history of the nation to know that any citizen of Ohio has inborn privileges and possibilities far and beyond those conferred upon all the scientific bodies of the world. This fact must be due to mental qualities unpossessed by the less fortunate sons of other commonwealths. But every calling in life has its special mental processes. So, the first thought which comes to the general practitioner, listening to the recital of his symptoms by the victim of a gastralgia, for instance, is "What remedy is indicated in this case?" The first thought of the ophthalmologist, however, if the disease be apparently functional, is, "Has this patient an error of refraction?" His past experiences have led him to suspect defective vision in every such case and the relief of the symptoms by optical assistance is the first of the thought impulses.

"Habit doth make slaves of us all," so it is not surprising that the ophthalmologist falls into a routine of practice which leads him away from therapeutics into material and manual methods. I am not here to say the error of refraction should not be given first attention. If it is the cause of the symptoms I think it should, but my point is that in this specialty there must be constant self-examination and reminder, or many a patient will be denied a means of cure. Undoubtedly, many a case of asthenopia is treated by the administration of spectacles when a broader view and wider study would result in a prescription of a remedy far more potent than glasses.

The Limitations of Homeopathy.

I desire not to be misunderstood. This is a homeopathic convention, and the members of this program are expected to exalt Homeopathy. Nevertheless, I cannot afford to pose in any false light and appear to be what I am not. To my mind homeopathy, like religion, has suffered by reason of hypocrisy in high places. To take part in any public function dedicated to homeopathy makes the participant, no matter how humble he may be at home, an important factor for the time being. In my judgment, many an actor under these circumstances, carried to heights of enthusiasm, has set a standard which no sane man in the monotony of actual practice can hope to attain.

Fifteen years of active work in ophthalmology have convinced me that the internal remedy, high or low, diluted or triturated, given frequently or at long intervals, it matters not, will not cure every disease to which the eye is heir. It never has done it and never will, until every possible medicinal substance has been proven, until every practitioner has perfect knowledge of all such provings and infinite power of perception of symptoms, and not until he has infinite wisdom in applying his absolute knowledge. Should that time ever come, the practitioner will fit the remedy to the disease, as the wing of the bird fits the air, but, since such wisdom and such knowledge are attributes impossible to finite man, that glorious day will never dawn. In the very nature of things, medicine can never be an exact science; it must ever be an art. There is no discouragement in this thought, because in this noble art, who best applies himself, who knows most of life and its secrets, who can best apply

the means of diagnosis and best interpret the manifestations of disease, who probes deepest the action of drugs and the symptoms they produce, who nearest approaches Hahnemann's ideal physician, he it is who will best succeed and whose professional fame will longest endure.

The Laboratory Idea.

Let us be honest with ourselves and among ourselves. If general medicine, hygiene, physiological chemistry and bacteriology have produced ideas or methods useful to us and superior to any other practice at our command, it seems sensible to employ them until others have displaced these in usefulness. His readiness to do this very thing is another reason why the ophthalmologist has too many times been led astray. He finds an eye congested in its palpebral conjunctiva, the patient complaining of photophobia, smarting, burning and the feeling of sand under the lids. The progressive opthalmologist knows of several drugs, notably cocaine and adrenalin, which, locally applied, will cause the immediate relief of these symptoms and for the time, at least, the apparent cure of the disease. He prescribes them repeatedly with satisfaction, but at last, contrary to the natural history of such cases, a patient develops secondary iritis, or cyclitis. The drug used, adrenalin perhaps, is an active astringent. It contracts the superficial vessels of the eye, causing the subsidence of the external congestion, drives the blood to the deeper parts and the uveal engorgement develops an inflammation of some part of that tunic. Belladonna, euphrasia, or rhus, prescribed correctly, would have spared this complication.

This experience, however, should not produce a wrong conclusion. It is not wise to abandon all laboratory suggestion because we misapplied our knowledge in one case. Next time adrenalin is employed it will be more sparingly used, and the effects more carefully noted. We would be the losers were we to abandon the gifts of the laboratory. Take, for instance, the disease commonly known as "pink eye." Much laboratory research seems a useless expenditure of time and material, but, in this disease, the bacteriologist has taught us a valuable lesson. Upon finding the bacillus of "pink eye," experiments developed a means of killing it without injury to the tissues of the eye. Chloride of zinc diluted materially, say one part to five hundred of water, is fatal to the germ and prevents

its further ravages. Locally applied, this drug is almost a specific in "pink eye" and, in my experience, will more quickly relieve the patient than any internal remedy I have ever used.

On the other hand, in a case of catarrhal conjunctivitis, of the chronic type especially, with all the symptoms of "pink eye," except the specific bacillus, I infinitely prefer the homeopathic remedy to any local application. But to be honest with myself and you, I have purposely spoken both of the value and of the harm of the laboratory idea. Because it is useful in one case, let us not be carried away from our homeopathic moorings, but because it fails in another, let us not condemn it all as an agency of the devil. There is a middle ground which, it seems to me, may be occupied with dignity and propriety.

Surgical Procedure.

A third reason for the neglect by the ophthalmologist of the use of the internal remedy is his reliance upon surgical procedure. Even now, after the performance of the cataract operation many hundred times, I confess, in every case, to a peculiar thrill of delight upon the safe delivery of the lens and a renewed feeling of admiration for the surgeon who first dared so bold a thing. It is no longer great, in a surgical sense, to make this common operation, but, in the moral sense, to the happy patient, restored to light and sight, the thing will always seem little short of miraculous. The immediate result, the ease and simplicity of the means and the enthusiasm of the patient, all these are a temptation to the humanity of the ophthalmologist and, I fear, would continue to be, even though he were advised of a certain therapeutic cure. But in this condition, where remedies, at best, are of but doubtful value; in diseases essentially surgical; and others occupying a common ground, where relief is possible by either means, surgical or medicinal; in all such cases the ophthalmologist is inclined to use the knife, because of the greater trustworthiness of his surgical art.

We cannot overlook the fact that many practitioners fail to appreciate the exact nature of cataract. You would smile were I to enumerate the different pathological conditions, intra and extra-ocular, which have been referred to me with this diagnosis. Anything which mars the appearance of the human eye, or interferes in the least with its vision, is "cataract," not only to almost every

layman, but also to the average practitioner. Many transient and superficial troubles have disappeared coincidently with the taking of this or that remedy. Commercialism has done the rest; the trade journals have awakened hope in many breasts and it is doubtless true that most persons within the sound of my voice have been induced to think that cataract is curable by remedial means. The ophthalmologist does not believe this. Too many times his disgust at the attempts to cure cataract and the evil results of this practice in cases where mistaken diagnosis for cataract has caused irreparable damage by the neglect of a more serious disease of the eye; too many times, I say, this disgust has led him to neglect remedial means and made him essentialy materialistic in practice.

Superiority of Homeopathy.

Without further attempt, I think we have shown sufficient reason why homeopathy is neglected in ophthalmology. Dependence of the specialist upon the test case, the laboratory methods, and surgical technique, has so engrossed his thoughts as to make him forget the wonderful resources of the materia medica. At times he fails to remember that the eye is but one small part of a great whole. Observation and study of the patient, the local disease for the time being subordinated, will give him a broader and a better view of the condition. With this general oversight and a careful compilation of the totality of the symptoms, the ophthalmologist will know more of the condition in hand. Then, with more frequent and more critical study of the materia medica, he will find in every case a helpful adjunct and, in many, the only hope of cure.

My plea, then, is that homeopathy is as essential to the ophthalmologist as to the general practitioner and, to both, is more simple, more useful, and more potent than all other measures at their command.

Dr. Stewart: If no one else wants to discuss the paper, I will have to say the few things that occur to me. The thing that we know most about is generally the thing we like. If we know something about the anatomy, physiology, and diseases of the eye we will do better by our patient, than if we do not know anything about the eye. We will go along the best way we can; if the patient doesn't get better, then we will send him to the specialist. How do

I know that? I have been in general practice and I know how the general practitioner feels in regard to diseases that he dosen't feel quite sure about. Dr. Copeland has brought out pretty clearly by comparison the idea that you can get at the disease of the eye for diagnostic purposes very much easier than some other organs. I think he has done right to strike at the root of the matter in his essay in criticising the specialist first and then the general practitioner. A good deal of trouble is in the colleges in the teaching of this specialty, its anatomy, physiology and disease; for many a student will go out without a knowledge that will tell him what is glaucoma, or iritis, or cataract. The fault lies somewhere in the teaching. But if the student knows he can tell the one from the other, then he is a long way better off than the ignorant one. He will know the first moment when it is necessary to send a patient to the specialist in order to save his sight. Let me cite you an illustration:

Here is a case with a coated tongue, some nausea and vomiting, bowels disordered—it doesn't matter which sex—the physician doesn't make any diagnosis, even the oculist may not feel very sure of the case if it happens to come to him. They let this thing go along and at intervals they see it and give medicine. They use good homeopathic remedies upon their indications, but they don't get the patient cured. They declare it was a case of bilious attack, liver and stomach involved. There was one other symptom that one specially noted and that was of the eye. The right eye was inflamed. If the physician had known that all he would have had to do was to palpate that eye he could have told right then whether it was a glaucoma or not. But he didn't know that. He was treating a primary eye disease and yet he looked upon the other symptoms as the primary ones and this as the secondary. The other difficulty comes in the teaching that our boys are getting. I do believe that the men who go out from our homeopathic colleges are a little bit better quality when it comes to the specialists. But when they go out of some of our institutions they look upon this specialty business as something to come later in life when they have had the experience of general practice.

Dr. Copeland: There is just one thing I want to say in closing, and that is there are some things every general practitioner

should know about the human eye. If I had my way I would require that every examining and registering board in the United States insist upon the applicant knowing: First, the treatment of ophthalmia neonatorum; second, the diagnosis of glaucoma; third, the recognition and treatment of iritis. It is a sad commentary upon the carelessness of the medical profession that many, many times the practitioner takes it for granted that any redness of the eye is simply a little passing hyperaemia which he regards as of no consequence, but which perhaps is an evidence of glaucoma. Only recently a case came to me from the hands of a general practitioner where the patient had a "redness of the eye." The doctor thought it was iritis and instilled atropine. In a few hours the patient was hopelessly blind. So there are certain things about the eye that the general practitioner ought to know. If I had my way I would not only arrest doctors so terribly ignorant and have them tried for malpractice, but also would have them boiled in oil, or give some other awful punishment.

CEREVISINE IN PURULENT CONDITIONS.

BY THOMAS M. STEWART, M. D., CINCINNATI.

If the title of this paper had been "Brewer's Yeast," as a remedy in purulent conditions, every one would at least have heard of its use, if indeed he had not used it in some troublesome cases. Cerevisine is simply dessicated yeast.

Yeast has been a useful remedy in the old days and has a place in the internal treatment of boils, furuncles, abscesses and all purulent conditions. If it had not done good service in the hands of our elder brothers in the practice of medicine, there would have been no effort made to overcome the difficulties in securing fresh brewer's yeast nor in presenting it in a more enticing form than in the days of yore.

Workers in breweries discovered that yeast taken internally cured boils. Empirical use of the remedy extended its field of use to smallpox, tuberculosis, malignant growths, and to purulent conditions in general. Success in overcoming some of the troublesome symptoms of otorrhoea, diabetes, ulcerative conditions wherever

located in or on the human body, gonorrhoeal vaginitis and gleet, led to deeper study of its action in bacteridian disorders.

The bacteriologist tells us that yeast has phagocytic properties to a remarkable degree, as demonstrated on the gonococci, staphylococci, and all pathogenic organisms.

The yeasts are classified among the hyphomycetes or web-like fungi, in which group the moulds are also classed. They are aerobic, growing only in free air or oxygen. Their absorption of oxygen is accompanied by an elimination of carbon dioxide. Nucleinic acid, the essential constituent of the nuclei of cells, is also a constituent of the yeast cells. It has been demonstrated by Horbaczewski that the nucleins produce a leucocytosis, thus increasing the body resistance. Other observers have demonstrated that the nucleins are the germicidal elements in the blood.

On account of the difficulty of getting brewer's yeast fresh, and in keeping it because of its liquid form, it has not been used as extensively as its therapeutic merit deserves.

A year or so ago we saw a report of several cases in a Spanish journal in which cerevisine was used with much success. Since which time we have learned that the remedy can be secured in this country through Fougera, of New York, the agents for the French chemists, Rigaud & Chapoteaut.

In our hands it has acted well in several cases of furuncles of the auditory canal. Cases that went on to the development of successive crops of boils in the auditory canal, in spite of care in diet, local anticeptic cleansing, and the exhibition of calcarea picrata, hepar sulphur, ferrum phosphoricum, mercurius, silicea, and other remedies. A few doses of cerevisine in the beginning of the attack now stops them short in these cases.

Three cases of small boils in the entrance to the nostrils have made more prompt recoveries than we have heretofore been able to obtain by other treatment. Two cases of boils in general accompanying a tonsilitis have been not only markedly relieved, but in addition the remedy has been used at the first sign of a second attack with great satisfaction to the patients.

In purulent conditions of the middle ear, aided by cotton cone drainage strips, cerevisine has been of decided advantage.

In all pus or septic cases the remedy will aid in the cure at that stage when intestinal fermentation is a factor.

The remedy is the dessicated yeast cells prepared at a low temperature in vacuo. It can be given in water with a little sugar or in beer. Some patients object to its taste or foamy appearance; in such cases it can be given in gelatine capsules. The dose is one teaspoonful before each meal. In several cases the No. 1 capsule has been the dose, and even in this small dose it has done its work. Locally it can be used in glycerine acidulated solution.

We think yeast in the form of cerevisine is a remedy of sufficient value to call it to your attention, and this short paper introduces an old friend in a new dress which we hope will aid you in some of the numerous purulent conditions that resist the indicated treatment.

NOTES ON INJURIES OF THE EYEBALL.

BY W. A. PHILLIPS, M. D., CLEVELAND.

Injuries of the eyeball for the most part come under the following heads:

1.—Blows upon the ball, producing concussion and perhaps laceration.

2.—Penetrating wounds produced by flying chips of metal or by various agents, such as points of scissors, forks, knife blades and the like.

3.—Burns and scalds.

Concussion of the ball even by a blow over the closed lid will often produce serious results by rupturing the retina or choroid, or both, or by inducing optic neuritis, followed by more or less complete atrophy of the nerve. This may occur, too, without any external visible signs that impairment or total loss of vision will ensue.

In the event of rupture of the retina and choroid, hemorrhage occurs into the vitreous when of course no view of the fundus can be obtained until absorption of the blood is brought about. If the iris is ruptured, the anterior chamber fills with blood and equally excludes a view of the interior beyond, so that it becomes uncertain whether there is extravasation into the vitreous body or not. After the anterior chamber clears, which will usually be in a day or two, the condition of the vitreous can be readily ascertained.

The lens is very liable to suffer in accidents of this sort by a rupture of its capsule, producing surgical cataract; or what is still worse, it may at the same time be dislocated into the vitreous, or more rarely, into the anterior chamber.

In order to save further complications, immediate extraction of the lens becomes necessary.

If the foreign body comes in contact directly with the cornea, an abscess, or an ulcer, or interstitial inflammation is likely to add to whatever other disturbance is present in the case. Extensive rupture of the cornea or of the sclera is comparatively rare. If, however, it does happen, extirpation of the ball generally becomes indicated sooner or later.

Yet it is not impossible that a large proportion of the vitreous and the lens also be lost, and still a fair degree of sight be maintained—the lost vitreous being replaced by the action of the structures that likewise secrete the aqueous humor.

Provided the cornea be ruptured, a complication arises—the iris being forced into the wound by the sudden gush of the aqueous fluid. This will displace and perhaps obliterate the pupil, and unless the prolapsed part be drawn from the wound and excised within a few hours it will heal up in this imprisoned condition with corresponding loss of sight. After all inflammatory symptoms have subsided, an iridectomy can be made which will give a more or less serviceable pupil according to the extent of the injury.

The scar tissue formed in certain cases by its contraction will sometimes make pressure on the nerve twigs caught in its meshes and will be accompanied by pain if not also by symptoms of sympathetic trouble. If the iris and ciliary body are seriously involved, it is commonly the case that the pathological changes in the ciliary region will lead to a softening of the globe, loss of sight, and eventual loss of the ball by operative measures for the relief of pain and for safety to the other eye.

The subsequent changes which occur in a badly injured eye, whether laceration has occurred or not, should be carefully watched lest the other eye gradually become involved to the extent of partially or completely impairing the function.

No little discussion in the past has resulted in respect to the immediate removal of an eye in which a foreign particle of metal

has been driven and which is so situated as not to be removed from the eye. So far as I am able to judge, if no severe inflammatory symptoms occur in the injured ball and no irritation of the fellow eye be present, it is reasonably safe to allow the suspicious member to remain. But it should be carefully watched, and if it become inflamed and painful, and certainly if any sympathetic disturbance appear in the other eye, the former should be extirpated at once.

It is, however, usually the case that the foreign body does not become so entirely encapsuled that it does not in the long run give trouble and demand operative treatment. If the foreign body be any substance that can be influenced by the electro-magnet, the chances of removing it without serious damage to the eye is much enhanced. The use of the X-ray for localizing the particle, if it be imbedded, is of great service and makes it possible to operate successfully in certain cases in which it would otherwise be impossible. But it cannot be too strongly impressed upon the mind of the physician that an eye containing a foreign particle is in much danger and that sympathetic inflammation is exceedingly liable to affect the sound eye. Hence it should be closely watched if not removed at once.

In burns of the eye occasioned by flying bits of hot metal or by acids or lime, the cornea is commonly acutely inflamed and resulting opacities may greatly impair the sight. Hot particles of metal or mortar often burn into the tissues and firmly adhere. They are best removed by first putting a few drops of oil into the eye and then gently scraping the pieces away with a piece of cotton or linen cloth over the end of a probe, or by the use of a scoop. A 1 per cent solution of cocaine should first be instilled into the culde-sac; and in many cases the use of chloroform will be required. The conjunctiva should not be lacerated more than is absolutely required in order to get the particles away.

Cold applications should then be used to combat the inflammatory action that is bound to arise. Atropine sulfate, a 1 per cent solution, should be dropped into the outer opening of the lids to anticipate iritis. Antiseptic measures should of course be freely employed so long as there is any broken or ulcerated surface.

I repeat that it must be recollected that the after effects of wounds and burns are much more serious than the severity of the

case would at first seem to indicate. The contraction of scar tissue and the opacities are very important results to be reckoned with in the great majority of cases, together with the danger that the lid becomes adherent to the globe in the process of healing (symblepharon). The prognosis therefore must be guarded or not given at all.

Hoping this condensed view of the subject may aid the general practitioner somewhat, I leave it for whatever good it may do.

DISCUSSION.

Dr. Copeland: I feel like thanking Dr. Phillips for this clear paper—his papers are always clear and always helpful. I have risen to my feet to make one suggestion. I had a case once of an injury to an eye-ball where there had been no infection apparently, but where there was great prolapse of the vitreous, the ball shrunken like a collapsed football. A simple procedure restored and preserved the eye. With a hypodermic we injected normal salt solution, passing the needle through the incision. The organ immediately took shape and recovery was uneventful and satisfactory.

KEIMOL IN SUPPURATIVE OTITIS MEDIA.

BY C. O. MUNNS, M. D., OXFORD.

Two years ago Dr. Walton called my attention to keimol as an excellent antiseptic, since which time I have found this remedy to be a valuable addition to my surgical and obstetrical bags for sterilizing my hands and operative surfaces.

It is an agreeable, bland, non-irritating germicide and antiseptic which is composed of pure phenyl salicylate and the active constituents of thymus vulgaris, gaultheria procumbens and mentha piperita, and is certified by reliable bacteriologists to destroy all bacteria in one minute's contact with the pure keimol, and a dilution of one to four parts water to destroy all bacteria in ten minutes' contact.

About one year ago I had a particularly stubborn case of suppurative otitis media come under my care, which was promptly cured by the use of keimol warmed and dropped freely into the ear after carefully cleaning with a solution of peroxide of hydro-

gen three parts and alcohol two parts. Following this success with the remedy, I used it in acute and sub-acute suppurative inflammations with excellent results. I have never had an opportunity to try its use in suppurative cases with destruction of bone tissue—what is usually termed operative cases—but believe the remedy to be worthy of a trial in the early stages of carefully selected cases of this class; also in old chronic cases. Where it is desired to medicate the deeper tissues when a hole exists in the drum, turn the affected ear up with the patient in the horizontal position, drop the medicine into the ear, and create a partial vacuum in the throat by closing mouth and nostrils, and instrucing the patient to inhale forcibly. The medicine will thus be drawn through into the throat in many cases. This effort can be repeated a number of times in succession, if necessary, to produce the desired result. Should you find it necessary to dilute the remedy, use alcohol as the diluting agent. I believe that water solutions should be avoided as much as possible in suppuration of the middle ear. Where it is desirable to avoid all water solutions, I have found a one to one and one-half per cent solution of picratol in alcohol to be the best. It has the disadvantage of causing a little pain in some cases.

On the whole, I have never found any other remedy the equal of keimol in giving me such uniformly good results in suppurative inflammations of the middle ear.

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

ELLA G. HUNT, M. D., Chairman - - - Cincinnati
"Hepar Sulphur in Nose and Throat Work"

P. T. KILGOUR, M. D., - - - - College Hill
"The Care of the Throat"

THE CARE OF THE THROAT.

BY P. T. KILGOUR, M. D., COLLEGE HILL.

This is a broader subject than would appear at first thought—broader than can be properly discussed in this brief paper. Although this paper belongs, properly speaking, to the Bureau of Diseases of the Nose and Throat, and they tacitly include only the in-

side of those structures, this brief effort will be found to be more or less of the shotgun order, taking in everything within easy range, including the outside as well as the inside. Then, too, its purpose is not so much to be technical as practical, not so much specific as general.

The causes that go to make up a weak throat are legion, both inherited and acquired. Some there are who are not conscious that they have a throat any more than they are conscious of the possession of any healthy organ, while others are scarcely ever permitted to forget that they are principally throat.

As on the care of the throat depends largely the quality of the voice, it becomes a vital question, and one of national importance, because of the national characteristics attaching to voice production. Each nation or people has its own peculiar quality of voice, due largely to peculiarities of structure of the throat, and to the care, or lack of care, which it receives. Who can not at once call to mind the soft, dulcet, persuasive tones of the Hibernian, who knows little or nothing of catarrh of the upper air passages; or the nasal twang of the Yankee, who fights catarrh continually, and who talks as though he had a clothespin astride the cartilaginous portion of his nose? What more attractive possession than a well-modulated voice, and how much this ought to be and is sought after!

In our national life too little thought is given to the matter of retention of good quality of vocal tones when they are natural, or of their production when not naturally possessed. It is said that there is a famous boys' school in London that has made for itself world-wide reputation for the sweetness and power of voice possessed by its members; and this is largely brought about by the fact that all screeching, shrieking and cat-calling are strictly forbidden, that the boys are compelled to talk in an easy, natural tone of voice, and to go bareheaded almost the entire year with little or no wrapping about the throat. It would be hazardous to predict what would happen if these boys were allowed to attend an American baseball game and take a few lessons in the gentle art of "rooting" as practiced by old and young in our glorious land, not to mention an experience of the violence perpetrated by college yells, and other ear-splitting vocal inventions.

With the general lack of thought given to the care of the throat, not to speak of its actual abuse, it is a matter of wonder that our national voice is as sweet and resonant as it is. We as physicians are, as our name indicates, teachers, and it behooves us to do all in our power to influence those under our care in such ways as will conduce to strengthen the throat and thus improve the quality and power of the voice. One of the commonest mistakes made is the habit of wrapping up the throat warmly at the first approach of cool weather in the fall of the year. This invariably paves the way for over-sensitiveness of the structures of the throat, and repeated colds, especially if the wrappings are for a single occasion forgotten. If, instead, morning spongings of the throat, neck and shoulders in water gradually cooled to a point from which the patient readily reacts were indulged in, followed by brisk friction with a coarse towel, the result would be more than gratifying. Much, too, can be done to strengthen the throat by systematic massage of the structures of the throat, neck, shoulders and chest, and by active and passive manipulations of the head and neck. The vocal practice of throwing the larynx forward as in an attempt to say ao, e, â, o and á with the lips first open and then closed, is also excellent.

It has been repeatedly demonstrated that public speakers, and those suffering from relaxed throat have been cured by a systematic course in vocal training at the hands of an experienced teacher when medicines alone had signally failed, showing the paramount value of so-called physical methods of cure. This is not intended to disparage the use of the properly indicated homeopathic remedy, but rather to aid its action; and it also pre-supposes that whatever of surgical measures are necessary, such as the removal of incurably diseased tonsils, and the opening up of stenotic conditions in the nasal passages, have been carefully looked after.

Dr. Pulford: A great majority of throat troubles are not due to exposure of throat, but to a chill, which deteriorates the quality of the blood, congests the glands and often leaves them chronically enlarged, especially the tonsils. Hence instead of treating the throat locally, let the physician direct his treatment to the patient generally and caution against taking cold or chilling.

HEPAR SULPHUR.

BY ELLA G. HUNT, M. D., CINCINNATI.

It is not that I shall say any new thing, but rather only bring as it were a word of commendation for a friend that has helped me many a time this past winter. We are not always of the same opinion as to the action of a remedy as our friends of dominant or eclectic schools, but I like to know their opinion. As to this remedy, we are all agreed. That to prevent the formation of pus or limit the quantity of its formation when inevitable, hepar is one of the best of friends. This is some of their testimony:

"Calcarea Sulphide is a valuable remedy on account of its power over cellular and cutaneous inflammation with suppuration, or tendency to suppurate. It influences glandular and lymphatic structure, proving a good remedy in suppurative adenitis."

"The best antisuppurative known when the condition is not due to syphilis."

"A remedy for nasal catarrh where the secretion is abundant with a tendency toward purulency and where patient readily takes repeated colds."

"In inflammation of areolar or connective tissue with tendency to suppuration and to prevent suppuration."—*Felton Lloyd.*

Again: "There seems to be little question that all suppurative processes are modified by calcarea sulphide in a most marked manner, ichorous pus being rendered laudable and abscesses hastened to maturation when once established or aborted if taken in time.

"Glandular enlargements of the strumous and scrofulous are benefited by its use."—*Foster.*

This testimony is so similar to our own experience that I wonder if it might not be borrowed from us; if so, we have more to lend, and that just as good.

Our Allen says: "A tissue drug of wide action. It simulates mercury in its action on glandular system, sulphur in its action on mucous membranes, calcarea in affections of respiratory tract and all foregoing in its general action on connective tissue."

I think we may find it of great use in diseases of nose and throat. It is in suppurative inflammation of nose and throat that I first found hepar so valuable.

Last winter one of the most distressing secondary symptoms of grip was the tendency to the formation of abscesses. The joints and alveolar processes were often attacked, so were the accessory sinuses of nose, and in these cases of acute sinus disease, both of frontal and sphenoidal sinuses I know hepar has brought relief, and so far apparent cures.

Even in some chronic cases it has relieved the distressing symptoms of severe pain, dizziness, loss of smell, etc., reducing the swelling of mucous membrane and affording an opportunity for better drainage.

Such a statement of calcarea sulphide is applicable to a number of maladies, chiefly those of a septic or pseudo-septic character. As grip might easily be classed as a disease of a septic or pseudo-septic character, we would expect calcarea sulphide to be of great service in its treatment. In fact, ten doses per day, one-tenth grain each have shown favorable action in influenza, frequently aborting the attack.

Finding it to so readily relieve the symptoms where pus had already formed, and as this tendency to abscess formation seemed to be a prominent phase of grip for a while last winter, I decided to use it early in grip cases.

I am not in general practice, but during the winter I am one of those unfortunates who board, and often act as a house physician to those in the house. An epidemic of grip struck the house about this time, expending its force on nose and throat, so I had an opportunity of testing this remedy.

There were in these cases extreme chilliness, cold shivers running up and down the spine, greatly aggravated by cold air, or even a suspicion of a draught. Patient very sensitive to all external impressions, noises or touch; marked headache, more marked in frontal region than at base of brain, of a sticking or boring character. Dizziness marked at beginning. General aching and backache quite pronounced. Perspired easily even when feeling chilly.

On inspecting nares, mucous membranes were red and swollen, especially turbinates and mucous membrane of the septum opposite middle turbinate. Discharge scanty at first, became yellow or yellowish green later. Pharynx red and two cases had tonsilitis.

Hepar sulphur 1X or 2X one-fourth grain every two hours, for one day, every four hours if necessary second day, was treatment. It seemed to act quickly and well. As I believe that many cases of suppurative inflammation of middle ear need never involve the mastoid if given hepar or silicea, so I believe that in hepar sulphur we have a remedy that will cure most cases of acute inflammation of accessory sinuses, especially if at first we rely on the remedy and do not use much forceful exploratory probing.

We may not be able to give as exact a diagnosis, but think we may cure more acute cases and prevent more chronic ones.

Hepar is useful also in chronic follicular pharyngitis with cough, muco purulent discharge, hoarseness with relaxed uvula, all aggravated in changeable weather, especially change from warm to cool.

Deep-seated, chronic inflammation of tonsils and of glands of pharynx.

For phlegmonous or suppurative pharyngitis, sometimes described as erysipelas of pharynx, hepar is a specific.

For quinsy, I generally give hepar at first, not waiting for sticking pains, chilliness and rigors indicative of oncoming suppuration.

In croup, chronic rhinitis, nose stopped up every time patient went into cold air, chronic catarrhal inflammation of nares and oro-pharynx, with much secretion of mucus, vocal defects of singers, over-use or strain producing hoarseness or aphonia and resultant laryngeal pain, soreness, congestion and inflammation. This remedy often restores the lost timbre of voice.

Says J. S. Mitchell: "In chronic laryngitis, this remedy has done so much for me that I consider it the most effective of all remedies. Its use in cases occurring in professional singers has been attended with such success that I do not hesitate on taking the case to express the belief that not only the laryngeal inflammation will be relieved but that a manifest improvement will be apparent in the quality of the voice."

This I have verified.

General characteristics of hepar: Pains usually splinter like in character, aggravated by cold and dry winds. Hepar patient very sensitive to any pressure, touch or cold air. Septum nose very sensitive to touch. Worse on uncovering body. Worse in dry cold. Better in damp.

Allen says: "There is no remedy that I know that has the amelioration so strongly marked in damp weather. Never give when there is a hot dry skin. Patient always sweaty and weak.

DISCUSSION.

Dr. Florence Smith-White wished to emphasize the value of the feeling of a splinter in the throat in these cases. This pain seems to be necessary to get the best effect from Hepar sulphur.

Dr. Kilgour: In regard to the use of hepar in croup, the essayist does not say that she used it, and yet it is one of our main standbys, not in the dry, barking croupy cough, but when it becomes loose and rattling and is still croupy.

Dr. Zbinden: We must distinguish between the commercial calcium sulphide and hepar sulphuris. While the two are similar chemicals, they are by no means identical. By looking them up in the pharmacopoeia we find that they are prepared by different processes. Hepar is white and calcium sulphide is gray.

BUREAU OF NEUROLOGY.

R. B. HOUSE, M. D., Chairman - - - Springfield

J. D. BUCK, M. D. - - - - - - Cincinnati
"Hallucination"

LINCOLN PHILLIPS, M. D. - - - - Cincinnati
"The Relation of Rheumatism and Allied Conditions to the Nervous Disorders of Childhood"

HALLUCINATION.

BY J. D. BUCK, M. D., CINCINNATI.

In studying the mechanism, conditions, and finally the nature of perception we are dealing analytically with our momentary experience. We constantly realize that we are hot or cold, comfortable or uncomfortable; that an object is rough or smooth, hard or soft; that a sound is soft or harsh; that a substance is sweet or sour, pleasant or disagreeable, and so on through all the varied sensations or emotions that result from our contact with the external world. The

varying result of all this experience in consciousness we call *perception.* Within, there is the *perceiver;* without, the external world of matter and motion. Connecting these two *ends* of the apparatus, is the sensory nerve mechanism. Consciousness may be conceived of, as a mental etherial, or psychic atmosphere, surrounding and including the whole apparatus. Consciousness is not an attribute or faculty like will or hearing, or perception. Consciousness subtends, includes and antedates all these. Consciousness is an ultimate. Consciousness *in itself,* does nothing, and we can do nothing without it. Indeed we should not know that we exist at all, without consciousness. Consciousness is therefore the first condition of existence or knowing. That without which we could not know anything, and that concerning which we know nothing except that it is, is consciousness. That is the meaning of consciousness as an ultimate.

Nine tenths of all the obscurity in psycholgy arises from the misapprehension of, and false ideas and relations as to what we call consciousness.

It is essential, therefore, that we start right here.

Now, returning to the mechanism of perception, there is first an objective stimulus, something in some way affecting the apparatus from without; as light to the retina; sound waves to the tympanum; contact to the touch corpusceles, etc., the result to the *perceiver* in consciousness is a sensation. While as to perception in general, and a sensation in particular, a mechanism is required and a process is involved, the result; viz. a valid experience in consciousness, constitutes perception *per se.*

Even so eminent a writer as Prof. Ladd speaks of consciousness as "perceiving."

Bear in mind, then, the mechanism and conditions of all perception, we find an external contact of some kind essential and initial in the process in an average experience. If now, an external stimulus is applied, like a hot iron to the skin, light to the retina, or sound waves to the tympanum, and no sensation results, and no perception follows, we say there is peripheral paralysis, or loss of the function of sensation, or the power, so far to perceive changes. We are now ready to define hallucination.

Where changes are perceived in the sensorium, and yet no external stimulus has been applied, the condition and the result are called "hallucination." This is usually designated as "false perception resulting from no objective stimulus at all."

Now let us take the following statement of Prof. Ladd of Yale University. "What every man sees will depend upon what sort of a percipient he is, upon his memory, imagination, feeling or will. *For every case of perception affords a new problem to consciousness; and precisely how that particular problem will be solved depends upon a great variety of conditions.*"

"No man has the gift to see things as others see them." Again: *"All perception is interpretation; and from partial or mistaken interpretation all degrees and kinds of illusions and hallucinations result."* And finally,—quoting from the same authority "it is ordinarily quite impossible to be sure that no peripheral stimulus is involved in what appear to be purest forms of hallucination," and, "if, further, we distinguish objective stimulus, from peripheral stimulus, then we must say of the former, that it has absolutely nothing to do with perception, whether true, illusory, or hallucinatory."

My whole purpose in writing this paper is to call attention to this important and radical distinction between "objective stimulus;" i. e. material contact, and periphereal stimulus, which may be altogether subjective; that is, beyond the ordinary tests for matter. We are thus driven back to the realm and conditions of consciousness, and the whole realm of nature's finer forces. In other words, to the ethereal rather than to the gross material conditions of human experience. The whole trend of modern psychology is in this direction.

The whole problem concerns the nature and conditions of consciousness, in relation to experience, and cannot be confined as heretofore to crude matter and objective contact.

To the individual intelligence, a genuine hallucination, as the term is ordinarily used,—that is, where no objective material contact can be shown to exist, is nevertheless as *valid* to the individual as any other experience. *As an experience* it is *valid* to the individual.

If this is denied by anyone, let him try to convince—say, a patient with *mania potu* that he does not see apes, or little devils; or an insane person, that he does not hear voices, and he will soon be convinced that *as an experience,* these so-called, hallucinations are, to him who perceives them altogether valid and real, no matter whether the average individual sees or hears them or not. Practically, therefore, the whole question of perception, no less than that of thought, feeling, emotion, desire, ambition, etc., comes back to the problem of self-control. That is, the individual may, and if he would be *sane, must* control his experiences. The *will* may control, and the imagination choose and select the *content* of *consciousness.*

This is the principle of mental and emotional gymnastics, and from this must arise our whole theory and method of treating the insane. All physical theories, except those that apply to recognized brain or nerve lesion, have signally failed. Occupation, recreation, music, and entertainment are to be credited with most improvement recorded in recent times in the records of the insane. And what is this, but substitution of new experiences for the old and habitual? In other words, mental gymnastics.

Nor is this all: If sanitation is preferable to medication; if it is a higher office to prevent, than to treat or even to cure disease, then is this principle of mental gymnastics in its application to man, and to modern life universal. It regards crime, no less than disease, for crime *is* a disease, and the time will surely come when disease will be regarded as a crime inflicted by society upon the individual, as in the case of filthy streets and open sewers, or poisoned water; or by the individual upon himself through ignorance or disregard of the plainest laws of his own being. The first case that comes to hand will illustrate practically what is meant by mental gymnastics. Three days ago I sent a woman to Longview, no doubt hopelessly insane. A German woman with the thrift of her race, had through a relation's bad investment lost the whole of her estate, and herself and two daughters were reduced to penury. The daughters said, "never mind; who cares?" and bravely went to work. But the mother, past middle life walked the floor, wrung her hands and night and day bemoaned her loss, imagining that she pitied her daughters, whom she claimed continually that she had ruined; she nevertheless multiplied their real troubles by her insane ravings,

deprived herself and them of sleep, and finally put upon them the sorrow and disgrace of sending her to an asylum. If she had even tried to realize the uselessness of her lamentations, as the hopelessness of her loss; if she had been willing to *let go,* mentally, of that which actually was gone beyond recovery, she might have comforted her daughters and secured a fair degree of happiness for herself. Possibly forcing her to occupation or amusement, or silencing her lamentations by music may result in improvement or restoration, though the unusual cerebral hyperaemia may result in lesion, before such improvement sets in.

Mental gymnastics thoroughly understood and systematically applied should constitute the foundation of all education for the child, and self-control should in every case and at all times be supplemented by the installation of high ideals and noble aims in life. This is not that pouring-in process, of the contents of books, good or bad, but the drawing out—*educo,* of the latent powers and the realization of the highest possibilities of the individual soul.

THE RELATION OF RHEUMATISM AND ALLIED CONDITIONS TO THE NERVOUS DISORDERS OF CHILDHOOD.

BY LINCOLN PHILLIPS, M. D., CINCINNATI.

In this brief paper I do not expect to offer anything very new or to propound any original theories, but I do want to call attention to a disorder that we have overlooked entirely too often in our daily work. We unfortunately base our ideas of rheumatism upon the well-known symptoms in the adult, viz: severe pain, great swelling, high fever, scanty urine, etc., forgetting that in the child it affects other tissues beside the muscles and the joints. In fact, the disease may affect almost any tissue, and at the same time present but few of the well-recognized symptoms accorded to rheumatism. Such being the case, we are liable to make an incorrect diagnosis and probably not aware of the real trouble until brought face to face with a serious valvular lesion.

The allied conditions to rheumatism of which I shall speak are lithaemia and gout. While recognizing the fact that acute in-

flammatory rheumatism is perhaps an infectious disease, yet at the same time there often lies in that great realm of metabolism many faulty conditions, making themselves manifest in rheumatic, lithaemic and gouty symptoms.

Metabolism is unfortunately but little understood in its finer workings. If it were understood a host of troubles might be interpreted, viz: rickets, marasmus, tuberculosis, etc. It affords a convenient stopping place in our pursuit where as Kant says: "Reason can repose on the pillow of obscure qualities."

Well-marked cases of rheumatism are rare before the fifth year, yet I have seen cases in infants but a few months old. Well-marked cases of acute articular rheumatism are rather rare in children, but the abarticular cases are all too common, and all too often overlooked. Among the manifestations are growing pains, eczema, chorea, migraine, gastralgia, renal colic, anaemia, intestinal trouble, tonsilitis and heart affections.

When we have a case of acute articular rheumatism, the swelling may be extremely slight, but little redness and pain and very moderate fever. The little one seems scarcely sick enough to go to bed—where it should be until all symptoms have disappeared.

How shall we diagnose the abarticular? Given an hereditary predisposition—attacks of tonsilitis, growing pains, easily fatigued, anaemia, functional nervous disorders viz: sleeplessness, irritability, erythema, and your case is rheumatism. Faulty assimilation, growing pains and tonsilitis are very reliable sign-posts; but you may not have all these indications. You may have only a history of tonsilitis, with a miserably slow recovery. Now don't fail to examine the heart, or before you are aware of it a dangerous endocarditis is in full bloom. The case may start with an endocarditis, and may cause you to make a faulty diagnosis. One attack predisposes, and these children need the very best hygienic care, for repeated attacks will surely produce heart lesions of greater or less severity.

Always look upon "growing pains" and tonsilitis with suspicion. An illustration will suffice. Some time ago a mother brought her two daughters, aged 9 and 12, to my clinic at Pulte College. The history was "restlessness at night on account of growing pain and being so tired." Questioning elicited the fact that both had repeated attacks of tonsilitis, were catarrhal, nervous and poor eat-

ers. The younger had the gas, red sand and afternoon aggravation of lycopodium. In the twelfth dilution it has given marked relief.

The older one has endocarditis and a very marked cachectic appearance. Arsenicum 3X has helped her, but prognosis not good.

In reference to the nervous conditions: Many skin diseases are now considered of nervous origin—erythema, eczema, etc. Ofttimes these are of undoubted rheumatic origin. Night terrors and sleeplessness are sometimes offshoots also. Migraine and gastralgia have been mentioned. There is one condition, however, upon which I wish to lay particular stress, and that is chorea. The majority of cases are but the manifestations of rheumatism. Uniformly you have the growing pains, tonsilitis and anaemia. The danger in chorea lies in the ofttimes accompanying endocarditis. By watching your chorea cases you will find that the attack is often preceded or followed by marked rheumatic symptoms. Authors differ as to the percentage of chorea cases that are rheumatic, but undoubtedly the great majority are engrafted upon that diathesis.

The treatment is to be hygienic, avoiding as far as possible all conditions that have a tendency to aggravate and cause rheumatism. In regard to diet, the consensus of opinion is to restrict the sugars and starches. The remedies are to meet the individual idiosyncracies and not the term rheumatism.

When the child has growing pains, tonsilitis, anaemia and functional nervous disorders, it invariably has rheumatism, and its heart is in danger.

DISCUSSION.

Dr. Arndt: I wish to call attention to the importance of watching the tonsils in these conditions. I have noticed that the removal of the tonsils has been followed by a complete and entire cessation of the symptoms. We cannot afford to trifle with a hypertrophied tonsil and depend solely on the internal remedy. It affords too fine a culture-medium for rheumatic heart trouble.

Dr. William Baldwin: I never remove the tonsils. The indicated remedy in the 30th or 200th is sure to bring satisfactory results. In chronic cases baryta carb. is most often called for, doses six hours apart. In acute cases bell., merc. cor., and especially phytolacca 200th cures my cases and brings me friends and money.

In the past ten years I have found phytolacca called for in 75 per cent of my cases, and but two cases have had recurrent attacks in that time. No class of cases brings more satisfaction in treatment.

Dr. Kilgour: I would call attention to the importance of an early recognition of rheumatism in children. It is a fact that even infants as young as two months old may have it and they may take on acute rheumatism independent of tonsillar involvement. The infant does not want to be touched—a regular hepar sulphur indication—and every time the child is moved it cries with pain, and it isn't long before there is discovered a valvular involvement of the heart. I say, therefore, it is very important indeed to diagnose these cases even where the diagnosis seems very difficult to make, and to watch closely the condition of the heart.

Dr. Childs asked why Dr. Phillips would diagnose these conditions as rheumatism rather than anaemia, which they seemed to him to be.

Dr. Phillips: I have never known a case of anaemia to simulate a case of tonsilitis, nor have I any recollection of finding any case of infantile rheumatism that might have been mistaken for anaemia. I do not think it is likely to mistake rheumatism with an endocarditis for anaemia, or vice versa. Your rheumatism may not manifest itself in any way except by an endocarditis. That may be the only symptom, so that I do not see how anaemia could be mistaken for rheumatism in young children.

Dr. Kilgour: The text books say that the majority of cases where the heart is involved are of rheumatic origin, especially in children under five years of age; that the percentage is as high as 80 per cent, and that it gradually decreases in regular proportion after that age until in old age it drops to five per cent.

Dr. Childs: I don't get what I wanted. What I wanted to get was whether these cases were rheumatic or not; these that the essayist reported. If they were, I don't know what rheumatism is. I have never had a case of rheumatism that I couldn't trace to an anaemic condition of the liver instead of the reverse. There is always some cause for both, but the anaemia precedes any other condition of rheumatism.

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PUERPERAL INFECTION.

BY A. W. REDDISH, M. D., SIDNEY.

Septicemia, pyemia and sapremia—three dreaded names, whose mere mention strikes horror into the heart of the obstetrician and brings a quiver to the pulse of the parturient woman. Formerly these diseases were the bane of hospitals, and to send a patient there, quick with child, was equivalent to writing her death warrant. While not so fatal in private practice, still every physician would gladly forego his nights of vigil with the woman in labor, if possible for him so to do.

The coming of the germ theory has made possible a better understanding of these diseases, and asepsis and antisepsis have changed results. The hospitals show the best results now and private practice among the lower classes must, of necessity, lead in the percentage of infection and mortality.

Septicemia is a condition in which there is an incursion of pathogenic germs into the blood and tissues of the body in general, with or without a discoverable avenue of entrance, but in which there are no foci of suppuration.

Pyemia is a septicemia due to pyogenic organisms, plus one or more foci of suppuration.

In puerperal septicemia the focus of infection is known to be a wound or abrasion in the parturient tract. In the majority of cases, septicemia is due to the presence of the streptococci or staphylococci, but it may be due to a combination or mixed infection or to any one of a number of pus-forming micro-organisms.

When septicemia starts from a local infective focus or foci, whence the micro-organisms enter the blood, as in the parturient woman, the invasion begins between the second and fourth days. The initial symptoms are those of all infectious diseases: chilliness, followed by fever, which tends to intermit gastro-intestinal symptoms such as loaded tongue becoming dry in severe cases, nausea, vomiting or diarrhoea, rapid, soft pulse, delirium, prostration. In septicemia due to the streptococcus, the chill is harder, the fever higher with a tendency to recurrence.

Pyemia is septicemia complicated by multiple abscesses arising from an original focus of suppuration. This suppuration is generally caused by the staphylococcus or the streptococcus, but may be produced by a number of other organisms such as the pneumococcus or typhoid bacillus. The veins and arteries in the neighborhood of the abscess become inflamed, septic thrombi form which break loose and float along in the blood current as emboli, forming fresh foci of infection in various parts of the body.

In the arteries they lodge in the capillaries of the tissues to which the particular artery involved is distributed. If the thrombi are formed in the veins when they break loose and float through the blood current as emboli, they pass from the uterine artery to the internal iliac and iliac artery to the ascending vena cava, through the heart to the lungs, where they form new foci of infection.

The symptoms of pyemia are hard chills at irregular intervals, recurring, it may be, in six hours, or it may be in forty-eight hours. The chill is followed by high fever, to be in turn followed by exhausting sweat, and then an interval of varying duration in which the invalid may feel fairly comfortable, only to be abruptly ended by a returning rigor. The chills are hard, the pyrexia unusually high, and the sweat drenching and exhausting. Pyemia and septicemia are caused by the incursion of pus-forming micro-organisms into the blood and tissues, and differ from sapremia, which is due to the toxic products of germs gaining entrance into the blood.

In sapremia the toxins are formed by the bacteria of a putrefying placenta in the uterus. The symptoms are malaise, restlessness, headache, chills and fever, rapid pulse and nervous agitation.

There is a type of puerperal cases of which I have seen two. In twelve or twenty-four hours following the completion of the puerperal act, the patient has a chill which is the initial symptom of peritonitis proving fatal on the third day. Byron Robinson, of Chicago, attributes these deaths to rupture of pus tubes during labor, and he demonstrates his diagnosis at the autopsies.

There is another variety of septicemia that comes on after two or three weeks, accompanied by the usual classical symptoms plus obstinate constipation. The trouble appears to be located in the sigmoid and colon from whence infection takes place. The sigmoid and colon must be thoroughly emptied and disinfected. Every wound and abrasion in the puerperal woman is a menace to life and should be looked upon with suspicion. She is particularly vulnerable to infection with micro-organisms of the pus-forming variety. In order, therefore, to prevent infection every preventive measure known to modern medical science should be employed. Outside of hospitals the physician is often seriously handicapped for the want of competent nurses or attendants, who appreciate the value of surgical cleanliness.

The physician should prepare his hands, instruments and dressings as carefully as for a major operation. Boiled water should be insisted upon for purposes of ablution and for cleansing the parts before and following the accouchement, and when the third stage of labor is finished, thoroughly inspect the parturient tract, especially the perineum, for evidences of abrasions or lacerations. These should be carefully cauterized, preferably with carbolic acid, and all tears coaptated with ligatures and dressed with gauzes.

I believe one fruitful source of infection is through the medium of the handkerchief, and another is by means of fecal discharges infecting the wounds. There is an evil practice among a certain class of women of using any soiled linen or piece of bedding as a pad during the parturient act. Eliminate all of these known causes and we still encounter infection, to our chagrin and mortification. Most cases of sepsis in my practice have been in

simple cases of labor, and I attribute it to my practice of being less energetic in antiseptic after-treatment in these patients.

Finally, do not be too caustic in your criticism of your unfortunate brother obstetrician, for you know not how soon his lot will be your lot and his chagrin will be yours.

DISCUSSION.

Dr. Meade asks in regard to treatment of such cases.

Dr. Reddish: I purposely said nothing of treatment, for I am discussing a poisoned condition that requires quick action on the part of the accoucheur. But I use cleansing methods. I don't curette as often as I used to do. Where there is any retained placenta, of course I remove it; but I have had some unfortunate experiences with curetting in opening up wounds. But as I say, I cleanse them all thoroughly, and of course aseptically. I have better results from quinine than from any other remedy. I would prefer quinine to all other remedies at such a time. I think it is an antiseptic in this case. I use large doses. I have used ten and fifteen grains at a dose. There are other remedies, but as I have said, I prefer quinine to any other. I also use large quantities of stimulants, alcoholic. And I had good results in two cases of pyemia by using the nascent phenic acid hypodermically.

Dr. Humphrey: This subject is interesting and one in which we always find sufficient difference of opinion to make the discussion profitable. We should bear in mind that all cases of puerperal fever are not septic by any means. It is estimated by the very best authority that only about 25 per cent of puerperal cases are septic in their nature. Of course if you cover everything and call it septic you might have a long line of recoveries and some bad results besides with the others. Another point to be kept in the mind and one that is coming back to us is the fact that we should be careful not to criticise our brother practitioner when he gets a case of puerperal fever. One of the best of authors avers that 70 per cent of perperal women carry about streptococci and many other of the colon bacilli. It has been proven in this same work that 25 per-cent of puerperal women carry streptococci in the uterus. This being true, it is not always due to the carelessness of the accoucheur that the infection takes place. Of course this sort of authority

doesn't make us careless in our treatment of these cases; it simply gives us the hope that we have not ourselves been the cause of the infection. It is probably and more frequently due to another cause than the uncleanliness of the accoucheur and his instruments. So far as the treatment is concerned in these cases, whatever the line may be, the first thing, and indeed the greatest element of success lies in getting every secretion of the body active. I find that in nine cases out of ten where you have a considerable degree of inflammation that a very simple clearing out and douching thoroughly will cause the condition to subside without any mechanical interference.

Dr. Jones: In the first place I have not been in the habit of giving quinine in any case of continued fever. I do not remember to have ever given a dose of quinine in a case of puerperal fever, and as far as my success is concerned, I believe it will compare favorably with any other of my colleagues with whom I am acquainted. I cannot quite understand how a 15-grain dose of quinine given in a case of puerperal sepsis with a temperature of 104 could be of any benefit. The same is true as to alcoholic stimulants, which I do not use in such cases. There seems to be a dreadful fear on the part of the younger members of the profession of sepsis, and that something desperate must be done at once. We have young men in Cleveland who use the curette quite frequently, and active cathartics and other means which they think are required. In reference to cathartics I take issue with the last speaker in that matter. We must remember that labor sometimes is very severe, that we have traumatic influences at work and that the intestine is frequently injured thereby. I have seen many cases of enteritis following labor, and to follow such a case of enteritis with a cathartic would be about the worst thing you could do. In former years it was practiced more than now, but I would have much more fear of the effect of the increased peristaltic action as a result of such a dose than I would to leave the bowel alone. We should individualize our cases and treat each by itself.

Dr. Sawyer: If I understand the prescription of Dr. Reddish, he makes it on an entirely physiological basis and does not concern himself with the symptomatology of the drug. In its use he does

not deem it necessary to pay special regard to elevation of temperature. He realizes, as the most of us do, that temperature is not constant. In the majority of cases of this kind there is no rise of temperature, but its existence does not contraindicate the use of quinine. I believe quinine always to be indicated in this particular class of cases. Its influence is as my own experience goes to increase the white blood corpuscles, and as the white blood corpuscle is the policeman of the system, and as it is necessary that this force should be greater than the invading force, anything which improves or increases the number of white corpuscles aids in overcoming the destructive influence of the disease germ.

Recent observation shows that alkalinity of the blood renders the patient more or less immune to disease germs and their toxines, and it is possible that it may be to this influence of quinine that such favorable results are traceable in conditions of blood poisoning; but let that be as it may, experience confirms me in the opinion that quinine is specifically indicated in these cases, and I believe that we as homeopaths should have no more hesitancy in using it than we would in giving any antidote for any other poison taken into the system. I contend that if we as homeopaths are confined exactly to the symptomatically indicated remedy in all cases that there are very few of us that are homeopaths, and in defense of Reddish's prescription, I wish to stand for a homeopathy that is broad enough to apply any reasonable means in the cure of disease, and I think we need offer no apology for any remedy which is prescribed on other than a symptomatic basis. That is to say, that homeopathy in its true sense implies the use of all rational means prescribed with a definite purpose.

Dr. Jones: According to Dr. Humphrey's statistics, in 75 per cent of the cases the alarm of fire is false. Does, then, this heroic dosage with quinine prove that it was the quinine which overcame the assumed invading forces? If it be true that many women carry the streptococci in their uteri, is the quinine as clearly indicated in that variety of cases as in the other cases that may be due to ordinary infection from without?

Dr. Bishop: Seventy-five per cent of these fevers are due to septic infection resulting from the absorption of toxins which orig-

inate in putrefying matter within the uterus. When we have a case of continued fever above 101 F. our first duty is to determine whether or not there is putrefying matter within the uterus. If it is present, the indication for treatment is to remove it. As soon as it is removed, nature will be able to take care of herself and throw off the toxins.

If the septic intoxication is not due to the absorption of toxins from putrefactive matter, it is due to the entrance of infectious micro-organisms directly into the blood current, and the condition is not a sapremia, but a septicemia. In such a case the less we have to do with the uterus the better. The indication for treatment is to so fortify the resisting powers of the body that it will be able to meet and destroy the invaders. It is in these cases that I believe quinine in large doses is particularly indicated. I also give strychnia almost up to the physiological action of the drug. Bromine is also a wonderful remedy in this form of infection.

In every infection, whether sapremic or septicemic, I use saline infusion by hypodermoclysis. The best results are obtained when it is given continuously, no more being allowed to enter the tissues than will be absorbed. Since I have been using saline infusion as a routine measure in this class of cases I do not worry about the case.

Dr. Reddish:. Dr. Jones says he does not use quinine in puerperal fever. He is most fortunate in his results. I never get any but negative results from anything else but quinine, in this class of cases, and it acts splendidly. It must be understood that a septic fever is not a continued fever, but rather of the intermittent type.

INDUCTION OF PREMATURE LABOR.

BY C. C. MEADE, M. D., CINCINNATI.

The cause of gestation may be arrested artificially at any time in the interests of either the mother or child. If it is arrested before the child is viable, it is termed abortion; if after (twenty-eighth week) the child is viable, it is called induction of premature labor. The date of fetal viability is therefore the dividing line between the two operations.

In abortion the welfare of the mother alone is considered, while in premature labor both the welfare of mother and child are to be considered; for in the latter, the operation preserves the lives of both mother and child, or it results in taking a life to save a life. While in abortion the life of the child is sacrificed to save the life of the mother.

I now drop the subject of abortion and treat induction of premature labor.

When the further continuance of gestation would seriously endanger the mother's life, the induction of premature labor is indicated, and any of the following causes may force such a proceeding upon us. Pernicious vomiting with exhaustion and progressive emaciation, in grave heart, lung and kidney troubles, pernicious anemia, severe chorea and jaundice after having resisted all remedies and methods known to medical science without relief, the induction of premature labor is indicated to prevent a fatal termination due to the abnormal conditions in question, or when the continuance of gestation to full term would expose the mother or child to serious risk which might be diminished or avoided by arrest of gestation, the induction of premature labor is indicated.

It is difficult to formulate definite rules to follow, consequently each must be judged and managed upon its own merits; and since the extremely high rate of successes from symphysiotomy and Caesarian section, especially the latter, I consider nothing but a constitutional condition or an emergency justifies the induction of premature labor. Authoritatively speaking, the causes which justify the operation are contracted pelvis, hemorrhage and eclampsia.

Personally, I do not consider deformed pelvis at all as justifiable. I doubt that eclampsia is justifiable, but I certainly think hemorrhage is. If gestation has advanced to the period of a viable child, excluding emergency cases, the mother's condition would not warrant induction of premature labor, as it would be better for the mother and far better for her offspring to continue gestation uninterrupted to term. The large per cent of premature babies die for want of vitality and sustenance, which are derived from normal temperature and normal nutritional foods.

In case of deformity of pelvis the length of diameters, especially the conjugate, must be considered, and if less than 2.36 inches,

the operation should not be performed at any period unless there is a positive diagnosis of an abnormally small child alive in the uterus.

We know the normal length of the pelvic conjugate; we also know the diameters of the fetal head, of greatest importance from an obstetrical standpoint.

Let us for sake of brevity consider only the most important one, the bi-parietal, which normal length at term is 3¾ in., at eight and one-half months 3.4 in., at eight months 3.2 in., at seven and one half months 2.96 in., at seven months 2.75 in. The fetal head may be compressed four inches. Remembering this degree of safe compressibility, having estimated the size of the fetus and the stage of gestation, the next important element in the problem is the determination of the degree of pelvic deformity present, which can be pretty accurately done by a thorough practice of the use of pelvimetry.

As long as the fetal presenting part can enter the pelvic brim, the time for induction of premature labor may be deferred, but just as soon as the presenting part engages with difficulty, the time is ripe for interference. Therefore every week the physician in charge should examine carefully to ascertain this fact.

After considering the above measurements of fetal cranium at different periods of gestation, the anterio-posterior diameters of pelvis being 3½ in., we see that in multiparae labor should be induced at eight and one-quarter to eight and one-half months. This is to be governed to some extent by size of fetus and difficulty in delivery offered by former labors. In primiparae, since the child is usually smaller, it is safe to wait a week before term.

When conjugate is 3.35 inches, premature labor, both in multiparae and primiparae, should be induced at from eight to eight and one-half months. If conjugate is 2.75 in., labor is to be induced at seven months to seven months and twenty-one days; where conjugate is 2.36 in., at seven months, seven days, and where below 2.36 in., the indications for premature labor do not exist. To resort to it would necessarily entail an embryotomy, and this carries risk to the mother and subserves not the child. At this point then the indication for artificial abortion in contracted pelvis begins.

Hemorrhage as an Indication for Induction of Premature Labor.—Hemorrhage occurring after the fourth month of gestation should always awake suspicion of abnormal implantations of the placenta. Obstetricians mostly agree as to the advisability of inducing premature labor on the appearance of the first hemorrhage.

If this first hemorrhage occurs within the last six weeks of term and is violent and seems to endanger the mother's life (it will of course cause the death of the child), labor should be induced immediately in behalf of the mother and also the welfare of the child. If it occurs at or near the fifth month, vigilance and care with the expectant plan is agreed upon as the proper course to pursue. Some authorities say to confine the patient to her bed will assist greatly in carrying the child to term. My experience has been, the woman is more likely to hemorrhage in recumbent position than erect.

However many opinions we regard in hemorrhage of the pregnant woman, unless properly treated the mortality rate is high for both mother and child. With prudent and fearless action on the part of the physician in charge, the mortality rate in the case of the mother is reduced to almost a minimum and also decreased in the case of the child.

Authoritatively speaking, the question may be summed up as follows: The risk to the mother increases progressively to term after the first hemorrhage. On the occurrence of this hemorrhage the child is viable. Renewed hemorrhage simply risks viability. The interests of the child, therefore, are not subserved by expectancy. Those of the woman are actually imperiled. The teaching is sound therefore which says: "On occurrence of first hemorrhage, whether profuse or not, elect induction of premature labor." The earlier the hemorrhage the greater the chance of the placenta being implanted centrally. It is the central attachment which at term subjects the woman to the greatest risk and holds out but very slim chance for the child. Personally, I prefer to care for the emergency cases, (by which I mean, those sufficiently profuse and violent to immediately endanger the life of both the mother and child, and especially the former), by at once emptying the uterus: cases of a less severe type, I place in hospital where they can have capable attendants and nurses to care for them if anything arises. This excludes all risk, and I am positive the nearer gestation approaches

term, the better are the chances for the living child, and the woman's chances are not lessened.

Eclampsia as an Indication of Premature Labor.—Absolute statement in regard to this indication is not wise, owing to the diversity of opinion among experienced obstetricians. To reach approximately accurate conclusion, it will be necessary to differentiate the instances where eclampsia seems imminent, and where convulsions have developed.

Albuminuria in pregnancy is frequently a forerunner of eclampsia, but in all cases of albuminuria we do not have eclampsia, nor do we have albuminuria in all cases of eclampsia. Eclampsia of a most fatal type is met with where neither casts nor albumen are found in the urine. Albuminuria may or may not depend upon organic renal disease, and it may not lead to organic disease. We have some cases of eclampsia coming from toxemia, possibly urinary in character, as the urea is diminished in amount, as is also the total quantity of urine secreted; the question, therefore, which the physician has chiefly to face, is the immediate risk to mother and child if pregnancy be allowed to progress to term, remembering that in no given case can it be predicted that emptying the uterus will ward off convulsions; also the interference with gestation will excite convulsions. It evidently is a most complex problem.

I resort to recognized methods of treatment for albuminuria, if the woman's condition indicates labor. I assist and hasten the delivery, but I do *not* indorse the induction of premature labor unqualifiedly for relief from eclampsia. I believe, if delivery will relieve, nature will indicate it by symptoms of labor in cases of threatened convulsions. I think to empty the uterus will ensure an attack unless nature indicates the necessity of such a procedure for relief.

It must not be forgotten that albumin may be absent and yet a deep toxemia be imminent. Therefore the sound rule, test for urea.

There are pages written pro and con as to the induction of premature labor in eclampsia, yet I do not think it an indication for such a procedure unless labor is imminent; then it is proper to assist nature, but to force her to delivery without symptoms being present will likely help "out of the mud into a bottomless mire."

The methods of induction of premature labor are numerous. I shall mention the objections to some of them most in practice,

also give in detail the technique of the one I consider the best and safest.

Administration of medical agents are unreliable. Injecting water or air between the membranes and uterine walls would be effective, but is likely to rupture the membranes; thus imperiling the life of the child, and may prove fatal to the woman from entrance of air into the uterine veins. Vaginal irrigation with hot water is slow and doubtful of action and may cause local congestion, which is dangerous to both mother and child. Electricity hastens and increases contractions when labor has begun, but, used alone, is problematical in effect, as well as highly uncertain. There are five other methods which are principally used by authorities and operators at the present time. 1. Puncture of the membrane. 2. Tamponade of vagina. 3. Injection of glycerine. 4. Insertion of elastic bougie between membrane and uterine wall. 5. Mechanical dilatation of os uteri.

Puncture of membranes was formerly very popular with the Vienna school, and it will certainly induce labor, and when aseptically performed, is safe to the mother, but not to the child, because of premature rupture of membranes and loss of dilating amniotic wedge, which precedes the presenting part of the fetus with retained fluid preventing violent contractions of uterine walls and exhaustion to the child before it is delivered.

Induction of premature labor by means of tamponade is neither safe to mother nor child, on account of the length of time required to dilate the uterus. It well fills the place under this subject, if there exists a hemorrhage of a serious type. Aseptic gauze should be used and aseptic care should be observed.

Injection of glycerine for premature labor has been both popular and successful in Germany. When glycerin is injected into the uterus between the membranes and the uterine walls, it acts by causing exosmosis from the amniotic sac. There is a profuse secretion of fluid from the uterus, and concomitantly uterine contraction set in. The objections are its being uncertain in action and the great length of time required when it does act.

Insertion of elastic bougie between the uterine walls and membranes, for induction of premature labor, is perhaps resorted to more than any other method. It usually succeeds, but is sometimes

slow. Like any of the methods which require the introduction of a foreign body, it is likely to rupture the membranes and exhaust the child, it also may cause a hemorrhage, either open or concealed, and endanger life of both woman and child. The elastic bougie is not easily asepticized, consequently sepsis may arise from the operation.

The last and most successful method of inducing pramature labor is dilatation of the cervix. Cleanse the intestinal canal; at least relieve the lower bowel. The bladder is emptied and the field of operation is asepticized. Place the patient in a position most comfortable to her and most convenient to the operator. Dilate cervical canal sufficiently to introduce sterilized gauze, up to, but not into, internal os. Pack the canal thoroughly, leaving the remainder of the gauze in vagina. Wait ten to twenty-four hours for uterine contraction to begin. If it does not take place, withdraw gauze and unpack. If contractions do not occur from this it will soften the neck and os, so that the attendant has the case under control and may be able to continue and complete the dilatation with the fingers.

In fact, I think the finger the best dilator in most cases, termed by the French *accouchement force.* Dilatation by use of Barnes' bag and McLean's bag is practiced by some with success.

Any aseptic method of dilatation, to my mind, is the ideal one for induction of premature labor. It evokes uterine contractions and simulates more closely natural labor than any other method. They preserve the membranes intact until the second stage is well begun, thereby lessening the risk to the child.

Prognosis depends upon cleanliness, the condition of the woman and child at time of operation, the cause for which labor is induced, the period of gestation, and the opportunity for election in the performance of the operation. In fact, the first and last named are the keynotes of success. Certainly the success, so far as the welfare of the child is concerned, depends largely on the period of gestation. In hospital practice it ought to be possible to save, with the use of incubator and forced feeding, 85 per cent of children born under operation for induction of premature labor, with an increase of mortality rate compared to the decrease in the period of gestation.

Under modern methods and strict observance of cleanliness in operating, the mortality rate in women is less than one per cent, and

this low rate should be farther reduced if the constitutional conditions were more normal in character and emergencies did not arise which hastily compel the attendant to elect a method of operation otherwise not well chosen.

A RARE CASE OF TWIN LABOR.

BY J. P. HERSHBERGER, M. D., LANCASTER.

I was called to see Mrs. G., age 36 years, in her fifth labor. Found she had been having labor pains for about twelve hours, and on digital examination found os completely dilated and a large sac of water presenting at the superior strait, and through the membranes outlined the position. Four feet presenting. I at once realized that I had a condition of affairs requiring prompt action, and as I was in the country where I could not get counsel under three or four hours, I proceeded first to think, consuming ten or fifteen minutes in this proceeding, and decided on a method of procedure. Then I made a second examination and found no progress, although the pains were regular and strong. Ruptured the membranes and brought down one foot quickly, blocking the second child from the pelvic inlet, after bringing the first child down into the pelvis. I proceeded to make traction with the pains, but found it impossible to advance the child by the most powerful traction I could make.

I then adopted the plan of making traction during the interval between pains, and found I was able to make slow progress in the delivery. In about thirty minutes was able to deliver the first child. Asphyxiated, the cord had ceased to pulsate. I turned the first child over to an old lady and proceeded to give my attention to the mother and other child, as the pains were constant and regular. The second child was born immediately without any trouble.

I think it is impossible to deliver first child in a twin labor, with children in this position, quick enough to save it. This position in twin pregnancies is very rare. Cazeaux gives a table covering three hundred and twenty-nine twin pregnancies, in which series of cases it occurred eight times. I have been unable to find any obstetric literature on the method of procedure in this position in twin labors.

DISCUSSION.

Dr. Meade: The object of all twin deliveries is, of course, to get the first child. The second is not so difficult, for as a rule nature helps there most effectively. The best methods in all these cases is to let nature do the major part of the work. Traction in labor cases, especially in twin labor, almost always produces a wrong presentation of your first baby's head; consequently your child's head will hang upon the pubic arch or the chin will hang upon the promontory of the sacrum, and necessarily your child will be asphyxiated.

Dr. Hershberger: The Doctor has not told me anything new. But he forgets the conditions of the case as I have tried to describe them. I found everything else in good order and the labor apparently going along as it should, when suddenly I discovered two pairs of feet where but one might reasonable be expected to be. I watched it awhile and found no descent was being made whatever. What was I to do—sit there and let that woman die? So I made traction between pains in order to make one child come down normally. The child was wedged in solidly. You might as well have tried to deliver a brick house as that child with help during the pains. I have a private communication from the Rotunda Hospital, Dublin, in which is the statement that out of 305,000 cases of twin labors this condition of which I have spoken occurred but eight times.

THREE UNFORTUNATE CASES.

BY G. D. GRANT, M. D., SPRINGFIELD.

My experience for ten years up to 1901 had been a very comfortable one in obstetrical cases, and I had begun to think that my dread of all cases was about over and that I could accept such cases and not be fearful of results. Yet at this time I began to have difficult cases, and in the next two years at least twelve were of the sort that leaves me dreading the time when I shall be called.

My first case which I shall recount occurred December 1, 1901, Mrs. H., with her second pregnancy. The first one, four years before, had been a forceps delivery, owing to inability to help herself, pains lacking force. I saw her early, and found complete dilatation and a face presentation. The frontal prominences were

wedged against the pelvic bone, and chin against the sacrum, and severe pains, holding it there firmly. I made every effort to change the position, but was unable, and calling assistance, my diagnosis was confirmed and we both tried to change the presentation, but were still unable to move it in the least, and that under complete anaesthesia. We decided to use forceps and deliver by force. My forceps were easily placed, and on traction slipped, and would slip every time I used traction. Finally I used a pair brought by Dr. Gotwald, and succeeded in keeping them on. I had used considerable force at different times in my life before this, but never did I know what was necessary for a forceps delivery. After nearly one hour's fruitless traction, with three persons holding against me, and braced by one foot against the bed, was I able to move the head, and had the satisfaction of seeing the head fill out the perineum, upon which I removed my forceps and delivered without force, and saved the perineum. The child was alive, but I found every bone in the head movable, showing that the slipping of the forceps had been fatal, and it died two hours later. Mrs. H. I watched very carefully for twelve days. Her temperature never went above 101 degrees, and at the end of two weeks was as well as the average woman after confinement.

My next case, December 29, was a Mrs. M., in her fifth labor. She had two sons living, and had lost two by reason of difficult labors. There had been nothing abnormal in her pregnancy, and when summoned I found that dilatation was progressing rapidly, and at the end of the first hour was nearly complete, membranes intact, and I had no difficulty in finding the head, which lay with occiput to the right. While making the examination, and during a pain, the membranes were ruptured, and a foot was shoved into my hand, and it was not difficult to make out the left one, and with the rush of water both head and foot were forced down and fixed firmly. Convinced that nothing could be done without anaesthesia, I summoned Dr. K., who lived in the neighborhood, and who quickly verified the position, and we decided on podalic version, pushing anaesthesia; we attached broad tapes to the presenting leg, and began traction. It took one hour exactly to turn and deliver, and the head was quite as difficult as the rest. The result was, that a half hour's work in an endeavor to resuscitate the child was fruitless. The mother made a very nice recovery, perfectly uneventful.

Aug. 14, 1902, Mrs. B., a large blonde, with her second pregnancy. She was an unusually large woman, but not abnormal, of good figure, and a roomy pelvis, had had a very normal pregnancy, and we only feared a very large child would make her labor difficult. Dilatation was rather tedious, and about seven o'clock in the evening the nurse summoned me, and I found it completed, and hard pains forcing the head against the brim of the pelvis, occiput against the pelvic bone. After two hours' ineffectual labor on her part I found no movement of the head had taken place. I applied the long forceps, and had no difficulty in doing so, and with the next pain I endeavored to help her by traction. About the third effort, while in the act of using considerable force, there was the ring of breaking steel and a slight slip of one blade. I immediately unlocked and found the female blade intact, and some resistance to my efforts to remove the male blade. I slipped a finger in and found that the upper segment had broken and sprung open, and with the slip had impaled the cervix just as a needle would, and then closed the gap in the metal. Of course my move was to get loose, and I succeeded by springing it open with my fingers and pushing the blade back until I succeeded in getting clear of the tissue. I at once sent for counsel, and Dr. Bell responded, and under complete narcosis we were unable to deliver by forceps, and determined to perform podalic version. It took us nearly an hour to do so, and delivered a twelve-pound boy, perfect in form, and the head in good proportion to the body. The child never breathed, and undoubtedly was killed by the compression of the cord.

The patient had a fight for life. For the next ten days her temperature ranged from 101 degrees in the morning to 102.5 degrees in the evening, and only by the painstaking care of her nurse was she kept as well as she was. After the second week she began to gain, and at the end of the fourth apparently was as well as ever.

I have found that the internal use of arnica following labor has been very beneficial, and I have made a practice of so prescribing for twenty-five years, believing it a great reliever of pain, and the soreness that follows a delivery.

No doubt others of this society have had cases just as difficult, and as discouraging, as mine, but these three have left their impressions.

DISCUSSION.

Dr. Reddish: In the Miami Valley Society some time since, Dr. Grant made the statement that in five years he had not been with a parturient woman longer than three hours. Dr. Walton corroborated the truth of this statement. I have often wondered what Dr. Grant's experience had been since then, and it is evident from his paper that he has had some unhappy experiences.

Dr. Beebe remembered that Dr. House had once said that he in his earlier practice, had been treating diphtheria for years without losing a case, but he finally reached the time when he also had trouble like the rest of us, with an epidemic of malignant diphtheria.

Dr. House: That experience happened in Michigan before ever I came to Ohio.

Dr. Meade: In the second case the patient undoubtedly had a contracted pelvis, and it was for that reason the trouble occurred. The first case was a face presentation which would never have been allowed had the doctor been present previous to engagement.

PUERPERAL ECLAMPSIA.

BY WILLIAM A. GEOHEGAN, M. D., CINCINNATI.

How many physicians carefully examine the urine of every woman whom they are engaged to attend in confinement? Of these, how many are content when no trace of albumin is found? How many realize that albuminuria may exist with little danger of eclampsia, and that convulsive seizures may occur without pre-existing signs of nephritis? How many experienced obstetricians have never encountered an unexpected case of puerperal eclampsia? An honest answer to these questions would be startling and humiliating.

Not over six to eight per cent of the albuminurias of pregnancy terminate in convulsions. Albumin may appear in the urine of pregnant women in several conditions:

First—In chronic or passive congestion of the kidneys due to organic lesions of the heart. The renal affection makes no progress independent of the primary disease, and there is no inherent ten-

dency to uremia. Pregnancy is always a serious matter, but the danger is from cardiac weakness and not from renal insufficiency. An abundance of nitrogenous food is needed to sustain the strength of the patient and prepare her for the ordeal of childbirth. The induction of premature labor is rarely indicated. When labor does occur, instrumental aid should be rendered as early as practicable. In such cases the weakness of the heart muscle, fatty degeneration and dilatation contra indicate veratrum.

Second—Chronic parenchymatous nephritis may first manifest itself during pregnancy and follow its usual course, or suddenly undergo an acute exacerbation. Oedema usually appears before the seventh month; the urine contains large quantities of albumin, granular and fatty tube casts and epithelial debris. Premature labor may occur, but the proportionate number of cases is small. Eclampsia is rare.

Third—Interstitial nephritis is occasionally but rarely found in pregnant women. It is always comparatively infrequent in females, and especially during the child-bearing period. It is easily diagnosed by the large quantity of urine of low specific gravity, by the scarcity of tube casts and slight albuminuria, and above all by the high arterial tension with arterio-sclerotic changes. During the acute exacerbations which sometimes occur, a positive pathological diagnosis may be impossible. The induction of premature labor or the use of veratrum viride are rarely indicated. It is in this class of cases that Tyson warns against the use of morphine.

Fourth—The most frequent form is the so-called acute nephritis of pregnancy, always associated with and probably due to toxemia. The structural changes are often degenerative rather than inflammatory and not always proportionate to the apparent degree of toxemia. Diminished excretion is the characteristic of this variety, and is the criterion by which its severity and danger must be judged. Albumin and tube casts are always present in the urine. Premature labor, with or without death of the foetus, often occurs. There is a marked tendency to uremia, the convulsions occurring before, during or after labor.

In contradistinction to the albuminurias of pregnancy with eclamptic seizures there are cases of puerperal convulsions, about five per cent of the total number, in which neither albumin nor tube

casts can be detected in the urine up to the moment of the spasm, though they may appear immediately thereafter. These cases usually terminate fatally.

From this classification it is evident that the presence of albumin in the urine of a pregnant woman does not necessarily indicate danger of eclampsia nor does its absence offer any guarantee of immunity. Far more valuable as a criterion is marked deficiency in the solids excreted with the urine.

The toxemia seems to be due to the retention of substances normally eliminated by the kidneys: First, the end products of the normal nitrogenous metabolism of both the maternal and foetal organisms. Second, non-utilized proteids absorbed from the alimentary tract in excess of the needs of the body. Third, alkaloids produced by intestinal fermentation which may be excessive during pregnancy, owing to disturbed portal circulation, deficient hepatic secretions, and the consequent impairment of their inhibitory action upon the fermentative processes in the alimentary tract.

The toxicity of the blood of all pregnant women, as demonstrated by experiments upon lower animals, is greater than normal; in eclamptics it is three times as poisonous. The urine, on the contrary, has much less than its normal toxicity.

An examination of the toxicity of the blood is not practicable from a clinical standpoint. The diminution of solids in the urine has proven a fair index of those retained in the circulation. An estimaton of the urinary solids may be made from the quantity of urine and its specific gravity by the formula of Haesen. While the results are not absolutely accurate, they are sufficiently so for practical purposes.

While urea is not the only etiological factor in the production of so-called uraemia, the quantity eliminated daily ought to be determined in all doubtful cases, and it may be accepted as a fair index of the elimination of other toxic substances.

When marked renal insufficiency exists as shown by diminished excretion of urea and other solids, there are usually manifested general symptoms including frontal headaches, mental depression, melancholia, stupor, impaired appetite, vomiting and retinitis. The coexistence of faulty elimination and these general manifestations of toxemia is always indicative of danger and demands active measures to avoid eclampsia.

Absolute rest in bed is necessary, for all muscular effort involves retrograde metamorphosis of proteid tissues and the presence of additional waste products in the blood.

Several times a day the Sims or a modified Trendelenberg position should be maintained for fifteen minutes to relieve the possible accumulation of urine in the pelvis of the kidney due to pressure upon the ureters and obstruction resulting therefrom.

Mental rest is important, as excitement or violent emotions may precipitate convulsions. The mental strain, and perhaps the tight lacing for purpose of concealment explain the greater frequency of eclampsia in illegitimate pregnancies.

Regulation of the diet is the principal prophylactic measure. The amount of proteids must be reduced to the minimum. Milk, bread and butter, green vegetables and fruits may be taken freely. In extreme cases, however, milk supplies too much nitrogen. Milk sugar added to milk increases its nutritive value and promotes diuresis.

Water should be given freely in the majority of cases, but not in all. Sometimes the kidneys fail to excrete it and the large amount of fluids leads to hyperemia and dropsy. Von Noorden claims that in such cases it may overload the right side of the heart and embarrass its action. Therefore when large quantities of water are given its elimination must be watched with care. Diaphoresis and catharsis may be employed to remove the excess.

In this connection is to be considered the use of salt solutions either by enemata or by hypodermic or intra-venous injections. In the majority of cases they are of great value. Enemata as a rule fulfill the indications and the older methods are rarely necessary. They are useful when they cause diuresis or even when added fluid can be withdrawn by diaphoresis or catharsis. When, however, dropsy rapidly increases they should be discontinued. Their diuretic effects during the convulsions can be determined by withdrawing the urine every four hours and estimating the solids contained. The recent experiments of Courmant, Widal and Javal upon the influences of sodium chloride in the production of oedema, and Koryani's apparently well-founded theory regarding the molecular interchange in the tubules of salt, from the glomerular secretion, for urea from the blood, warn us that even saline solutions may

occasionally be harmful by disturbing the osmotic tension of the body fluids.

Diuretics as a rule are harmful, especially so during the eclamptic period, for at all such times the kidneys are secreting little or not at all.

Diaphoresis is of value especially if there is a scanty excretion of urine and much oedema. The amount of urea excreted with the perspiration is not large, but even a little aid is not to be despised. If there is slight or no dropsy or other evidences of excess of fluids in the body, profuse sweating may be injurious by concentrating the blood and increasing the relative proportion of toxins. In such cases the amount of liquids withdrawn by the sweating must be replaced in some other way.

Chloral has been extensively used and abused as a means of controlling the convulsions. Administration by the mouth is often impossible. Given in enemata its absorption is uncertain, and in some cases the system is suddenly overwhelmed by the drug and the physician is almost powerless to counteract it. It has few if any advantages over chloroform, and the latter can be perfectly controlled.

Notwithstanding the many recommendations of morphine, I believe its use to be unqualifiedly condemned. Its action in checking all secretions counterbalances any good results to be obtained.

Veratrum viride has many warm advocates who employ it in massive doses (10 to 20 drops of the tincture), until the pulse is reduced to 60, and insist that eclampsia cannot occur under such circumstances. Others, however, claim that such favorable results are by no means uniformly obtained, and that convulsions may occur when the pulse is under 60 and dangerously weak. In my own cases such heroic treatment has not been required. In some cases seen in consultation, patients have died in spite of large doses of veratrum.

As a prophylactic measure, the induction of premature labor is rarely warranted. If, however, the toxemia and general symptoms increase in spite of enforced rest and rigid restriction of diet, pregnancy should be interrupted in the interest of both mother and child. When convulsions occur, delay is no longer permissible.

The after treatment of eclamptic patients is of the utmost

importance. The proportion of cases ultimately developing chronic nephritis has been underestimated, but it can be reduced by prolonged observation and care of the physician.

THE BEST METHOD OF SOLVING SOME OBSTETRICAL PROBLEMS.

BY CHARLES HOYT, M. D., CHILLICOTHE.

The problems are numerous and varied in the practice of midwifery, and the best method of solving them becomes of vital interest to every practitioner of medicine who responds to obstetrical calls.

There are many different ways of solving some of these obstetrical problems, but the one best way is the method we are all looking for when we come in contact with a troublesome case.

When called to a case of confinement we should go properly equipped with the necessary instruments and appliances to solve any problem that may happen to come our way, and therefore our obstetrical bag should contain at least one pair each of long and short forceps, catheters, fountain or bulb syringe, dilators, placenta forceps, uterine dilator, chloroform, ergot, apparatus for using normal salt solution, some reliable disinfectant such as corrosive sublimate, creolin, lysol or carbolic acid, also some good liquid soap such as synol soap, plenty of sutures, needles, forceps, scissors, cotton, needle holders, etc., etc., and last but not least, the Galloway obstetrical pan and outfit, the technique for the use of which I would refer you to my paper of last year written for this bureau.

In all obstetrical work and operations, cleanliness is the first consideration. The field of operation and everything coming in contact therewith, such as the hands and instruments of every kind and description, should be thoroughly aseptic. The external genitals should be thoroughly scrubbed with soap and hot water, and the vagina and the internal parts will be rendered aseptic by the Galloway method of using hot water. Any hair upon the external genitals likely to interfere with thorough cleanliness should be shaved or cut close with the scissors. Natural labor has been defined as being one where the mother is in good health with a pelvis not less

than normal size, the child living and of not more than normal size; the vertex presenting and the child's back to the front; the membranes remaining unruptured until the os is at least three-fourths dilated, and when uterine contraction and retraction go on at regular intervals, and at such a rate that the child is born within twenty-four hours from the beginning of labor pains; the soft parts of the mother being uninjured by the process of labor. In cases of difficult labor the variations from the above description are numerous and varied. I shall attempt to discuss only the most common and every-day troubles that are liable to confront the general practitioner in his contact with mid-wifery cases. The importance of early diagnosis in all confinement cases cannot be overestimated, this being especially true and important when there are problems to solve, or difficulties to be overcome, for by knowing the exact difficulty at an early stage of the labor in most cases the trouble can be overcome, and the mother safely delivered. The most frequent cause of difficult labor is a faulty presentation on the part of the child, the mother's pelvis and parts being normal. Occipito-posterior positions may be very difficult, and in some cases the final termination of labor is natural. For instance, the vertex presents, the head is flexed and the child's belly is turned forward instead of backward. As the head comes down, the occiput meets with resistance on the pelvic floor, and is pushed forward and the head and body turns so the occiput comes under the pubic arch and delivery terminates naturally, and as though naturally begun. But when extension instead of flexion takes place in the above described presentation unless it can be corrected early before the head becomes thoroughly engaged, it cannot be corrected at all, and the labor ends as it began, and constitutes a very difficult labor and one usually requiring the use of forceps, as the result is in cases of extension of the head, that you have a frontal, or if complete extension occurs, a face presentation. The diagnosis of such a case should be made early before the membranes rupture, when the child can usually be turned so the back will be to the mother's belly, when the head will engage properly and labor go on naturally. Face presentations should be corrected whenever possible by introducing the fingers of one hand into the vagina and pushing the hips up with the other hand on the outside of the mother's abdomen. If this cannot be done and

reasonable progress is being made, the pelvis roomy, and the head not too large, leave the case to nature, and if necessary later on apply forceps and deliver. When there is no progress and the presentation cannot be corrected, perform podalic version by introducing the hand into the vagina and uterus, getting hold of the feet and bringing them down. Pelvic presentations are full of problems and are of frequent occurrence especially where the children are dead or premature, also in the case of twins. Any part of the child's body may present such as the foot, knee, breach, elbow, hand or shoulder. In all essential points the management of delivery is the same. The danger to the mother is no greater in breech presentations than in head presentations, nor is the labor especially prolonged on account of it, but the danger to the child is very greatly increased owing to the pressure upon the cord. It is also claimed that the cold air coming in contact with the child's legs and hips provokes premature inspiration, causing the child to suck in mucus instead of air into the lungs, thereby clogging up the air passages and causing asphyxia. In breech presentations the membranes should be kept unruptured as long as possible, as it is necessary to get as complete dilatation of the os and vagina as possible before the membranes rupture, as the body being smaller than the head, it can pass down and out before dilatation is sufficient to make it possible to deliver the head. Watch the progress of the case carefully and if the breech does not come down properly after complete dilatation of the os, it is because the pelvis is contracted or the child very large, or the pains very feeble. In event of such a condition it is best if possible to bring down a leg and hasten delivery by traction. The same condition prevails in cases of breech presentation when the cord becomes prolapsed. Breech presentations, where conditions are favorable, should be left to nature with child's legs flexed upon its body, because in this position the cord is protected. Assistance can be rendered in these cases of breech presentation by passing the fingers over the anterior groin of the child and making traction, or by the use of the fillet passed around the thigh at the groin, or by using the blunt hook. Great care should be exercised in using the blunt hook, or the groin and thigh of the child may be seriously lacerated.

Forceps are recomemnded by some authorities in breech cases, but they are very unsatisfactory in such cases, and their use is to be discouraged. In all cases where any part of the body presents first or where podalic version has been made necessary for any reason, the delivery of the after-coming head becomes one of the chief problems. This must be done quickly in order to save the life of the child. In normal cases where the pelvis is of normal size and the foetal head not abnormal in size, there is no obstruction to the delivery of the head excepting the soft parts of the mother. When the pelvis is too small or the head too large, the delivery of the head becomes difficult, and there are three ways of overcoming this difficulty. First: By pressing from above with both hands on the mother's abdomen over the uterus, this can be done by the nurse or assistant, but the best method to deliver the after-coming head may be used alone or in conjunction with the pressure from above as just indicated. I refer to jaw traction. By introducing a finger into the child's mouth and making traction upon the jaw, complete flexion of the head is produced and great force can be exerted without injury to the child. The body of the child should gradually be carried up toward the abdomen of the mother so as to carry out the proper mechanism of labor. Some recommend pressure with the fingers of one hand against base of occiput while making traction with the finger of the other hand in the child's mouth. When this method fails or is not feasible in the delivery of the head in any given case, resort must be had to the forceps, which should always be at hand and ready for use should occasion require.

Prolapse of the cord is another accident that occasionally complicates labor and is at all times a troublesome problem. It is caused by some form of mal-presentation of the child preventing the head from properly engaging in the pelvis. This accident frequently complicates the birth of twins. A contracted pelvis preventing the head from engaging properly may be productive of this complication. This accident does not in any way endanger the mother, but more than one-half the children whose cords come down are still born. The proper way to treat this accident before the bag of water ruptures is to place the mother in the knee chest position during several pains and see if the cord will not by gravity be carried above the presenting part. If this fails and the bag of water

ruptures, introduce the hand into the vagina and, taking the cord between the tips of the first and middle fingers, pass it up clear above the presenting part and away from danger. Various instruments have been devised for this purpose, but none equal the hand and fingers in usefulness. If the cord again prolapses and cannot be kept out of danger, the forceps should be applied whenever possible and the delivery hastened unless it is a sure fact that the child is dead. I shall not attempt to enter into the various complications that may arise from malformation of the child, such as double monsters or some peculiar complication that may arise in the birth of twins, or serious pelvic deformities of the mother, as these cases become largely as a rule surgical, and the detail of their proper handling would far exceed the limits of this paper.

Another not very uncommon problem that comes to the general practitioner for solution are cases of placenta previa. These cases vary in degree all the way from those where the placenta is implanted upon the lower uterine segment to those where the placenta is implanted centrally over the os uteri, and upon examination the finger comes in contact with the placental tissue all around. Fortunately this accident occurs most frequently in multipara and in the later years of the child-bearing period, thus affording the attending physician a better opportunity to carry out the rapid dilatation and manipulations necessary in the proper handling of these cases, as on account of frequent labors the vagina is roomy and the os uteri readily dilatable. In cases of placenta previa where centrally implanted or nearly so, the placenta is usually larger and somewhat thinner than the normal placenta. Hemorrhage is the great symptom and danger in these cases and is due to the separation of the placenta from its attachment owing to the gradual enlargement of the womb in the latter months of pregnancy. Hemorrhage usually comes on without pain or warning and is quite as likely to occur at night while lying in bed as at any other time. It may be so profuse as to cause death immediately or at least render the woman very anemic. This accident usually occurs from the twenty-eighth to thirty-sixth week of pregnancy, depending upon the location of the placenta; the more central the implantion the earlier the hemorrhage occurs. In placenta previa the life of the mother and that of the child are often to be weighed in the balance,

as often what would be best for the child would endanger the life of the mother, and vice versa. The mother's welfare should at all times be paramount, and if either life must be sacrificed, let it be the child's. The earlier labor comes on the less danger. For this reason as soon as placenta previa is diagnosed labor should be induced so as to lessen the dangers. Induce labor by dilating the os uteri either with the fingers, tents, Barnes' bags, Hegar's dilators or Champetier's bag; the latter is undoubtedly the safest and best dilator. As soon as the os is dilated sufficiently to admit two fingers, loosen the placenta all around so as to get past it on one side if not centrally implanted, and through it if central, turn the child by external and internal manipulations, if possible, then rupture the membranes and bring down a foot and leg, plugging the os and stopping the hemorrhage. Then the case should not be hurried, but leave the case to nature, as it would not be any advantage to the child to do so, and a decided disadvantage to the mother.

In these cases the patient is not out of danger when she is delivered, as the sudden emptying of the tired uterus may cause it to relax and a post-partum hemorrhage come on, rapidly sapping the little remaining vitality and a fatal collapse occur. From rapid dilatation of the os uteri the maternal parts may be and usually are more or less injured, and this together with the lowered vitality of the mother increases the danger of infection and puerperal fever; therefore all antiseptic precautions should be carefully looked after and everything possible done to build up the patient's strength.

The next problem to be considered is post-partum hemorrhage and in otherwise normal labors, it is fortunately rare when proper care has been used in the management of the case. Undue haste in delivery in the absence of pain, for instance in cases of instrumental delivery or undue traction in cases of breech presentations without waiting for regular labor pains will often be found to be the cause of a post-partum hemorrhage. "The principle *not* to deliver in the absence of uterine contraction is the first point in the prevention of post-partum hemorrhage." The causes of post-partum hemorrhage may be divided into three groups. First, those cases due to imperfect contraction of the uterus. Second, some serious tear or injury to the uterus. Third, disease of the blood or blood vessels. The first thing to be done in all cases of post-partum

hemorrhage is to empty the uterus of clots, or any portion of placenta that may have been left within the body of the uterus from any cause and then make the uterus contract firmly by kneading it through the abdominal wall, with the other hand inside the uterus providing it has been necessary to introduce the hand to remove the clots or any placental mass. The injection of hot water is an excellent method of stimulating contractions and washing out any debris that may be left within the uterus. Instead of hot water ice or ice water are somtimes used. The use of ergot in material doses, also bell., ipecac, hamamelis, geranium, etc., etc., are to be used as indicated. Where the hemorrhage is due to an extensive laceration of the cervix the only rational treatment is to expose the bleeding part and with needle and suture properly repair the laceration. The last problem I shall consider in this paper refers to the management of the second stage of labor in preventing injuries to the pelvic floor, and when these injuries do occur in spite of our most intelligent efforts to prevent them, their proper repair. The frequency of pelvic floor lacerations in general practice has been estimated to be thirty-five per cent in first and ten per cent in subsequent labors. In at least a part of these cases this accident is certainly unavoidable. Numerous procedures have been proposed for the prevention of perineal injuries during delivery. Most of them have been discarded as useless if not even harmful. Any measure to be of value must act to promote relaxation of the outlet and pelvic floor and lessen the tension to which the parts are subjected. This is best accomplished by the slow and gradual delivery of the head giving the tissues time to stretch, and by regulating the expulsion of the head so as to keep the smallest circumference in the grasp of the resisting girdle, and the propelling power directed in the axis of the outlet. Chloroform or ether should be given for its relaxing effect and to lessen the torture incident to this stage of labor. The head must be held back and kept from advancing up against the pubic arch. These manipulations can best be carried out with the patient lying upon her left side with the buttocks near the edge of the bed and the physician seated on the edge of the bed facing toward the foot. Then by passing left hand over patient's body and between the legs and the right pressing against the head from behind he becomes master of the situation and can control exactly the expulsion of the head dur-

ing this critical part of the delivery. There is no objection to the use of gentle pressure applied to the head through the lateral aspect of the pelvic floor, but pressure must be avoided against the thinned out medium portion, as this would tend to increase rather than decrease the danger of rupture. Episiotomy when rightly timed and properly executed is very successful in preventing lacerations in cases where without it laceration would be unavoidable. The structures involved in the incision are unimportant. The length of the incision should be about one inch, its depth a quarter inch and about one-third way from the posterior to the anterior commisure when the parts are on the stretch. After labor these cuts should be immediately repaired. After the head is delivered it should be supported in the hand and great care used in delivering the shoulders, as without this care they are quite as apt to damage the perineum as in the delivery of the head. Only in very rare cases when the condition of the patient is such that it would imperil her chances of recovery, all lacerations of the pelvic floor should be immediately repaired as soon as the delivery is completed, although the work could be postponed a few hours if necessary for any reason without endangering the chances of success. An anaesthetic is usually necessary for this work to prevent too great suffering, especially if the laceration is pretty extensive. Various kinds of sutures are used according to the fancy of the operator, and the operation is performed in the usual manner, after which the patient's toilet is made by carefully cleansing all soiled portions of the body, her linen changed if necessary and all soiled linen and blood-stained articles removed from the bed and the wrinkles smoothed out of the sheets and everything possible done to give comfort and ease to another tired soul who probably at this particular moment wishes she had never left her happy home.

I am greatly indebted to the works of G. Earnest Herman on "Difficult Labors" and the "American Book of Obstetrics" in the preparation of this paper.

DISCUSSION.

Dr. Bishop: There is one point in reference to obstetrical technique that is very important. While it is true that all extensive lacerations of the perineum are immediately repaired, yet I believe that it is equally important that every injury of the birth canal

should be repaired during the lying-in. The cervix should be examined forty-eight hours after labor, and if lacerated, it should be repaired. If it is found that there is any old injury resulting from a previous labor, this also should receive attention. There is no more danger in doing this work during the lying-in, if the aseptic technique is correct, than at any other time.

BUREAU OF ANATOMY, PHYSIOLOGY AND PATHOLOGY.

G. D. CAMERON, M. D., Chairman - - Chagrin Falls
"The Health Standard for 1904"

CLARK E. HETHERINGTON, M. D., - - - Piqua
"The Bacteriology of To-day"

R. O. KEISER, M. D. - - - - - Columbus
"Some Comments on Renal Calculi"

THE BACTERIOLOGY OF TODAY.

BY CLARK E. HETHERINGTON, M. D., PIQUA.

There is an element in all schools of practice, and perhaps especially in the homeopathic school a contingent which is inclined to look with suspicion and doubt, if not with ridicule, upon any claims which the bacteriologist makes in determining the causative factors of disease.

The physiologist may elaborate his theses, the pathologist spin his web of theories in his special department and his explanations of phenomena, be they physical or mechanical, meet with no skepticism; but the bacteriologist, he that deals with the germ, labors under suspicion. Perhaps this suspicion is to a degree justifiable, in that he has as yet given us a very narrow strait connecting the great seas of disease and cure.

It is in harmony with the spirit of the age, an age of science, that the cause of disease, not one factor, but all should be sought.

No intelligent physician will ignore the cause of disease if it is to be discovered, any more than he will ignore its phenomena. Bacteriology has given us the first facts regarding the causation of

disease which are tenable. This of course is within the scope of those pathological conditions whose presence cannot be otherwise explained.

However, the suspicion of the present rests chiefly upon those, who in their ardor have seen in bacteria, the only cause worth considering, and in their destruction, the cure and prevention of a large number of human ills.

The first few days of the germ theory saw the exploitation of antiseptic surgery with all of its excesses. Sober judgment and experience have at the present day come to the rescue with a surgery that may more rightly be termed aseptic.

In therapeutics the day of the internal or intestinal antiseptic and all that sort, is rapidly giving place to more rational methods.

Bacteriological science is today seeking to imitate nature's cures and is studying the phenomena of immunity, natural, acquired and artificial. There is going on the work of finding out what susceptibility means in terms of the body-chemistry. This turn from therapeutics began again upon the demonstration of the efficacy of the antitoxin of diphtheria. The serum therapy is by no means a novelty.

Immunization and cure are the two uses to which the various sera have been put. Vaccine virus is the one serum longest in use, and its efficacy is undoubted, although there is much doubt as to the entire wisdom of its present manner of administration. Coley's mixture in malignant growths, Pasteur's work in the prophylaxis of hydrophobia, the "streptolytic" sera of today and the antitoxin of diphtheria, have sufficiently demonstrated their wide range of usefulness. And if any method of treatment or any remedy demonstrates its efficacy in a large percentage of cases it is worthy of acceptance as a remedy, just as much as iron, arsenic and mercury.

Immunity has found one explanation in the phagocytic theory of Metchnikoff. After the discovery of Behring of the antitoxin of diphtheria, Ehrlich after a series of experiments, advanced the following conception: "Toxins which in the living body lead to the production of antitoxins, have this capacity only through the possession of specific affinities called haptophore groups, for corresponding haptophore groups belonging to side chains or receptors of certain cellular constituents of the body, and that in consequence of

this appropriation of receptors, others of like nature are produced in excess of the needs of the cells, and these being shed in to the blood, there constitute the antitoxins.

The essence of Ehrlich's theory is thus tersely put by Behring: "The same substance which in the cells of the living body is the prerequisite and condition for an intoxication becomes the means of cure when it exists in the circulating blood." Taking other poisons in their toxic action upon the living cells, Flexner and Noguchi have shown that "the toxic action of the snake venoms, depends upon the presence of intermediary bodies with affinities for different cells, the complements being contained not in the venom, but in the cells and fluids of the animal acted upon."

Keyes has shown that in the case of the cobra poison, "the necessary complement in hemolysis may be found within the red cells of *certain* animals, (endo complement) and further that lecethin may act as a complement and complete the hemolytic potency of the venom." These experiments show that our serum and cells contain substances that may be turned against our own cells by the intervention of a foreign intermediary body.

Further study has led Professor Welch to advance the hypothesis that since the mere disintegration of dead bacteria does not sufficiently explain the production of toxins, there are cell poisons of bacterial origin produced by special stimuli from the cells of the host.

This transfers the application of the former hypothesis from host to the bacteria. The facts in the case of the serpent poisons mentioned above strengthens this view. The following is borrowed from a resume of the lecture by Professor Welch.

By the same sort of mechanism, both organisms, the host and the bacteria, under the mutual stimuli of their cells, produce substances that under the complicated conditions present, become antagonistic in so far as they tend to destroy or injure the cells from which the stimuli in the form of atom complexes are derived. It is recalled that familiar haemolysins and bacteriolysins are in reality made up of two substances: the intermediate body which is the specific element produced by the injection of foreign cells into an animal, and the pre-existing complement which is the actually toxic element. The intermediate body joins the complement with the

foreign cell, which started the reaction, thus completing the destruction.

If reactions like this are produced in the host cell, why not also in the case of the bacteria and other parasites exposed to analagous conditions. Expressed in the terms of Ehrlich's side chain theory, certain substances of the host of cellular origin assimilable by the parasites through the possession of haptophore groups, with proper affinities become anchored to the receptors of the parasitic cell, which if not too much damaged, is thereby stimulated to the over-production of like receptors. These excessive receptors of the parasite if cast off into the fluids and cells of the host then constitute intermediate bodies, or amboceptors with special affinities for those cellular constituents or derivatives of the host, which led to their production, and for others which possess in whole or in part identical receptors. Provided the host is supplied also with appropriate complements, there result cytotoxins with special affinities for certain definite cells or substances of cellular origin in the host. Either the parasite or the host may provide the complement.

It will be seen by this conception how it is possible for the infecting bacteria to produce many special toxins for various cells in the body; toxins that might be absent in the cultures because of the absence of special stimuli.

Some of the things which this study promises to explain are: First, by the demonstration of special toxins of bacterial origin, we are to explain many of the anaemias secondary to infectious diseases. Second, the discovery of bacterial cell poisons with affinities for certain cells other than the blood cells, which will explain the occurrence of such lesions as those of typhoid fever, etc.

Herein lies the explanation of the difference in the extent of involvement of other organs in such diseases as typhoid. At the risk of a digression of unpardonable degree, I ask your indulgence if I suggest a few reasons why this study of immunity is, or ought to be, of special interest to the homeopath.

Because the serum therapy is so manifestly a system which has its real basis in the law of similars. It has simply been approached from a different direction.

To the prescribers of the "nosodes" it is of unusual interest, because of the analogy if not identity.

The sera used in this therapy are dilutions not in any degree "low," even in the homeopathic conception of it.

Hahnemann himself saw the value of vaccine virus, claimed it to be a demonstration of his law.

It is demonstrable from his writings that Samuel Hahnemann had a very vivid conception of the facts of immunity and susceptibility; natural, artificial and acquired. He insisted that disease was not an entity, but that "symptoms" whether of drug or natural disease, were the product of stimulated tissue energy, and further, that the drug, the homeopathic prescription, ought to be such as to call forth a sufficient reaction only, and that there was no "humor" or disease entity of which to rid the body.

Who shall deny until further experiments are made that the poisons of the plant of high order or certain chemical substances are not nature's antitoxins? Or, why will not the investigations of the future show that the same theories which apply to the serpent venoms and bacterial poisons, are applicable to poisons of any other class. Herein lies the work which is to relieve homeopathy from the long borne burden of ridicule arising from the fact that we have no *scientific* demonstration of our law.

It is in the light of the investigations that homeopathic drugs need study, especially those whose service in the acute infectious and contagious diseases has been established. We need to know by experiments on animals the immunizing power of various remedies and potencies. We need to discover and prove in scientific terms the claims of the empirically proven superiority of the potenized drugs. We may discover that potentization is identical in its results chemically with antitoxin production.

When Professor Welch says in speaking of his added view of the action, "It will be seen by this conception how it is possible for infecting bacteria to produce many special toxins for various cells in the body, toxins that might be absent in cultures because of the absence of special stimuli," we may take the cue and from his standpoint investigate the reasons for the superiority of one drug over another in the individual cases of the same diseases.

For example: By reason of special stimuli from the cells of some special organ we get a peculiar involvement of that organ, say the kidneys in scarlatina, herein we find explanation and justifica-

tion for the choice of a remedy which by its "symptoms" shows it to be peculiarly fitted to complete the reaction in the presence of this special toxin.

We ought to have, to further justify our claims, provings of the new sera. There is a frequent cry raised for the reproving of our remedies, but most are too well tried to demand the great task, but we do need additional knowledge concerning their manner of exhibition, their strength and range of application in view of our knowledge of disease.

The homeopath surely has no quarrel with those who are investigating the causation of disease. Hahnemann himself recommended that we discover *all* that is to be known concerning any disease, and if a disease is demonstrated to be bacterial in origin, it does not follow that the specific serum is the only remedy, but one of them most to be trusted.

The discovery of the cause of disease ought to be simply a factor to be considered in its proper place, as an indication for a certain drug.

The serum therapy is to give us no real short cut or abbreviated system of treatment. There is not now, nor will be any royal road in medicine; achievement is ever the result of labor, the laws of the world, psychic and physical, forbid great results without corresponding expenditures of energy.

SOME COMMENTS ON RENAL CALCULI.

BY R. O. KEISER, M. D., COLUMBUS.

In this paper the word calculus is used in the general sense, and is taken to mean, any concretion of any size which is formed in the kidney. The calculus may be (1) Primary:—developing from urine which has undergone no decompositional change, and is the result of some defect of, or addition to the composition of the urine. (2) Secondary:—due to decomposition of the urine resulting in precipitation of its elements. Concretions may consist of one or several ingredients, may be of any size or shape, may be of regular layer formation, or consist of irregular deposits.

The conditions favoring the origin of calculi have, to a certain extent, been explained through the researches of Carter, who

found "that the actual nucleus nearly always consists of globular forms of urates and calcium oxalate, rather than crystals of these substances; and that a colloid matrix was always an essential element of nuclear formation. The precipitation always takes place on an organic base; this may be mucus, epithelial cells, blood clot or colloid material. All concretions, whether they are the size of a grain of sand or a goose egg, have a distinct albuminoid framework, upon which the constituents of the urine are deposited."

Calculi may originate in the secreting structure of the kidney—usually in the tubules, or in the renal calyx; but their development is most common in the renal pelvis. They are usually unilateral, but may be bilateral. They occur at all stages, including the intra-uterine life; are most common before the age of fifteen, and after fifty. In young people, calculi are most common among the poor, while in advanced life calculi are more common in people of comfortable circumstances, and of luxurious habits. As a rule, the calculus of infancy is of the ammonium urate variety, in young adults of the uric acid variety, and after forty, calcium oxalate.

The chief symptoms of renal calculi are pain, hematuria, frequent urination, fragments of the calculi appearing in the urine, pyuria, oliguria, or suppression, gastro intestinal irritation.

The symptoms caused by kidney stone are due to obstruction rather than the presence of a foreign body. Hence, the position of the stone is of more importance than its size.

The pain is commonly referred to the lumbar region of the affected side. It is increased by motion, by jarring, and by pressure over the kidney. It begins as a weight and tenderness, not as an actual pain. It is subject to sudden exacerbations, often occuring at night when the patient is at rest. The pain may be referred to the healthy kidney, or to the bladder. It usually radiates along the course of the ureter into the testicle, and may cause contraction of the cremaster muscle with retraction of the testicle. It may be referred to the thigh or the calf of the leg. Attacks of rectal and vesical tenesmus, and reflex troubles in the form of vomiting and intestinal colic, are also quite common. Attacks of renal colic are particularly characteristic of renal calculi. Perfectly characteristic paroxysms may occur without the presence of stones.

Hematuria is usually slight and transitory, and, except after attacks of kidney colic, can be detected only by microscopical examination. There is found in the urine at times uriniferous tubules, made up of blood cells. These are absolutely characteristic of hemorrhage of renal origin.

Gastro-intestinal disturbances are either reflex or due to imperfect elimination on the part of the crippled kidneys. Tympany, vomiting, and exquisite tenderness at times complicate and greatly obscure renal colic. Chronic epigastric tenderness, feeble digestion, and constant pain may direct the attention entirely away from the kidneys.

The Urine.—Blood appears in the vast majority of cases and presents the following features: Hemorrhage, not profuse, but with or after each paroxysm, or without apparent cause. The blood is intimately mixed with the urine; is not bright in color, but smoky, brownish, or porter colored. The urine is sharply acid, and high colored. After pyelitis is established, the urine and urinary symptoms are as follows: Pus and mucus appear in the urine in greater or less quantities. More or less frequency of micturition is present, and the act is accomplished by uneasiness, sometimes amounting to pain. The latter may be so pronounced as to lead to the impression that cystitis exists.

The deposits in the urine are significant, but care should be exercised to secure only primary deposits, not those due to decompositional changes. Urates and oxalates are often observed in the sediment, the former frequently in quantity. With the advent of pyelitis, more or less phosphatic deposit is found. Epithelium is also present. Lastly, the presence of small sized concretions in the urine furnish diagnostic data of the highest value.

The diagnosis of kidney stone is based on lumbar pain, with intercurrent attacks of kidney colic, hematuria, the passage of gravel, or the fragments of calculi, tenderness and the detection of a tumor. These symptoms are rarely all present. Pain and hematuria are the most constant, and with the exception of the passage of calculi, are the most characteristic. Unfortunately, they are also symptomatic of a number of other conditions. Thus, movable kidney often causes constant pain, with sudden acute exacerbations, exactly like those which arise from stone; sometimes blood is mixed with the urine, but only after an acute attack of pain.

Nephralgia may simulate renal calculus in all respects, except in the condition of the urine. In women, the paroxyms of pain are especially marked at the menstrual period; the pain may radiate in the same direction as in stone. The urine, is, however, passed in large quantities; is of low specific gravity; is limpid and colorless, and contains neither pus nor blood, nor is there any history of the passage of calculous material.

Tuberculosis of the kidney, in its early stage, may simulate renal stone so closely that an exploratory incision will be required before a differential diagnosis can be established.

Malignant growths are characterized by a much more pronounced hematuria than that due to calculus; clots appearing in the urine in the form of urethral molds; the growth rapidly and steadily increasing in size. Fragments of the growth are sometimes passed in the urine, and these may be the only reliable means of forming a diagnosis.

Ordinary pyelitis cannot be differentiated from calculus with infection, except by the history of the case. The distinction between kidney stone and gall stone may be quite impossible during an acute attack of pain, especially if the right side is the one affected. During the intervals of attack, repeated examinations of the urine should throw light on the question.

The most characteristic diagnostic symptoms, placed in order of their importance, are: passage of gravel or fragments of stone; attacks of typical renal colic, hematuria, and ultimately pyelitis. It is clear that prolonged study of the urine is necessary before forming a diagnosis, the results of the study often sufficing to exclude affections, the symptoms of which in every way simulate those of renal calculi.

Treatment.—During the attack of renal colic, relief is usually experienced from a hot bath, and this is often sufficient to relax the spasm. Local applications are often grateful—hot poultices, or cloths wrung out of hot water. The patient may drink freely of hot water, hot lemonade, weak soda water, or barley water. Occasionally, change of position will give great relief, and inversion of the patient is said to at times be followed by immediate cessation of pain.

During the interval of attack, the patient should, as far as possible, live a quiet life, avoiding sudden exertion of all kinds. The urine should be kept abundant, and in the majority of cases alkaline. The patient should drink daily, a large quantity of water. Pure distilled water is just as good as any of the mineral waters, and the only advantage that any of them have in this condition is, that the patient can be induced to drink more freely of them than of the ordinary distilled water. The bowels should have due attention, and one or two good passages a day are absolutely essential.

The diet should be carefully regulated. The patient should eat at regular intervals—eat slowly, and not too much. Meat is allowable, but should not be taken more than once a day. The quantity of starches and sugar should also be limited. Fresh vegetables and fruits may be taken freely, but strawberries and bananas should be avoided. Fats, especially in the form of good butter, may be taken freely.

As for the remedies, any remedy may be indicated, and whatever remedy is indicated, and indicated clearly, should be given.

Those most likely to be indicated are:

Sarsaparilla for children; nux vomica; arnica; arsenicum; berberis, calcare renalis praeperata; calc. carb.

DISCUSSION.

Dr. Biggar, Jr.: Last December Mr. J. H. C., from Duluth, Minn., presented himself with severe pelvic pain and symptoms indicating ureteral calculus. We were fortunate in obtaining a very excellent radiograph which distinctly showed a calculus of the left ureter located about three inches from the vesicle extremity. He was given tincture belladonna carried to the physiological point of atropism, with belladonna ointment externally, and instructions to drink large quantities of Cambridge Springs water. On the third day he passed a ragged, irregular stone the size of a small pea, and has since become perfectly well.

I think it is Murphy who reports in this month's "Annals of Surgery," a case of calculus of the prostate, and in this connection I would like to show a prostatic instrument that Dr. Hugh Young of Baltimore, has devised for the purpose of assisting in prostatectomy. I have recently had occasion to use this instrument in

a case of perineal prostatectomy and find it of inestimable service. Its advantages are that the entire prostate is drawn far down into the perineal wound, and the seminal vesicles and the ejaculatory ducts remain intact. I was fortunate in seeing Young do this operation at Johns Hopkins and telegraphed for his instrument for this operation. My patient will leave the hospital this week with full control of the bladder.

Dr. Biggar, Jr., then proceeded to describe the use of the instrument and passed it among the assembled physicians.

THE PRESENT PHYSIOLOGICAL STANDARD.

BY G. D. CAMERON, M. D., CHAGRIN FALLS.

The fact that in this paper there is nothing new does not make me wish to apologize for it. Old thought still so much outruns present practice that it will bear repeating, and additional duties would be excess. Viewed from year to year through the ever-shifting kaleidoscope of progressive thought, that which we might call the normal public health changes. Normal man takes on a shade in color, drops a pound in weight, or an inch in stature; now an organ assumes greater proportion and another assumes less, and still another becomes obsolete. His days are numbered differently. His walk is not the same. His mind wanders. His life, as an individual and as a nation, is but a succession of changes. Any effort which attempts to locate man as a physiological being is of first importance since it takes into account the line which separates him from his destroyers, and by this knowledge best of all may his way of escape be pointed out. This paper must be brief.

Let us apply some of the general laws of organic life to man's existing conditions and attempt to draw conclusions therefrom.

The first great law is heredity. Men have known from away back that we do not "gather grapes from thorns" nor "figs from thistles." This state sends out pamphlets on garden seeds, hogs, mules, mushrooms, black-knot and what not, endeavoring to make out its case that man can, by his knowledge of heredity, breed organic forms better suited to his purpose and comfort than does nature unaided by his intellect. No one doubts that the San Jose scale receives the majority of its dangerous and mental and physi-

cal proclivities from its ancestors. No one doubts the law of heredity in any and all scales except when applied to man. Here, by some strange fetish, the majority seem to look on him as outside of and above this inviolate law. This touches man today as a member of society as to his physiological condition at many points, and when its proper recognition obtains, besides in a measure revolutionizing our methods of dealing with the "submerged one-tenth," it will tend to do away more and more with the chance and fanciful miscegenation which at present keeps the country courts working overtime. A proper appreciation of this law would change punitive to reformative measures, and at least modify a system of school work which to its discredit puts the same task before the slow and the swift, the toiler, the feeble minded, the astute, the sick, the well, imbecile and genius, each and all forced through the same gimlet hole, fed on the same spoonful of treacle and porridge. As a result of this apathy natural selection is at present, as it ever has been, the main factor in determining what types posterity is to present. This is hardly in harmony with the keen interest which man takes in the law of heredity in breeding a candidate for the futurity.

So much for the law of heredity which man, when applied to himself, ignores with almost as much regularity as he does the ten commandments. Again, every organ has a function which is its life work. The integrity of that organ depends upon a certain amount of activity. As long ago stated by some physiologist and often since repeated, *"use is the price of possession."* We have been told that it is not always necessary to go back to barbarism to escape the evils of civilized life. Nature has, however, warned us on divers occasions in the history of the past that a civilization which forgets her laws is doomed to destruction. This law of use and disuse holds. It did not receive the governor's veto.

The people of Ohio died in appalling numbers last year, as in previous years, from respiratory diseases. There was no week in the so-called epidemic of typhoid fever in Cleveland in which pneumonia and tuberculosis did not each lead it in numbers in the death list, with bronchitis sometimes crowding it for third place, yet the people took it as a matter of little import and as something to be expected. As we look at these alarming respiratory figures and search for cause we find respiration habits now counted normal,

which two or three generations back were exceptional and extreme. Air is the great necessity of human life. Good lung power, good air supply, good breathing habits, are all important to any race which is to preserve the physical legends of a people whose lung power has been developed in the open air. In our climate the first two or three years of civilized infancy are spent in artificially-heated air space, which, as a rule, means poor air. Later come the school years, with bad air four months of the year in the daytime and a bedroom no better at night. From public school a considerable per cent passes to college life, clerkship, mill work, and various modes of indoor life, entailing cramped positions and an excess of carbon dioxide, often breathing the air that has been twice or thrice exhaled from his own or other lungs; not for an hour, not for a day, but day after day, and year after year. What of it? This pale specimen is a normal man. This expresses the relationship from one standpoint. We must not forget, in connection with it, the increasing nervous strain under our competitive system. This dearth of oxygen is coupled with high and higher nervous tension. The doubling of the per cent of nervous diseases in the last few years shows that man's engines, under these conditions, are hardly able to follow the clip and dispose of the ashes. What one thing so fraught with good, so cheap in the best sense of the word, so practical, so possible as for the physician to cultivate and develop the oxygen habit in his community? "Use is the price of possession." Under this head again comes the condition of present day care of the reproductive organs. There may be a realm or realms that interpenetrate our own; the spirit may be a higher mode of vibration than the senses can recognize. Dives may or may not be still lifting up his eyes in torment; society spends much time discussing these and kindred questions, and they are, no doubt, full of interest to the community at large, *but what question is of more burning importance?* And what question ought more to engage the attention of the physiologist and social reformer than the present conflict between physiological law and social economic progress as applied to the sexual organs? Under the present distribution of light, heat, electricity, magnetism, etc., the sexual organs are developed along in the early teens. Under our present educational, professional, and social progress conditions the marriageable age is

somewhere from twenty-five to thirty. That society has gradually come to ask for a total disuse of sexual organs during this lengthening period of years in the face of natural laws seems to me strange. The statement of one authority that from eighty to ninety per cent of the up-to-date young men in large cities have gonorrhoea before they are twenty-one seems to show that natural law has a little the better of the argument. The disappointment of society in her bad young people with this high per cent becomes a matter of conscience. It makes it almost appear that under the name of chastity society had purchased a gold brick. If not gonorrhoea then some other "oea" may be there present, and if the figures are correct, the question at once comes up as to what the physiological status of this interval is. This proposition is more difficult of solution than is the one about "good air and lots of it." It brings us again to the realization of the fact that economic conditions are of great importance in the creation and maintenance of any particular physiological type or condition. If this interval could be shortened, on one end or the other, society would not be compelled to face so much disappointment, and the gonococcus and the influences he leaves behind would be more likely to take the other fork in the road. "Use is the price of possession."

Again, under "over-use and disuse alike bad," did time permit we might again allude to our competitive system in its effect on the nerves as shown by increased heart action. Men work and worry too many hours without rest in the recumbent position. We might allude to its effect on rapid eating and decay of teeth, to its nerve strain, making the proper predisposing conditions for the use of alcohol and narcotics. Any class of men in Ohio today who are not invaded by some of these conditions would be a small class. It is the duty of the physician to stand for a physiological type and against all conditions which weaken physical man. He should not only talk but live them. Great cures may be wrought with medicine, surgery may astonish us with the brilliancy of its achievements, comfort may be given in the hour of extreme need to the distressed and panic stricken by trust in the strength and resource of the physician; yet all these are not so great and not so much in accord with the light that we have, as to increase by laborious and persistent

effort the size of a class which may be termed physiology in the highest that the term implies to us.

Summing up what we may do in a word, we may attempt to:

1. Put practical work into schools.

2. Have people breathe atmospheric air in winter months.

3. Encourage better daily respiratory habits.

4. Favor educational systems that will start persons in business when young.

5. Advise early marriage and simple living.

6. Look up the ancestry and training of our criminals and weak minded as much as we do that of our road horse or pointer dog, to the end that their treatment may be scientific.

7. Point out the safety and saneness of quiet and rest amid the great worry and strife of the years to come.

8. Teach that he who puts alcohol and narcotics into his system is "monkeying with very delicate machinery."

9. Encourage athletics and work to keep boys and girls busy.

10. Believe that whatever victories you win will all, somewhere, in some way, be placed to your credit.

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SCARLET FEVER.

BY CLARA E. COOK, M. D., PORTSMOUTH.

During the past winter, scarlet fever was quite generally prevalent throughout this section of the United States. In fact, in some localities it was considered epidemic. It is manifested by its sudden onset, with a decided chill or chilly sensations, usually vomiting at night, rapid pulse, pain in the throat, then follows a high degree of temperature, soon reaching 105°. The pulse ranges from 110 to 140. The next day, a diffused scarlet eruption, generally smooth, with no intervening healthy skin, announces itself with a stinging, burning sensation, and our patient knows what a true dermatitis feels like. A heavy coated tongue, the coat covering the middle and back part of the tongue, allowing the swollen papillae to project through, leaving the edges clear, and the tip bright red.

With this peculiar appearance we at once recognize the "strawberry tongue" of scarlet fever. There is some headache.

When we pronounce a case scarlet fever, almost the first thought of the family will be concerning its contagious nature. For it is one of the most acutely contagious of the exanthematous diseases. Isolation of the patient is desirable, and is right if possible, but among the very poor people, it is almost impossible, as we often find a large family occupying limited quarters, it may be only two or three rooms. However, municipal laws come to our aid, and

quarantine is made possible. The contagiousness is most active during the period of desquamation. The average time for incubation is from one to seven days, but may be as late as twenty-one days. The eruption fades gradually, beginning to fade about the fourth or fifth day.

The fever declines by lysis, and is followed by desquamation, and recovery. This in uncomplicated cases. But with a serious case before us, matters are different, and we feel a great responsibility rests upon us, and we are on the alert to meet the complications that may arise. For it is the complications or sequellae that cause the greater troubles and anxieties in this disease. Pathological anatomy shows granular changes in all glandular structures, noticeably in the Peyerian glands, although showing in the stomach and kidneys. There is an acute inflammation of the skin. All areas of suppuration have an abundant supply of streptococci. The bacillus of scarlet fever still remains undiscovered. But because of the vitality of the especial poison peculiar to the disease, it is probable the investigators will be successful in their search for this particular bacillus. There are many who believe Klebs' micrococcus, the "monas scarlatinosum" may prove to be the poison.

Because of the dangers attending the disease, we carefully regulate our treatment. Several organs or structures of the body may be attacked at the same time, and we must be ready to combat these attacks. For instance, diphtheria may show itself, or nephritis, or otitis, conjunctivitis, otorrhoea, suppurating glands, peri, or endocarditis, chorea, diarrhoea, rheumatism, arthritis. Water is one of the most potent factors in the cure of this disease. Kellogg, in his book, "Rational Hydrotherapy," recommends the use of cold affusions. But hot water is more generally used, and is safer in the hands of the laity. Usually a hot sponge bath given the patient in bed, only uncovering a small portion of the body at a time, rubbing with moderate vigor, then covering with a blanket, will be sufficient. The bath ought not to occupy more than ten minutes. But where a bath tub is accessible, immersing the patient in water, the temperature of which can be comfortably borne by the patient, will be really more effective.

When the fever is high sponge baths can be given frequently, from two to eight in the twenty-four hours. Cold bathing may be

useful and of great benefit under some conditions, but in general practice we meet with few people who are competent to give a cold bath properly, and experience has taught there is danger attending if the reaction does not follow such a bath. If the patient is a strong, healthy child, with a good heart action, and the fever is high, cold sponging may relieve him for awhile, but the results from a tepid bath will be as good, and probably longer lasting.

After the bath the skin may be anointed with olive oil, or vaseline, to soothe the itching and burning which is so annoying. Later, when desquamation sets in, the use of oil may prevent the spread of the disease to some extent by preventing the desquamated epidermis from floating in the air.

The bed should be so placed that the bright daylight will be screened from the eyes. Alarming conditions of the eye may follow as a sequela, such as conjunctivitis, abscess about the eye, phlyctenular keratitis, albuminuric retinitis, and other conditions.

The throat always requires attention. There is always an angina present. A tonsilitis or a pharyngitis will be present, and local treatment will be necessary. A true diphtheria may develop, which will require careful treatment. There will be more or less disturbance of the alimentary tract. While there is fever the diet should be liquid. The bowels must receive necessary attention. See that the urine is voided. The skin is so much inflamed that unless the kidneys act very well, a nephritis may result.

In choosing remedies, aconite, belladonna, bryonia, gelsemium, or veratrum viride, will probably be the remedies first thought of. If the condition is serious, we may have to alternate two of these, or we may have to think of hyoscyamus, or rhus tox. During the past winter rhus has served me well in several instances. The throat may give so much trouble that we may prefer to use hepar sulphur, merc. protoiod., or the biniod., or lachesis, or kali bi., instead of the first mentioned remedies.

Violent pain in the ear is very common, and can be relieved with warm water. The ear troubles are also of the sequelae, and are of a serious nature. Hepar sulph., pulsatilla, belladonna may have to be called into use.

The cardiac disturbance must be recognized. There may be valvular lesions, or the heart muscle itself or the structures sur-

rounding may cause permanent disability. The nervous disturbance may also be very great.

A very trying, but an interesting case, I had recently was that of an eleven year old girl. She was found one morning, after she had dressed for breakfast, lying across the bed in an unconscious condition. When I arrived at the house a few minutes later, she had regained consciousness, but presented well-developed symptoms of scarlet fever. She had a high degree of fever for several days, first one ear, then the other gave a great deal of trouble, and both were discharging pus. Every new manifestation of the disease was heralded by an attack of unconsciousness, and a very weak action of the heart. Her mother would notice a cyanotic appearance of the face and finger nails, followed by a state of unconsciousness lasting sometimes for five minutes or more. After recovering from such an attack there would be a weak and rapid pulse for several hours.

Remedies in this case were rhus, belladonna, bryonia, cactus grand and hepar sulph. as they were required. Recovery came slowly, but today she is as strong as ever.

DISCUSSION.

Dr. Hoyt: Scarlet fever is one of the diseases with which I have had much to do in my work. I have seen a great many cases and thus far have been especially fortunate. I attribute my success to my exaggerated care to keep the patients from taking cold. I do not permit them to sit up or leave the bed until the desquamation is complete. I permit my patients to use a bacon rind to allay the itching consequent upon the pealing off process.

SOME FUNDAMENTALS IN THE MANAGEMENT OF INTESTINAL DISORDERS OF CHILDREN.

BY S. R. GEISER, M. D., CINCINNATI.

The reason bowel disorders are more fatal to children than to adults is because they possess much less vital resistance than do adults. The therapeutic principle which applies to one applies to the other. While there may be *some remedies* that act peculiarly upon children, there is really very little difference as far as concerns homeopathy, whether it be an infant, a child, or an adult.

A long continued elevated air temperature seems to be one of the main remote or predisposing causes of summer intestinal disorders, both in the child and in the adult. Add to this some error in diet, and there results usually undue bowel action. In other words, the immediate cause of morbid frequency is improper food. Diet, then, is one of the fundamentals is the management of the disorders under consideration.

Constitutional debility, either acquired or congenital, unfavorable surroundings and previous attacks of the acute disease are remote causes of the chronic variety.

Granted that every physician is familiar with the character of the fecal discharges in the healthy state of the infant or child, viz: yellow, smooth and of the consistency of rather thin mush or paste, the odor being simply fecal, a variance from this being abnormal. The green stool indicates fermentation. We should remember, however, that all stools are inclined to take on a greenish hue after exposure to air for some time, therefore fresh samples should be inquired for and examined.

Curds in the evacuations usually depend upon the indigestion of the casein of the milk. Undigested fats also take the form of curds; these curds are smoother than the former. The passage of the curds through the intestinal tract sometimes cause much uneasiness and consequently crying and fretting. Crying and fretting is not always due to intestinal disorders. Lithaemic poisoning is oftentimes the cause of much of the uneasiness of infants. It is in reality an auto-intoxication, due to an excess of uric acid, xanthin, etc.

We are apt to forget that even new-born infants eliminate much uric acid, and it may cause infarcts in the kidney and small calculi in the ureter. A reddish deposit in the napkin is an indication of this disorder. Hot baths and lycopodium relieve this condition.

Slimy stools result from a catarrhal condition of the lining of the bowels. When this mucoid material is well mixed with the feces we know that the irritation is quite remote from the outlet. Otherwise it is in the large intestine, very likely in the rectum. Very thin yellow stools occur in hot weather, when the child is relaxed and in a general way "below par." This state unless checked will

result in cholera infantum, now fortunately an infrequent disorder. Excessively foul stools result from decomposition of the albumen of the food.

Cholera infantum or gastroenteric infection is very different in its stool peculiarity from all the preceding. In this disease the stools are watery and profuse, there being only flakes of fecal matter. The nursing child, when not overfed, and who has a healthy and unworried mother, rarely has bowel trouble. It is the artificially fed and the one subjected to overcrowding and unhygienic conditions of large cities that are likely to be affected by bowel disorders.

In cholera infantum prompt and energetic means are required. By energetic, I would not think of antipyretics, as there is usually high fever accompanying this variety. Fever in this as in other diseases is simply one symptom. The use of an antipyretic, which would not be removing in the least the cause, would be harmful and unphilosophic.

Every internal medicine used for direct reduction of temperature is a heart depressant. We all know that every drug given in doses sufficient to depress the heart will bring about a decided reaction, and hence is harmful to the patient. The high temperature should be modified, the chief aim of temperature reduction being the comfort of the sick one. Hyperpyrexia may be combatted by tepid water spongings and aconite and belladonna, according to the indications.

It should be remembered that during the early stage of acute cases, digestion is practically arrested, hence it does not at this moment become a question what to feed, which in the chronic and subacute cases is important, but to know the importance of not giving food at all. Stop all food at once, especially milk. Thirst must be relieved by bland fluids given frequently in small quantities, and cold.

The treatment for all other varieties will be mainly dietetic. Rid the intestines of fermenting and irritating material.

Professor Alexander Hamilton, M. D., Edinburg, in the year 1804, says: "Nature has very fortunately rendered the stomach of infants so irritable that when it is overfilled, or loaded with indigestible substances, vomiting is usually induced, but an habitual

vomiting gradually impairs the vigor of the stomach, and any precaution which can be suggested should be employed to guard against the causes of this complaint." Again he says: "Often as the stomach is in this manner emptied, the contents of the bowels should be evacuated by proper doses of a gentle laxative."

He suggested calomel, cream of tartar and castor oil. This old doctor and others before him knew the importance of sweeping out the *prima viae*. Castor oil should certainly be preferred; while this is an old and abused remedy, is nevertheless a good one today. This sometimes relieves a relaxed condition of the bowels by removing the cause.

Then again it should be remembered that a child is sometimes starved to death by overfeeding. "Feed! feed!" is the cry. The mother should know that the child's nutrition depends upon what it assimilates, not upon the amount it eats. When milk can be given with propriety and can be retained, too, after its suspension for a while, this should be done; the effects should be carefully watched, and as long as undigested material appears in the evacuations, such as curds, the milk should be somewhat diluted. When the point is reached at which these disappear, then dilute less.

Therapeutics.—While proper diet and hygienic surroundings are *fundamental* and alimento therapy of much less importance, the well-selected remedy aids greatly in bringing about a favorable termination.

Bell.—When a hot atmosphere, or exposure of the child to the sun has brought about fever and irritable stomach with predominant head symtoms, congestion, heat, redness, fullness of blood vessels, cold hands and cold feet with drowsiness, half sleeping and half waking with moaning, bell. should be thought of rather than remedies acting more directly upon the gastro-intestinal canal. Later, for this watery diarrhoea, especially for teething children, in continuous and exhaustive diarrhoea, with indications of cerebral effusion, *gauco* will come to our aid.

Croton tiglium in toxic doses produces irritation of the entire gastro intestinal tract. In other words, it is a powerful drastic purge. To our old school friends it appears ridiculous even to suggest this drug for a relaxed condition of the bowels, yet from clinical observation and from experiments based on pathogenic effects,

it has been proved a very valuable remedy in many forms of diarrhoea. With the general character of sudden expulsion and great aggravation from taking anything into the stomach, stool occurring immediately after eating or drinking, generally very watery and yellow, sometimes associated with nausea and vomiting, at other times with pain following the colon down to the rectum, *croton tig.* will meet the case very happily. Should the diarrhoea only be controlled by this remedy and vomiting continue, *kreosotum* will be the curative drug, especially if dentition is seemingly painful and the child is sleepless, and its teeth decay rapidly and are dark and crumbly, with spongy, bleeding gums. The vomiting of food comes on several hours after eating, while in croton it comes on shortly after. The multiplicity of remedies and their numerous indications transferred from text-book to text-book, from aconite to zincum, are certainly confusing to the student, even to the physicians. How shall he make the selections? He will think of *ars., ver., nux, mer., ipecac.,* etc. *Arsenicum ver.,* frequently indicated, even alternated, without discrimination, can well be differentiated. *Ver.* will be called for when profuse watery, painful stools prevail. Painless stools never indicate *ver.;* then there is likely to be simultaneous purging and vomiting, while in *ipecac* there is vomiting and purging, independent of each other, the former predominating. With *ars.,* scantiness of secretions is characteristic. Small, dark, offensive stools with great prostration following, preceded by restlessness, anguish and pain in the abdomen and burning in the rectum. *Mercurius* and *nux* have some symptoms in common. *Nux* is often called for when babies are getting used to change of food and nurse. The nux child is an uneasy and fretful individual. The stools are small, frequent, possibly mixed with mucus, straining even when nothing is passed. *Merc.* calls for frequent, green mucus or bloody mucus stools, with violent tenesmus and nightly aggravations.

PNEUMONIA.

BY C. E. WELCH, M. D., NELSONVILLE.

In a short paper we can hardly go into detail and consider the nomenclature, so diversified, in our text-books, the pathological conditions, morbid anatomy, etc.; neither is it necessary to consider, separately, the three stages of the disease. What we are most interested in is a general discussion of the disease from the standpoint of the family physician.

Pneumonia is one of the most dreaded and fatal of the diseases we are called upon to treat, in fact the death rate is so high and the physicians of the "old school" are so helpless that a recent newspaper, Chicago Saturday Evening Post, published an editorial based upon the opinion expressed by a "regular" practitioner that "pneumonia is not influenced by medical treatment." It is unnecessary in this meeting of homeopathic physicians to say that we can produce statistics and cite innumerable cases to refute the above as applying to the disease under scientific treatment. The fatalities, however, are largest among the very young—having a more favorable prognosis when coming, as a primary condition, between the ages of three to six years. The most important features for us to consider are the diagnosis and treatment.

In the diagnosis we must necessarily take into consideration some of the etiological factors. Primarily, especially in children, it comes more often from exposure, which may be very slight, especially in the winter months and in this State where the climate is so changeable. The little fellow contracting the cold or first stage, when the mother thinks she is the most careful, not allowing the baby outdoors. The cool air, circulating near the floor, coming from beneath the doors, in a nice warm room, doing its deadly work while the child is innocently playing; or, getting warmed up and perspiring from playful exertion, he drops to the floor to rest. The cool air suddenly checks the perspiration, and this is soon followed by the usual symptoms.

We need not discuss the diplococcus pneumoniae, as the majority of us have not the means nor the time to hunt for it, and therefore can only absorb from our literature and believe according as we interpret the importance of the investigations of the bacteriologists.

Secondly, we find pneumonia following closely upon or complicating many diseases. Probably first in the list which predisposes to it is measles; then scarlet fever, meningitis, diphtheria, typhoid, whooping cough, etc.

Our diagnosis made as to the disease, we find difficulty in determining the extent of tissue involved and the probable complications, which are most often pleuritic and an involvement of the pericardium or the endocardium, when the left lung is affected. The fact, however, that its ravages are usually confined to one lobe or one lung helps the patient to a recovery.

When first called to see our patient we usually get a history of a sudden onset—a chill, more or less pronounced, followed by general depression, which is followed by a high fever. We find dyspnoea, pain over the chest, and a dry, hoarse cough, rapid breathing, and alternating flushed face with dry skin and pale features with perspiration. The respirations, pulse and temperature rapidly increases, but the respiration out of proportion to the temperature and pulse rate. In no disease do we find such a vast degree of difference in the pulse-respiration ratio.

Dr. Orrin Smith reported a case to the Clinical Society of Hahnemann College, Chicago, in 1896, in which the pulse-respiration ratio was most interesting. A boy nine months old, from the fourth to the ninth day, inclusive, had an average pulse of 148—the lowest being 125 and the highest 160—and an average respiration of 93—lowest being 65 and highest 120. The symptoms began to subside during the morning of the tenth day and the boy made a satisfactory recovery.

Average cases are not so pronounced, however, and we usually watch the pulse and temperature range, and probably allow this to determine our prognosis more than we should, losing sight of the importance of the respirations.

The cough, which is first dry, soon loosens up and the sputum is often streaked with blood, giving it a rusty color, being tenacious, however, and hard to raise, although the rattling in the chest at this stage indicates an abundance, and it seems as though it ought to come up easily. The pain is often acute and causes extreme restlessness and a slight catch in the breathing. The eyes are bright and staring and the whole expression one of anguish or anxiety.

Our first duty is to prescribe the indicated remedy and direct the nurse, usually the mother, as to the care and diet of the patient. Locate the child in a room where the bed will be free from direct draught, but room freely ventilated, better indirectly through an open window in an adjoining room, and maintain a steady temperature of about 65°. Have the patient isolated, if possible, and especially free from visitors and noise. If we see the patient early enough, aconite 3x is the remedy; but we are usually too late for this, when bryonia or ferrum phos. must be considered, then a little later we will often get the indications for chelidonium pronounced. Its action on the liver, and relief, in this way, from accumulated poison makes it the remedy par excellence. We have to choose from, however, phosphorus, kali mur., gelsemium, etc. The average case can generally be handled with bryonia, chelidonium and sulphur. We have our materia medica for indications for these remedies, so we need not expand upon them here.

The question of stimulants must be left, somewhat, to the judgment of the physician and the exigencies of the individual case. Their general use throughout the case is to be strongly condemned. I think many cases are lost by the injudicious and persistent use of stimulants, especially strychnia and alcohol. In cases of extreme exhaustion and where stimulation is necessary in the later stages, I use almost exclusively hypodermics of whisky with good results.

The old method of quinine and strong stimulants with wet poultices, throughout the course of the disease, is, no doubt, responsible for the newspaper article referred to; but we must confront the poultice question to satisfy the laity, and if possible benefit the patient. I think the wet poultices commonly used and frequently changed should be condemned, as the frequent changing, without proper protection, exposes the child and does much damage.

Strips of fat meat may be stitched to a flannel cloth and applied during the first stage, or antiphlogistine changed once in twenty-four hours, or what I get the best results from, slices of raw union placed between cloths, pounded a little and warmed and applied, leaving explicit directions not to remove it until I order it taken off. When the loose, rattling condition develops, remove and apply a closely fitting flannel jacket.

Cotton on oiled silk can be used throughout the course of the disease, in some cases with benefit, replacing with dry cotton as often as it becomes moist from the perspiration.

The friction treatment, with the naked hand, applied to the chest, twice a day, is giving good results.

The prophylactic treatment would mostly apply after the first attack, for while pneumonia is a frequent complication and sequela, it is also a strong predisposing factor or stepping stone to our most dreaded disease, pulmonary tuberculosis. One attack predisposes to another, and another soon follows, and this process weakens the lung tissue and impairs the general health of the patient until phthisis pulmonalis gets its start, hence the care in the after treatment. This should consist mainly of a toughening process, out of door life as much as possible, less bundling up and more cool bathing, the object being to make the child less susceptible to mild changes in the asmosphere. This toughening process should properly began at birth.

The diet during a case of pneumonia should be liquid and nutritious. In young infants this is usually fixed, being mother's milk, or some artificial diet as Horlick's, Mellin's, etc. In older children the liquid diet, usually prescribed in most cases is allowed, as beef broth, cow's milk, etc.

The greatest care should be exercised during the convalescing period, as the tissues are tender, and too early liberation from the sick room may cause a fatal relapse.

OUR CRIPPLED AND DEFORMED CHILDREN.

BY C. E. SAWYER, M. D., MARION.

For the past year and a half there has been a special effort made to obtain state aid for the crippled and deformed children of Ohio. That you may be more familiar with the progress of the work, I take the liberty of reading the findings and recommendations of the Commission appointed by Gov. Nash to report on the necessity, feasibility and desirability of the State taking up the charitable work of providing an institution for the care, treatment and education of crippled and deformed children.

This report is self-explanatory and shows the difficulties encountered, and the results obtained, regardless of all difficulties the investigation proved beyond question to the Commission that Ohio had many cases of this kind which were deserving care and attention they were not getting, and as the recommendation of the Commission shows, they are unanimously in favor of a complete modern and thoroughly equipped institution for the care, treatment and education of the indigent crippled and deformed.

As the report is brief and to the point, I take the liberty of presenting it in full.

REPORT.

To the Honorable George K. Nash, Governor of Ohio:

DEAR SIR—The Commission appointed by you in January, 1903, in compliance with the provisions of an Act passed by the General assembly in special session in October, 1902, "to report upon the necessity, feasibility and desirability of the State caring for, treating, and educating crippled and deformed children," respectfully presents the following:

Organization.—Having duly qualified according to law, all the members of the Commission met in the Governor's office at the State House on the 16th day of January, 1903, and organized by electing the Rev. John Hewitt, President, and Dr. E. C. Brush, Secretary.

After brief discussion an agreement was easily reached as to the purpose of the Act of the General Assembly and the duties devolving upon the Commission in carrying out the same.

The President and Secretary were then appointed a committee to secure information as to (a) the number of crippled and deformed children in the State under the age of eighteen years; (b) how many of such children are able and how many are not able to attend school; and (c) what has been the experience of other States in the establishment of institutions for crippled and deformed children.

Methods.—The following methods were adopted for securing this desired information:

1. Through the office of the Commissioner of Public Schools, two blank forms for returns were issued to the county Auditors

throughout the State—one for each Auditor and one for each school enumerator.

2. A circular letter was addressed to about eight thousand five hundred (8,500) physicians and surgeons; also to three thousand (3,000) clergymen, and one thousand three hundred (1,300) newspapers.

3. Correspondence was opened with county and state elecmosynary institutions, asking for the names of crippled and deformed children cared for by them, as well as for an expression of opinion as to the necessity of establishing an institution for their care.

4. Correspondence was also opened with existing institutions for the care of crippled and deformed children in other states—namely, Massachusetts, Minnesota and New York.

5. Finally, the President of the Commission met and conferred with the Superintendent of the Minnesota institution, and afterwards visited in person the Massachusetts State institution, at Baldwinville, Massachusetts; the Boston city institution; the New York State Hospital at Tarrytown, and a private institution in New York City.

Results of our Investigations.—It has been apparent from the first, that it would be quite impossible to secure a full registration and description of the crippled and deformed children in the State. The Census Department at Washington has not been able to successfully collect such statistics, and similar efforts in other states have been unsatisfactory to a degree. To whatever cause or causes this may be attributed, whether to the very general tendency of parents and physicians to withhold information, or the indifference of enumerators, the fact remains that we have been able to locate less than half of these children. This assertion is based mainly on the apparently full returns received from Cuyahoga County, which we have used as a basis for estimate.

As a result of the various efforts of the Commission to collect statistics, we find ourselves in possession of the names and addresses of one thousand and seven (1,007) children, reported from seventy-nine (79) counties. No returns whatever were received from Ashland, Athens, Carroll, Mercer, Morrow, Noble, Union, Wayne and Wyandot Counties.

How complete the returns were is seen by a comparison of counties of the same approximate population. In Cuyahoga County, the county that seems to have made the fullest, yet we feel satisfied far from complete report, we have the names of three hundred and thirty-six (336) children; while from Hamilton County we have received but thirty (30). Not a single child was reported from Ashland, Mercer, Union and Wyandot Counties, while from Clinton and Warren Counties, with the same approximate population, there were reported eighteen (18) and ten (10) respectively.

The members of the Commission are agreed, from all information and evidence at hand, that in every instance the cases reported are far below the actual number in the State.

It is a matter worthy of note that although physicians, ministers, school superintendents, institution officials and citizens generally were requested personally, and through the press, to send to the Commission names of all crippled and deformed children known to them, that out of one thousand and seven (1,007) names so reported from these divers sources, only fifty-one (51) were duplicates; that is to say that only fifty-one (51) children were reported by two persons. This, in the mind of the Commission, confirms the estimate we make, based on the returns from Cuyahoga County; that there are in Ohio, not less than three thousand one hundred and sixty (3,160) crippled and deformed children.

While our inability to secure more definite returns is cause for regret, it was to be expected in view of the remarkable indifference shown so generally by physicians, ministers and county officials. Out of the eight thousand five hundred (8,500) blanks sent to physicians and surgeons, the number returned was but two hundred and twenty-nine (229); out of the three thousand (3,000) sent to ministers of all demoninations, only forty-six (46) were returned. Only twenty-eight (28) replies were received from school superintendents and principals. Only nine(9) out of eighty-eight (88) infirmaries reported, and only twenty-five (25) children's homes out of fifty(50). Miscellaneous replies, made largely through the publicity given the work of the Commission by the press, were received from one hundred and thirty-eight (138) individuals.

The returns made by the County Auditors through the State School Commissioner, though in some respects less satisfactory than

others received, furnish valuable data and, so far as they go, reliable statistics upon which we believe definite conclusions may be safely reached. Partial reports were received from only thirty-six (36) auditors. They show a total of five hundred and ninety-one (591) children, two hundred and fifty (250) of whom are unable to attend school on account of their physical condition. These and other returns have been tabulated, and appear as part of our report.

We believe our first estimate of three thousand one hundred and sixty (3,160) crippled and deformed children in Ohio, based on returns from Cuyahoga County, is conservative and well below the actual figures. But it may be claimed that conditions in Cuyahoga County are abnormal; that the very large proportion of the foreign population in the city of Cleveland, ignorant and indifferent alike to rules of health and sanitary regulations, contributes a disproportionate number of these children; and that it is not safe to base an estimate for the State on this one county. That this is true to an extent worthy of notice, we do not accept. In order, however, that we may not appear to magnify to the people of Ohio the importance and extent of the conditions given us for investigation, we have made a second estimate, based on the reports made by the thirty-six (36) County Auditors, Cuyahoga County not being of the number. The counties are Ashtabula, Athens, Belmont, Butler, Carroll, Clark, Clinton, Defiance, Erie, Fairfield, Franklin, Fulton, Gallia, Hamilton, Hocking, Lake, Lucas, Madison, Medina, Mercer, Miami, Monroe, Morrow, Noble, Ottawa, Pike, Putnam, Richland, Ross, Seneca, Trumbull, Van Wert, Vinton, Warren and Williams.

The population of the foregoing counties was, in 1900, one million eight hundred and nineteen thousand two hundred and sixty (1,819,260). We feel safe in assuming that the class of children whose care we are considering, are evenly distributed in our general population, and that the whole number in the State bears the same relation to the whole population as does the number reported by these thirty-six (36) counties to the population of the same counties. This being true, we have in the State based on these partial reports, one thousand three hundred and fifty-one (1,351) children under eighteen (18) years of age, of whom five hundred and seventy-one (571) are not able to attend school. This is one

of the most significant facts developed by our investigations—that a large number of children, mentally sound, are, on account of physical defects, deprived of school advantages. How large the number really is no one can say. Of one thing we are confident, that the five hundred and seventy-one (571) above noted do not represent one-half the children thus excluded from our public schools. Even though we claim that the number of this class of children in Ohio is less than in the States of Massachusetts and New York, still a comparison of our statistics with those of the last named States will prove that we are justified in making this statement.

In many instances the physical condition, cause of deformity, etc., of the children whose names have been furnished us, has not been clearly stated, except under the general terms of "crippled," "deformed," "can't walk," "weak back," etc. However, among the one thousand and seven (1,007) children whose names we have, we find

103 cases of hip joint disease.
99 cases of paralysis.
139 cases of spinal disease.
43 cases of infantile paralysis.
63 cases of club feet.
27 cases of rickets.
26 cases of dislocation of the hip.
17 cases of tuberculosis of knee or ankle joint—a total of 517.

A great majority of these and other cases of deformity could be cured if taken in time and kept under treatment until cures were effected. In probably over ninety per cent of all cases cures, or greatly modified conditions, would result from early care and treatment. The presence of so many deformed children in our State, who have advanced to an age where little or nothing can be done to relieve their condition, goes far to disprove the claim advanced in some quarters, that there is already ample provision made for them in general and special hospitals. Another unwelcome truth is that so many of these children, probably forty per cent., are being kept from school, reaching maturity in ignorance, idleness and misery.

Conclusions.—Our investigations up to this point lead inevitably to the conclusion that these children are equally entitled to the privileges and benefits of mental and manual training with the

blind, the deaf and dumb, and therefore that a State institution for their care, treatment and education is equally desirable and necessary.

In considering the feasibility of State provision, the Commission has naturally turned to the experience of other States, where such institutions have been established. We find but three: Minnesota, New York and Massachusetts. Dr. Arthur J. Gillette, of St. Paul, surgeon-in-chief of the hospital, states that the success attending the work in Minnesota has placed the hospital high in the estimation of the people of the State, and that it has become one of its most cherished philanthropies. The work accomplished in Minnesota, where a beginning was under adverse influence of an untried venture, has taken the proposition of a State institution for the care and treatment of these children out of the domain of experiment. There seems to be no doubt of the important place such an institution must fill in the field of public charities. And more: The contention heretofore made by those in Ohio who have given thought and interest in this work, that in addition to care and treatment such an institution must provide educational facilities, with trades instruction, is made good by the experience of Minnesota. Dr. Gillette holds that the institution to meet its full measure of usefulness, must be equipped with an educational department including, as of paramount importance, trades instruction.

The State of Ohio in its beneficence has unhesitatingly and uncomplainingly charged itself with the care of the vicious and criminal, the insane and epileptic, the feeble-minded, the deaf and blind, wayward youth, the soldier's orphan and the old soldier, and has provided for the county care of the poor, and the dependent child of sound mind and body, and for all these a period of care is provided that is in most instances limited only by the life of the individual. But up to the present, absolutely nothing has been accomplished in the care, treatment and education of a class of children whose neglect yields to the State no inconsiderable number of life-long dependents, and brings upon it the shame of permitting the unspeakably sad afflictions of these children to develop and mature, when early care under modern treatment will wholly remove the defects in fully half, and materially modify and mitigate them in nearly all of the others.

If the State, in discharging its obligations toward the blind, has deemed it necessary to provide for them a separate institution where they may be educated, given trade instruction and medical treatment, the average number being about three hundred (300), and similarly with the deaf and dumb to the number of five hundred (500), continuing the care of these deaf and blind children for a period of twelve or more years, what shall be said of its duty to these crippled and deformed children whose bodily infirmities debar them from enjoying the pleasures of childhood, deny to them the benefits of education, the ability of self-support, and opportunities of future usefulness?

Your Commission is of the unanimous belief that the State of Ohio should without delay provide an institution for the care, treatment and education of crippled and deformed children. We believe that such an institution is *"necessary, desirable and feasible."*

We are convinced the results to be attained would amply justify its establishment and reflect credit upon our State, and that in a short time this class of children and young people would be taken from the lists of those dependent upon public charity.

Recommendations.—The institution should be founded on broad lines.

It should provide the best surgical and medical skill, with hospital facilities and mental and manual instruction adapted to the requirements of these children.

It should be located near a large industrial center with facilities for expert medical service and mechanical works.

It should have not less than fifty (50) acres of land.

To accomplish this, we would recommend an appropriation of two hundred thousand dollars ($200,000.00).

Trusting that the facts herein stated and the conclusions reached will be regarded as satisfactory proofs of a faithful endeavor on our part to discharge the duty imposed upon us, we are most respectfully,

JOHN HEWITT, *President.*
E. C. BRUSH, *Secretary.*
A. B. VOORHEIS.
ADELBERT L. SPITZER.
C. E. SAWYER.

After this report had been formulated and presented to the outgoing Governor, it was the consensus of opinion of those most interested that owing to the present numerous demands on the finances of the State it would be next to impossible to carry out the plan without making unfavorable concessions, and fearing that compromises might arise which would defeat the full purpose and objects of the plan contemplated, it was decided to hold the matter in abeyance until the reconvening of the Legislature. This will give those interested a better opportunity of acquiring more explicit information as to the number and class of cases to be treated and the particular needs and requirements of such.

In order that intervening time may not be lost I am especially anxious that the Ohio State Society should keep on its list of committees one whose duty it would be to take up this subject definitely and in detail when needful to the carrying out of the project, and I would urge that each and all of you aid in every way in creating a public sentiment favorable to the carrying out of the report of the Commission.

As Chairman of the Committee of the Associated Charities of Ohio, on "Crippled and Deformed Children and General Hospitals," I propose to organize in each county of the State a sub-committee to aid in getting definite statistics, in the accumulation of such information as may be desirable to demonstrate the needs of such an institution and to help acquire the influence of such persons as will be helpful in the passage of the bill when it is finally ready for presentation.

During the interim we expect to work out all of the details and when the matter is presented to the next Legislature we hope to be in position to obtain an appropriation which will justify the end sought. I feel assured that it is only a matter of a short time until Ohio will have one of the best state institutions for the care, treatment and education of the indigent crippled and deformed and I trust that your assistance may always be available.

ARTIFICIAL FEEDING OF INFANTS.

BY SARA E. FLETCHER, M. D., COLUMBUS.

In presenting this subject for your consideration, I am not vain enough to think I shall tell you anything new. Our worthy President remarked, when I gave him the title of my paper, "That is a problem which we have always with us." Such being the case, it calls for frequent study and refreshing of the memory.

The specialist in diseases of children may not consider the undertaking a difficult one, but when the general practitioner is called upon to pilot a baby just beginning the voyage of life, through the shoals and quicksands of artificial feeding, he feels the burden of responsibility weigh heavy on his shoulders, and he welcomes any light which will guide him and his charge into a safe harbor.

To an infant deprived of its natural food, cow's milk, as a rule, offers the best substitute. In order to prescribe it intelligently one must have a well-defined idea of its composition. Such knowledge is best gained by comparing it with human milk.

The following tables taken from Holt are sufficient for all practical purposes, although finer analyses are made and there are frequent variations of the standards given:

HUMAN MILK.

Fat	4.00 per cent.
Sugar	7.00 per cent.
Proteids	1.50 per cent.
Salts	0.20 per cent.
Water	87.30 per cent.

Reaction alkaline.

COW'S MILK.

Fat	3.50 per cent.
Sugar	4.30 per cent.
Proteids	4.00 per cent.
Salts	0.70 per cent.
Water	87.50 per cent.

Reaction neutral or slightly acid.

Thus you see that in cow's milk the fat is slightly deficient, the sugar considerably so, while the proteids are greatly in excess.

Now just a glance at some of the uses of these various constituents in building up animal tissue in order that we may better appreciate their value in the baby's food.

Physiologists tell us that the most important part of living matter is the proteid part of its molecule. In proper combination with fat and carbo hydrates, it furnishes the greater part of the energy which carries on the processes of growth, repair and nutrition. It is the only kind of food which supplies nitrogenous waste. The proteids are industrious little bodies, and were it not for the fats and carbo hydrates, would use themselves up in the production of heat, as well as growth and repair. These latter, conservators of energy, furnish the heat, add to the weight of the body, and fulfill many other duties in the activities of life.

The salts help largely in absorption and building up the bony system.

Two-thirds of the weight of the body is due to the water, which is taken in through food and drink. Through its presence circulation and elimination are made possible.

Having all these substances, and knowing their uses, the problem is to combine them in such proportions as shall best suit the digestive power of the baby's stomach.

The proteids in cow's milk are chiefly casein and lactalbumen. It is the casein which causes most of the trouble. Aside from the fact that it is greatly in excess, it coagulates in coarser, harder curds than the casein of human milk. The most reliable indication that it is in excess in the food is the presence of curds in the stool and colic in the baby. In order to reduce it to the proper proportion, water is added as a diluent. This, of course, still further reduces the amount of fat and carbo hydrates, which must later be added in the form of cream and milk sugar.

Should it be necessary to further aid digestion, a gruel made of barley or oatmeal may be used instead of plain boiled water. In young infants this should not be continued for a great length of time on account of the starches contained. In an attack of acute indigestion these gruels may often be the only food for a few days.

An excess of fat will most likely show itself in loose stools and a regurgitation of food several hours after feeding, while constipation which results from a lack of fat may be overcome by the addi-

tion of cream to the food. I have sometimes found, where the baby's stomach will not permit the addition of cream, that a few drops of pure olive oil, given daily, will produce a normal action of the bowels and will not disturb digestion.

The form in which the carbo hydrates are furnished in milk is that of milk sugar. Of all the constituents of milk, it is the one most easily digested, although even an excess of this will cause colic and green, watery stools. There may also be a rapid increase in weight, due to the large amount of sugar in the food, but there is not a corresponding increase in strength. This deceives many mothers, who think that because the baby is white and plump and full of dimples, that the food is all that could be desired. They do not know or do not appreciate the fact that the lusty youngster who lacks the dimples, but whose kicks and struggles give evidence of muscular development, has much greater power of resistance to disease. A gradual increase in weight, even if it be not more than three or four ounces a week, is the best proof that the baby's food agrees with it.

In these days of rapid transportation it is much easier to obtain fresh milk than formerly. When it can be procured, the fresh, raw milk, warmed to the temperature of the body, is to be preferred. Sterilization, which consists in heating to 212 F. for an hour or more, alters the taste and causes certain changes which lessen its digestibility and tend to constipation, but hot weather, lack of ice in crowded cities among the poor, make this a necessary precaution. Pasteurization which maintains the temperature at 167 F. for twenty minutes, then cooling rapidly, is sufficient for ordinary occasions, and is said not to change the character of the milk. These processes are merely preservative, and milk treated in this manner must be modified in the same way as plain milk.

The amount and intervals of feeding are largely governed by the health of the infant. Those of feeble digestion requiring more frequent feeding and a smaller amount than more robust children. The average capacity of an infant's stomach at birth is but little more than one ounce, at three months four ounces, at six months six ounces. Regurgitation should be the signal to reduce the quantity of the food. Should it continue, then look to the quality.

The intervals of feeding may range from two to two and a half hours during the day and twice at night, up to three months of age, when the time may be gradually increased to three hours during the day, and once or not at all during the night. Experience shows that there can be no arbitrary rule laid down which will govern every case. A careful and frequent observation of the child is necessary in order to prescribe intelligently.

A formula used by Dr. Joseph P. Cobb, of Chicago, makes a very good basis for the home modification of milk. It is as follows:

1 oz. milk;

2 oz. cream;

3½ oz. water;

1⅜ dr. milk sugar.

Table spoonful lime water, if needed.

This makes a mixture in which the proportion of proteids is considerably reduced. Of course there are children who need less fat or who need less of all the other solids, but as a normal standard it furnishes the proper proportion.

Often one or two pellets of cale phos. added to each feeding does away with the necessity for the use of lime water.

In Boston, New York, Philadelphia and a few other cities, the Walker-Gordon milk laboratories have been established, where the cows supplying the milk receive every care, and every effort is made to keep the milk as pure as possible. The cream is separated from the milk, and cereal jellies, lime water, boiled water and sugar solutions are kept in readiness and in exact percentages. The physician writes a prescription for each case, giving the proportion of proteid, fat, sugar, etc., with the same care that he would write a drug prescription. The milk modified as directed is delivered at its destination until the physician sees fit to change it.

This laboratory or "percentage feeding," as it is called, would seem to be the ideal way, but unfortunately it also has its limitations. Dr. Louis Fischer is quoted as saying: "The percentage method of feeding has always seemed to me plausible in theory, but it cannot be applied in practice. It is a fact well known by chemists, that once an emulsion of milk is broken up by centrifuging or other mechanical process, as in separating the top milk from the skim milk, we cannot have again as homogeneous an emulsion

as prior to the breaking up of the same." We have yet to learn the secret process by which that great chemist, Mother Nature, furnishes the food best adapted to her children.

Of the many commercial baby foods on the market, I have personal knowledge of but a few. They served me well in the emergency which called for their use. The principal objection to most of them is that they contain too little fat and too much starch and sugar. It has been urged that their prolonged use induces rachitis. Should they cause fermentation and chronic indigestion with the resulting formation of acids and poisonous compounds in the system, one can easily see how such a condition follows, (the same would be true of any food,) but used with discrimination and a knowledge of their composition they often render valuable aid in that difficult problem of infant feeding.

BUREAU OF CLINICAL MEDICINE.

A. B. SMITH, M. D., Chairman - - - Springfield
"Haemophilia Again"

J. H. COOK, M. D., - - - - - New Carlile
"A Comparison"

H. E. BEEBE, M. D., - - - - - Sidney
"The Golden Mean"

W. L. PETERS, M. D., - - - - - Circleville
"A Clinical Case"

A COMPARISON.

BY J. H. COOK, M. D., NEW CARLISLE.

In these days when the glorious results of surgery are continually sung and when therapeutic nihilism is the order of the day, particularly in the dominant school, one case which came under my observation seems to me worth recording. For a year prior to June last Mr. O. had noticed an enlargement between the seventh and eighth ribs on the right side, but as it did not trouble him much until in June, no attention was paid to it. During my absence at the American Institute he detected fluctuation and consulted Dr. D., who had him poultice it until it opened, discharging considerable pus. Not liking Dr. D., he consulted Dr. S., who by the way

is an ex-house physician to the Columbus Protestant Hospital, and whose student days were spent in the office of one of the most prominent surgeons of Columbus in the regular ranks. Dr. S. treated the case from June until November 12 by means of probing, drainage, moist and dry antiseptic dressings, etc., but gave no constitutional treatment.

At the end of this time patient was no better, and Dr. S. admitted he could do no more unless he would go to the hospital and have the side opened, sinus curetted and rib resected. Then the came to me. I found I could introduce readily a probe four inches into the fistulous tract and feel the roughened surface of the eighth rib very plainly. The mouth of the sinus was pouting, red and angry and a continual discharge of thin watery pus exuded. I said, "I can cure you, but it will take three months." "All right," said he; "only do not cut."

I gave him silicea 3x trit., a powder four times a day. No local treatment of any kind except a pad of absorbent cotton to catch the discharge and keep from soiling the clothes as usual. Silicea was continued all the time, and an occasional dose of phosphorus was given.

Just two days under the three months the discharge had entirely ceased, the wound was closed up solid, and nothing remained to show there had ever been any trouble except the cicatrix. At my request he showed the results to Dr. S., whose only comment was, "Be careful it don't break out somewhere else." Of this I am not afraid, as the case was cured by internal treatment alone and not suppressed. Could surgery have offered anything better, safer or surer?

A CLINICAL CASE.

BY W. L. PETERS, M. D., CIRCLEVILLE.

Mrs. H., age 65 years, was born and lived on the farm until 35 years old. Although not a child or woman of robust health, she was subjected to the usual sorts of labor and exposure that fell to the lot of women on the farm in those years. She was the subject of frequent asthmatic attacks until 14 years of age, and at 17 had a mild attack of typhoid fever, after which her general health and strength

were improved. She was married at 20, and in the following eighteen years as a result of ten pregnancies had two miscarriages, six still-born and two living and fairly healthy children, each living about sixteen months, one dying of summer complaint and the other of whooping cough. Her labors were rather difficult and she was usually several months in recuperating from their effects.

She passed the climacteric at 50 without any special difficulty. Just following this epoch she suffered very much from hemorrhoids, which were treated by the injection method until a treatment produced an almost fatal collapse. From the time of this affliction—now nearly fifteen years—she has not missed a single day in using one or more rectal enemas and never has a movement of the bowels without this method. For almost a year following the hemorrhoidal trouble she was very much of an invalid, the last three or four months of which she spent in driving over the county soliciting funds for the establishment of a hospital in connection with an Ohio Ladies' Home in which she was an interested worker. This out-door recreation and work did wonders in restoring her to a reasonable degree of health and strength. Five years ago she had a second attack of typhoid fever, lasting ten weeks.

Having no family and being in comfortable circumstances, after recovering from this siege of fever she devoted her time and energies very largely to the work and management of the Home and Hospital. In her zeal for the success of the institution, she frequently engaged in some of the most arduous and disagreeable parts of the work, and taxed her strength and powers of endurance far beyond a reasonable degree for one of her physical condition.

After some months of this kind of care and work she began having occasional attacks of sudden blindness, becoming very weak and faint, but by the use of a little stimulant—usually whisky—and a few minutes' rest she would recover and go on with whatever she was previously engaged.

Similar attacks have occurred at irregular intervals ever since. About this time her limbs began to fail in strength and her knees and ankles would sometimes give out, and during the summer of 1902 she became unable to walk a distance of two squares, and her feet gave her more or less pain after a little walking. Soon the left foot around the edge of the heel and along the outer edge of the

sole and at the base and ends of the great and little toes became quite painful from very little use, so that in the fall she was obliged to use crutches to keep her weight off that foot. The painfulness of this foot increased in severity until by the last of December she was never free from pain and was suffering with frequent paroxysms of severe, cutting, burning and boring pains in this foot, but worse around the edge of the sole and in the great and little toes, which felt during these paroxysms as if the nails were being gouged out with a knife. At this time heat aggravated and cold temporarily relieved the pains.

During the month of January, 1903, she took osteopathic treatment, and February and March were spent in Florida, and during the summer and fall she was under the treatment of three different old school specialists in nervous diseases and had about five weeks of homeopathic treatment. Through September, October and November she used hot air treatments to the foot and limb quite frequently, and these were more efficient in giving temporary relief from pain than any other means used. At times the Faradic current semed to give some relief.

During the fall the limb became flexed at the knee and the knee quite painful at times, and late in December there appeared several rows of bead or shot-like lumps along the front part of the limb from the ankle to knee, and above the knee two clusters of larger and more flattened lumps, the latter being quite sensitive, and all freely movable under the skin. About two months later, or in February of this year, there appeared on the front and outer side of the right thigh rows of lumps the size of a small bean. These were quite sensitive at first, but like the others became less so after a time. At this time the skin and flesh—of which there was very little—of the whole body and limbs was so tender that she could scarcely be handled at all without adding much to her suffering.

For thirteen months now she has been confined to the house, and most of the time since last August to her bed. While she has suffered much from various other afflictions of short duration, the left foot has been a source of almost constant suffering for the past seventeen months, and recently the thighs have added much to that of the foot.

One thing quite constant and characteristic in her case has been the agrgavations during stormy weather and at every change, whether to foul or fair. A great many local applications have been used, but no one thing has been as efficient as dry heat. She is conscientiously opposed to the use of opiates and will not knowingly take them, but has used anodynes, principally the coal-tar products. Recently she has had some codeine, but in all her suffering, which at times has been very severe, she has been extremely cautious in the use of such drugs, seldom using them except at night.

No treatment that has been used in her case has produced any permanent improvement. The homeopathic remedies she has had are arnica, asenicum, cimicifuga, hypericum, ferrum phos., magnesia phos., nux vomica, rhus tox., secale cornutum and sulphur. What can we promise her in the way of treatment or results in the future?

"THE GOLDEN MEAN."

H. E. BEEBE, M. D., SIDNEY.

Is clinical experience a reliable guide in practice? I think I hear some one say, "Yes, of course it is, why ask so foolish a question?" But how much clinical experience is wanted before it is a true guide? That depends largely upon the judgment of the clinician. If he or she be an enthusiast, which is a valuable quality, it may demand more experience than if the worker belong to the slow, plodding class in general practice, not the back numbers in this branch of the profession.

Now, don't think we are making a thrust at the learned specialist, for no one has a higher regard for the thoroughly trained worker along special lines than the writer, but it must be remembered the student taught along one idea, valuable as his knowledge is, he is at the same time too often biased, and therefore not always to be depended upon for positive final deductions.

In practice, before reliable conclusions are deduced, sufficient time should elapse and a good array of cases recorded to judge fairly. Furthermore, in time the general profession renders an unbiased opinion, which is usually about correct. With this prelude

permit the quoting of the following, though the topic be rather worn out, this is today the expressed view of many in our ranks:

"*Appendicitis.*—J. J. Brownson (American Medicine, January 16, 1904), believes that there are three periods in which the operation for appendicitis can be safely performed: (1) At the inception of the disease before fever. (2) After the fever and distention have subsided and suppuration has taken place. (3) In the interval after all signs of inflammation have disappeared. He says that there have been more deaths from appendicitis since the operative method has been in vogue than during the expectant plan. He believes that this is due to interference being practiced at the wrong time. He concludes that the operation for appendicitis ought to be done in the primary or before-fever period. The appendix should be removed, to guard against fulminating cases and those in which rupture occurs into the abdominal cavity. In the secondary period, after suppuration, drainage should be instituted, and nature left to take care of the appendix. In the interval, after all symptoms of inflammation have subsided, the appendix should be removed. The operation ought not to be done in the intermediary period when there is fever and distention of the abdomen, because the danger from operation at this time is greater than the risk of the case becoming fulminating, or the abscess bursting into the abdominal cavity."

Now, are these conclusions valid, and has clinical experience proven them to be true? Our brother surgeon specialist says: "Why, this is only one man's opinion, and his utterances are mere assertions; *we* simply assert to the contrary, and our opinion is formed from practical work."

Possibly this is so, but does not the prevailing sentiment of today confirm these assertions, and ask for more conservative measures? It certainly does, and besides, is not the golden mean being now established according to Dr. Brownson's opinion? We believe it is.

Appendectomy is quite often a most important, and necessarily skillful operation, but to know when to do it is as important a question as to know how it ought to be done. Don't think all cases of appendicitis require a surgical operation.

The surgeon is usually called to operate and nothing more, for as to the need of an operation that matter has been settled before he is called into the case. I, myself, have had this experience, having operated where I felt it was not really required, but the family physician said: "I called you to operate and if you don't do so I shall get some one who will operate, for we have decided that is a necessity." Well, I didn't let them call some one else. Fortunately the patient recovered.

Again, I have operated where the attendant thought it unnecessary, and I knew it must be done. But I don't cut into these cases as frequently as I formerly did, depending upon more conservative attention. Dr. Terry's oil treatment is my favorite measure. He says that out of fifty cases, under his personal supervision, forty-four were successfully treated without operation.

Oophorectomy is a very beneficial measure when needed, and when well done, but today this surgical operation is not resorted to once to where it was performed a dozen times ten years ago. Again the golden mean has been established.

Gall bladder surgery is another great necessity, but we are having too many bad results, not always fatalities, but biliary fistulae, which may be more annoying than the primary liver trouble. The risk is too great to do this operation promiscuously, and, too, by amateur surgeons. Gall stones do not always cause trouble, for they are found unexpectedly in many post-mortems. The decision is coming as to when to operate, not so much how, the same as in appendectomy.

One of the latest, and a most important surgical operation today, one that gives satisfactory results as a rule, is prostatectomy, but enthusiasts are, we fear, overdoing it. Honest of course, but doubtless removing this gland where not necessary and sometimes bringing the work into disrepute.

No single operator has yet had sufficient experience to enable him to speak authoritatively upon the subject, and such extremes of experience have been reported that it is difficult to estimate the real danger and difficulties of prostatectomy. It it too grave an operation to be resorted to as a routine treatment for enlarged prostate, and is only applicable to properly selected cases. The greatest danger after the operation is uremia, and the kidney should be

carefully examined before operating. The next danger is sepsis, particularly in the presence of an infected bladder. Watch closely, and in due time this operation, like the others referred to, will reach its climax and seek its level.

Certainly clinical experience *is* a most vaulable aid in determining the reliability of much in the practice of medicine and surgery.

Dr. Brownson's opinion on operating for appendicitis is but one example, while many others can be furnished. That clinical experience will find the "golden mean" in due time is, we believe, an established fact.

HAEMOPHILIA AGAIN.

BY A. B. SMITH, M. D., SPRINGFIELD.

At the meeting of this society last year I read a paper entitled "A Case of Haemophilia," which case was a typical one in every detail. As this present paper will treat of this same case, it may not be amiss to give a brief outline of it, so that in following out the course of the disease, if such it may be called, we may get a more complete picture of it.

The patient, aged 44, male, was the only child. The father was a haemophiliac and died from a hemorrhage resulting from an injury when in middle life. When the patient was about 12 years of age he had a severe attack of articular rheumatism, from which he has not been entirely free. It was at this time that the tendency to excessive hemorrhage from even the slightest injuries manifested itself, and several times the bleeding proved almost fatal, usually requiring several days to stop entirely. Some years ago the patient married, but had no children. At the time of the attack in regard to which my former paper was written, viz., August 19, 1901, the injury was caused by an iron ring striking the man on the head, causing hardly more than a bruise which bled profusely, not from arteries, but more of a capillary oozing. This was controlled to a great extent, I am convinced, by phos. 6x, together with pressure over and around the bleeding surface. At all events, I was told that the hemorrhage was stopped more promptly than was usually the case, and the patient made a good recovery. There

were no more injuries or hemorrhages until shortly after the meeting of this society last year.

On May 27, 1903, he was brought to my office bleeding copiously, and covered with blood from the waist up, from a cut about two and one-half inches long on the forehead, where he was struck by the handle of a street scraper which broke while he was operating it. The cut was rough, jagged and bruised, tearing the periosteum from the bone, which was exposed, and fracturing the outer table of the skull. The man was perfectly conscious and aware of the gravity of his condition, as he wept continually and was sure he was about to die at once.

It was useless to think of suturing the wound, for the punctures of the needle would merely increase the flow of blood, and something evidently had to be done promptly. I saturated a strip of gauze with adrenalin chloride 1/1000 and packed the wound as tightly as possible with it. This allayed the hemorrhage somewhat, but not entirely, though reinforced by several repeated packings at short intervals, together with pressure on the surrounding tissues, and adrenalin, in 20-drop doses, at half-hour intervals, internally. Finally the bleeding subsided sufficiently for the patient to be moved, and I strongly urged him to let me call the ambulance and have him taken to the hospital, where he could be attended more promptly should the bleeding recur, but his confidence increased as the hemorrhage diminished, and he insisted upon going home, at least for a while.

In the afternoon when I returned to my office I found him waiting for me, and bleeding about as before. I used the same treatment as in the morning, and, when the hemorrhage was somewhat under control, sent him at once to the hospital. Here he remained for a few days, the wound still bleeding some, but not so much as at first, and gradually lessening as the edges of the cut united, until there was left only a small opening at the extreme lower edge of the wound about a sixteenth of an inch in diameter, through which there was a constant oozing. It was impossible to force into this opening any haemostatic which would entirely affect the raw surface inside, though this was attempted repeatedly. Various remedies and methods were also tried with only indifferent success. Finally the bleeding from this opening was controlled by

pressure brought about by placing a small pad of closely folded gauze, cut exactly to fit the bleeding surface inside and bandaging this as tightly as possible.

After forty-eight hours of this, the patient, thinking further dressings unnecessary, removed the pad and the bleeding again began, though not nearly to such an extent as before. The patient had already violated several rules of the hospital, being very obstinate and insolent; therefore, and because of the influence this had upon other patients, he was discharged from the institution. A few days later I met him on the street, still wearing a bandage. He said there was still some slight bleeding and that he was being treated by another physician.

After that I lost sight of the case and heard no more of him until, on my return from my vacation, I was told the man was dead from another hemorrhage. I looked up a step-son of the deceased, from whom I got the following history: Some time in July, while unloading gravel from a wagon, he was struck on the side of the neck by the sideboard of the wagon. A swelling immediately appeared, and the man was taken at once to the office of the physician who had him in charge formerly. This physician diagnosed the case as a traumatic hemorrhage into the thyroid gland, causing the swelling mentioned, and advised the man to go home at once and keep perfectly quiet. No internal treatment was given. The patient returned home, but became very restless and uneasy, and in spite of the directions given him, got up and went out of doors, walking about for some time, crying and bemoaning his condition and complaining that he could not get his breath, until he was almost hysterical. The family tried to quiet him until the physician, for whom they had sent, could arrive. Suddenly the man fell to the ground, gasped and fought for breath as though choking, and in a very short time was dead. During this paroxysm there was a very little bright red, frothy blood expectorated, probably due to the rupture of some small blood vessels in the throat due to straining. The doctor gave it as his opinion that death was caused by the hemorrhage into the thyroid gland, causing it to swell until it shut off the patient's supply of air. While this may have been the case, there was no way of verifying it as an autopsy was not allowed.

CONSTITUTION.

ARTICLE I.

This Society shall be known as the Homeopathic Medical Society of the State of Ohio; and its objects shall be the advancement of the medical science.

ARTICLE II.

Any physician of good moral character, who is a graduate of any legally constituted and reputable medical college, and who subscribes to the doctrine *Similia Similibus Curentur,* may be elected a member of this Society, upon recommendation of the Board of Censors, by a vote of two-thirds of the members present at any annual meeting.

ARTICLE III.

Every member shall, upon admission, sign the Constitution and By-Laws and pay the initiation fee.

ARTICLE IV.

Any non-resident physician, or such other person, resident or non-resident, as may be judged worthy from his superior attainments in medicine or collateral branches, may be elected an honorary member by a vote of two-thirds of the members present at any annual meeting, and may participate in the proceedings of the Society, but shall not vote and shall not be eligible to office.

ARTICLE V.

The officers of the Society shall consist of a President, two Vice Presidents, a Secretary, Treasurer, and seven Censors, who shall be elected by ballot by a majority of the members present at any annual meeting; and who shall hold office until the adjournment of the annual meeting next after that at which they were elected, and until their successors are chosen and qualified.

ARTICLE VI.

It shall be the duty of the President to preside at all meetings of the Society, to preserve order, to put questions, announce decisions, and to name members of committees not otherwise appointed.

ARTICLE VII.

It shall be the duty of the Vice Presidents in the order of their appointment, to discharge the duties of the President in his absence.

ARTICLE VIII.

It shall be the duty of the Secretary to give notice of the annual and other meetings of the Society, keep a record of the proceedings, conduct its correspondence and have charge of its archives.

ARTICLE IX.

It shall be the duty of the Treasurer to receive all moneys, make all necessary disbursements and report the same at the annual meeting.

ARTICLE X.

It shall be the duty of the Censors to receive all applications for membership, and to receive and report to the Society upon the possession by the candidates of the qualifications required by the Constitution. Three members of the Board of Censors shall constitute a quorum.

ARTICLE XI.

The annual meeting of the Society, at which time its officers shall be elected, shall be held at such place as shall be designated in the By-Laws, on the second Tuesday in May of each year, and such other meetings shall be held as shall be ordered by the By-Laws.

ARTICLE XII.

Nine members of the Society shall constitute a quorum.

ARTICLE XIII.

Any article in this Constitution may be altered or amended by a vote of two-thirds of the members present at the annual meeting, provided that notice of each intended alteration or amendment shall have been given to the Society when in session at the annual meeting next preceding.

BY-LAWS.

Section 1. The annual meeting of the Society shall be held at such place as may be determined by a majority of the members at each regular meeting.

Sec. 2. The annual dues shall be three dollars, invariably in advance.

Sec. 3. At each annual meeting committees shall be appointed to report upon such subjects as the Society may designate.

Sec. 4. All communications read before the Society shall become its property; but no paper shall be published as a part of the transactions of the Society without its sanction.

Sec. 5. The regular order of business of each meeting shall be arranged by the President and Secretary.

Sec. 6. All papers presented to the Society may be read by synopsis or in full, not to exceed ten minutes, except the Chairman's, which may be fifteen. Discussions shall be limited to five minutes to each speaker, and no person shall speak more than twice on the same paper. Each paper shall be offered for discussion immediately after its reading.

Sec. 7. The Committee on Legislation shall consist of seven (7) members, of which the President shall be an ex-officio member. The President shall appoint two (2) members annually to serve a term of three (3) years.

Sec. 8. The President shall appoint the Ohio members of the Inter-state Committee of the American Institute of Homeopathy. One member appointed on this Committee shall be a member of our Committee on Legislation.

Sec. 9. It shall be the duty of the President, at the opening of the annual session of the Society, to appoint two (2) Supervisors of Election. All names of candidates for election as officers of the Society shall be endorsed by at least seven (7) members of the Society and placed in the hands of the Supervisors of Election;

and it shall be their duty to publicly post the names of all the candidates in the room where the meetings of the Society are held by five o'clock in the afternoon of the first day of the Society's meeting.

The Supervisors of Election shall furnish printed ballots containing all the names of candidates for office, designating the office for which they are placed in nomination.

The ballot shall be the Australian system of placing an X before the names of the several candidates voted for.

The Supervisors shall hold the election from the hours of eight to ten o'clock a. m., on the second day of the meeting, and at the hour of ten o'clock a. m., they shall proceed to canvass the result of the election, and certify the same to the President, who shall announce the result to the Society.

The candidate receiving the highest number of votes shall be declared elected.

Sec. 10. The Publication Committee shall consist of the Secretary, Treasurer and President for the year of which the proceedings are recorded. It shall be the duty of the Secretary to edit the transactions, and all the proof shall be submitted to the President and Treasurer for their approval.

Sec. 11. The President-elect shall appoint a Committee of five members, whose duty it shall be to arrange all the minor detail business of the meetings of the Society over which he presides, and present it in such order as to interfere the least with the regular bureau work.

Sec. 12. These By-Laws may be altered or amended at any regular meeting, by a vote of a majority of the members present.

STANDING RESOLUTIONS.

Resolved, That we do not deem it best to issue certificates of qualifications to any person or persons except they be already members of this Society, but would refer all such cases to local, county or congressional district Societies.

Adopted June 9, 1868.

Resolved, That hereafter no paper shall be published with the proceedings of this Society, the substance of which, at least, has not been addressed to the Society.

Adopted May 11, 1870.

Resolved, That all members of the Society who shall remove from the state shall remain members of Society only on payment of dues up to the time of removal, after suitable notice.

Resolved, That all members of the Society, non-residents of the state, shall be exempt from all financial obligations to the Society.

Adopted May 14, 1873.

Resolved, That hereafter when any member becomes in arrears for three years his name shall be stricken from the list of members, after due notice. No member in arrears shall receive a copy of the transactions.

Resolved, That such members may be restored to the list upon payment of arrearage to date of restoration.

Adopted May 12, 1875.

Resolved, That the Secretary and Treasurer of this Society shall not, during incumbency, be required to pay annual dues.

Adopted May 14, 1890.

Resolved, That whenever any assessment is made which any member of this Society believes to be prejudicial to the Society's best interests, such asssment be considered to that individual null and void without any official action of the Society.

Adopted May 11, 1898.

OFFICERS OF THE SOCIETY

SINCE ITS ORGANIZATION, 1864.

1865

President—A. O. Blair, M. D., Cleveland.
First Vice President—E. C. Witherill, M. D., Cincinnati.
Second Vice President—W. Webster, M. D., Dayton.
Third Vice President—A. C. Barlow, M. D., Lancaster.
Secretary—C. Cooper, M. D., Cincinnati.
Treasurer—G. H. Blair, M. D., Columbus.

1866

President—Lewis Barnes, M. D., Delaware.
First Vice President—J. Bosler, M. D., Dayton.
Second Vice President—A. Shepherd, M. D., Glendale.
Secretary—E. P. Penfield, M. D., Bucyrus.
Treasurer—C. C. White, M. D., Columbus.

1867

President—D. H. Beckwith, M. D., Cleveland.
First Vice President—Geo. H. Blair, M. D., Columbus.
Second Vice President—H. S. Barbour, M. D., Galion.
Secretary—W. Webster, M. D., Dayton.
Treasurer—C. C. White, M. D., Columbus.

1868

President—J. Bosler, M. D., Dayton.
First Vice President—G. H. Blair, M. D., Columbus.
Second Vice President—E. C. Beckwith, M. D., Zanesville.
Secretary—A. Shepherd, M. D., Glendale.
Treasurer—C. C. White, M. D., Columbus.

1869

President—W. Webster, M. D., Dayton.
First Vice President—E. L. Flowers, M. D., New Lexington.
Second Vice President—A. Shepherd, M. D., Glendale.
Secretary—T. P. Wilson, M. D., Cleveland.
Treasurer—C. C. White, M. D., Columbus.

1870

President—E. B. Thomas, M. D., Cincinnati.
First Vice President—S. S. Lungren, M. D., Toledo.
Secretary—T. P. Wilson, M. D., Cleveland.
Treasurer—C. C. White, M. D., Columbus.

1871

President—E. C. Beckwith, M. D., Zanesville.
First Vice President—W. Webster, M. D., Dayton.
Second Vice President—Lewis Barnes, M. D., Delaware.
Secretary—H. H. Baxter, M. D., Cleveland.
Treasurer—J. C. Sanders, M. D., Cleveland.

1872

President—T. P. Wilson, M. D., Cleveland.
First Vice President—M. H. Slosson, M. D., Dayton.
Second Vice President—J. M. Parks, M. D., Cleveland.
Secretary—H. H. Baxter, M. D., Cleveland.
Treasurer—J. C. Sanders, M. D., Cleveland.

1873

President—S. S. Lungren, M. D., Toledo.
First Vice President—J. D. Buck, M. D., Cincinnati.
Secretary—H. H. Baxter, M. D., Cleveland.
Treasurer—J. C. Sanders, M. D., Cleveland.

1874

President—J. D. Buck, M. D., Cincinnati.
First Vice President—J. H. Coulter, M. D., Columbus.
Second Vice President—G. J. Jones, M. D., Grafton.
Secretary—H. H. Baxter, M. D., Cleveland.
Treasurer—J. C. Sanders, M. D., Cleveland.

1875

President—J. R. Flowers, M. D., Columbus.
First Vice President—C. C. White, M. D., Columbus.
Second Vice President—W. M. Detweiler, M. D., Findlay.
Secretary—W. A. Phillips, M. D., Cleveland.
Treasurer—J. C. Sanders, M. D., Cleveland.

1876

The following year, 1876, being the Centennial, and the profession being largely occupied with the World's Convention, which met in Philadelphia, no session of the Society was held.

1877

President—W. M. Detweiler, M. D., Findlay.
First Vice President—R. B. Rush, M. D., Salem.
Second Vice President—William Owens, M. D., Cincinnati.
Secretary—W. A. Phillips, M. D., Cleveland.
Treasurer—J. C. Sanders, M. D., Cleveland.

1878

President—J. B. Hunt, M. D., Delaware.
First Vice President—H. H. Baxter, M. D., Cleveland.
Second Vice President—E. P. Gaylord, M. D., Cleveland.
Secretary—A. N. Ballard, M. D., (pro tem,), Shelby.
Treasurer—J. C. Sanders, M. D., Cleveland.

1879

President—H. H. Baxter, M. D., Cleveland.
First Vice President—E. P. Gaylord, M. D., Toledo.
Second Vice President—William Owens, M. D., Cincinnati.
Secretary—H. M. Logee, M. D., Oxford.
Treasurer—J. C. Sanders, M. D., Cleveland.

1880

President—E. P. Gaylord, M. D., Toledo.
First Vice President—William Owens, M. D., Cincinnati.
Second Vice President—E. Gillard, M. D., Sandusky.
Secretary—J. A. Gann, M. D., Wooster.
Treasurer—J. C. Sanders, M. D., Cleveland.

1881

President—H. M. Logee, M. D., Oxford.
First Vice President—M. H. Parmelee, M. D., Toledo.
Second Vice President—G. W. Moore, M. D., Springfield.
Secretary—H. E. Beebe, M. D., Sidney.
Treasurer—J. C. Sanders, M. D., Cleveland.

1882

President—William Owens, M. D., Cincinnati.
First Vice President—E. Van Norman, M. D., Springfield.
Second Vice President—C. C. White, M. D., Columbus.
Secretary—H. E. Beebe, M. D., Sidney.
Treasurer—J. C. Sanders, M. D., Cleveland.

1883

President—C. C. White, M. D., Columbus.
First Vice President—C. E. Walton, M. D., Hamilton.
Second Vice President—W. A. Phillips, M. D., Cleveland.
Secretary—H. E. Beebe, M. D., Sidney.
Treasurer—J. C. Sanders, M. D., Cleveland.

1884

President—J. C. Sanders, M. D., Cleveland.
First Vice President—J. P. Geppert, M. D., Cincinnati.
Second Vice President—M. P. Hunt, M. D., Delaware.
Secretary—H. E. Beebe, M. D., Sidney.
Treasurer—William, T. Miller, M. D., Cleveland.

1885

President—R. B. Rush, M. D., Salem.
First Vice President—G. C. McDermott, M. D., Cincinnati.
Second Vice President—E. R. Eggleston, M. D., Mt. Vernon.
Secretary—H. E. Beebe, M. D., Sidney.
Assistant Secretary—S. R. Geiser, M. D., Cincinnati.
Treasurer—William T. Miller, M. D., Cleveland.

1886

President—H. E. Beebe, M. D., Sidney.
First Vice President—A. Claypool, M. D., Toledo.
Second Vice President—O. D. Childs, M. D., Akron.
Secretary—C. E. Walton, M. D., Hamilton.
Assistant Secretary—H. A. Chase, M. D., Toledo.
Treasurer—William T. Miller, M. D., Cleveland.

1887

President—A. Claypool, M. D., Toledo.
First Vice President—J. W. Clemmer, M. D., Columbus.

Second Vice President—R. N. Warren, M. D., Wooster.
Secretary—C. E. Walton, M. D., Hamilton.
Assistant Secretary—C. L. Cleveland, M. D., Cleveland.
Treasurer—H. Pomeroy, M. D., Cleveland.

1888

President—N. Schneider, M. D., Cleveland.
First Vice President—E. R. Eggleston, M. D., Mt. Vernon.
Second Vice President—J. A. Gann, M. D., Wooster.
Secretary—C. E. Walton, M. D., Hamilton.
Assistant Secretary—M. P. Hunt, M. D., Cleveland.
Treasurer—H. Pomeroy, M. D., Cleveland.

1889

President—C. E. Walton, M. D., Hamilton.
First Vice President—C. L. Cleveland, M. D., Cleveland.
Second Vice President—Frances G. Derby, M. D., Columbus.
Secretary—Frank Kraft, M. D., Sylvania.
Assistant Secretary—C. D. Crank, M. D., Cincinnati.
Treasurer—H. Pomeroy, M. D., Cleveland.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1890

President—John A. Gann, M. D., Wooster.
First Vice Pres.—Orpha D. Baldwin, M. D., E. Portland, Ore.
Second Vice President—C. A. Pauly, M. D., Cincinnati.
Secretary—Frank Kraft, M. D., Sylvania.
Assistant Secretary—C. C. True, M. D., Cleveland.
Treasurer—H. Pomeroy, M. D., Cleveland.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1891

President—E. R. Eggleston, M. D., Cleveland.
First Vice President—O. A. Palmer, M. D., Warren.
Second Vice President—O. D. Childs, M. D., Akron.
Secretary—R. B. House, M. D., Springfield.
Assistant Secretary—T. G. Barnhill, M. D., Findlay.
Treasurer—C. D. Ellis, M. D., Cleveland.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1892

President—C. D. Crank, M. D., Cincinnati.
First Vice President—M. H. Parmelee, M. D., Toledo.
Second Vice President—T. G. Barnhill, M. D., Findlay.
Secretary—Thos. M. Stewart, M. D., Cincinnati.
Assistant Secretary—S. R. Geiser, M. D., Cincinnati.
Treasurer—C. D. Ellis, M. D., Cleveland.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1893

On account of the World's Fair at Chicago, Ill., in 1893, no meeting of the society was held in Ohio. The officers elected the previous year were therefore retained, and the Homeopathic Medical Society of Ohio attended the sessions of the World's Congress of Homeopathic Physicians and Surgeons, held in Chicago, May 24 to June 3, 1893.

1894

President—M. H. Parmelee, M. D., Toledo.
First Vice President—H. B. Van Norman, M. D., Cleveland.
Second Vice President—S. R. Geiser, M. D., Cincinnati.
Secretary—Thos. M. Stewart, M. D., Cincinnati.
Assistant Secretary—A. C. Roll, M. D., Toledo.
Treasurer—R. B. House, M. D., Springfield.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1895

President—R. B. House, M. D., Springfield.
First Vice President—William Watts, M. D., Toledo.
Second Vice President—W. C. Hastings, M. D., Van Wert.
Secretary—Thomas M. Stewart, M. D., Cincinnati.
Assistant Secretary—Frank Kraft, M. D., Cleveland.
Treasurer—T. T. Church, M. D., Salem.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1896

President—W. A. Phillips, M. D., Cleveland.
First Vice President—Thomas M. Stewart, M. D., Cincinnati.
Second Vice President—Emma L. Boice, M. D., Toledo.

Secretary—A. C. Roll, M. D., Toledo.
Assistant Secretary—J. C. Fahnestock, M. D., Piqua.
Treasurer—T. T. Church, M. D., Salem.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1897

President—M. P. Hunt, M. D., Columbus.
First Vice President—W. A. Geohegan, M. D., Cincinnati.
Second Vice President—J. T. Ellis, M. D., Waynesville.
Secretary—A. C. Roll, M. D., Toledo.
Assistant Secretary—R. B. Carter, M. D., Akron.
Treasurer—T. T. Church, M. D., Salem.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1898

President—W. A. Geohegan, M. D., Cincinnati.
First Vice President—R. B. Johnson, M. D., Ravenna.
Second Vice President—F. O. Hart, M. D., West Unity.
Secretary—R. B. Carter, M. D., Akron.
Assistant Secretary—M. P. Hunt, M. D., Columbus.
Treasurer—T. T. Church, M. D., Salem.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1899

President—R. B. Carter, M. D., Akron.
First Vice President—A. W. Reddish, M. D., Sidney.
Second Vice President—Martha Canfield, M. D., Cleveland.
Secretary—A. B. Nelles, M. D., Columbus.
Assistant Secretary—G. D. Grant, M. D., Springfield.
Treasurer—T. T. Church, M. D., Salem.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1900

President—C. E. Sawyer, M. D., Marion.
First Vice President—F. W. Morley, M. D., Sandusky.
Second Vice President—Laura C. Brickley, M. D., Cincinnati.
Secretary—A. B. Nelles, M. D., Columbus.
Assistant Secretary—G. E. Wilder, M. D., Sandusky.
Treasurer—T. T. Church, M. D., Salem.
Necrologist, D. H. Beckwith, M. D., Cleveland.

1901

President—J. W. Means, M. D., Troy.
First Vice President—C. A. Pauly, M. D., Cincinati.
Second Vice President—L. K. Maxwell, M. D., Toledo.
Secretary—A. B. Nelles, M. D., Columbus.
Assistant Secretary—C. E. Silbernagel, M. D., Columbus.
Treasurer—T. T. Church, M. D., Salem.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1902

On account of the meeting in Cleveland of the American Institute of Homeopathy, no meeting of the State Society was held in 1902. The officers elected the previous year were retained and the members attended the sessions of the Institute in June.

1903

President—Thos. M. Stewart, M. D., Cincinnati.
First Vice President—G. D. Grant, M. D., Springfield.
Second Vice President—J. P. Hershberger, M. D., Lancaster.
Secretary—A. B. Nelles, M. D., Columbus.
Assistant Secretary—C. E. Silbernagel, M. D., Columbus.
Treasurer—T. T. Church, M. D., Salem.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1904

President—W. B. Carpenter, M. D., Columbus.
First Vice President—J. H. Wilson, M. D., Bellefontaine.
Second Vice President—Katherine Kurt, M. D., Akron.
Secretary—C. E. Silbernagel, M. D., Columbus.
Assistant Secretary—M. P. Hunt, M. D., Columbus.
Treasurer—T. T. Church, M. D., Salem.
Necrologist—D. H. Beckwith, M. D., Cleveland.

1905

President—J. H. Wilson, M. D., Bellefontaine.
First Vice President—Sara E. Fletcher, M. D., Columbus.
Second Vice President—J. A. Mitchell, M. D., Newark.
Secretary—C. E. Silbernagel, M. D., Columbus.
Treasurer—T. T. Church, M. D., Salem.
Necrologist—D. H. Beckwith, M. D., Cleveland.

MEMBERS.

A

NAME.	LOCATION.	ADMITTED.
Allen, Alice Gillespie,	Columbus, 203 West Goodale Street,	1898
Allen, H. C. (Honorary),	Chicago, Ill., 5142 Washington Avenue,	1883
Ames, C. S.,	Ada,	1894
Arndt, G. D.,	Mt. Vernon,	1896

B

Baldwin, H. D.,	Elyria,	1900
Baldwin, Wm. M.,	Newark,	1903
Baldwin-Bruce, Orpha D.,	Tampa, Fla., 1032 Florida Avenue,	1887
Ballard, A. N.,	Birmingham, Ala.,	1877
Banning, Carina, B. C., B. S.,	Fort Wayne, Ind., 181 Clinton Street,	1895
Banning, Edward P.,	Fort Wayne, Ind., Box 364,	1895
Barnhill, J. W.,	Napoleon,	1898
Barnhill, T. G.,	Findlay,	1875
Bashore, J. I.,	Tippecanoe City,	1899
Baxter, H. H.,	Cleveland, 275 Prospect Street,	1868
Beckwith, D. H.,	Cleveland, 94 Dorchester Avenue,	1864
Beckwith, S. R.,	New York, N. Y., 170 Fifth Avenue,	1864
Beebe, H. E.,	Sidney,	1873
Benson-Silber, Martha E.,	Akron, 326 South Main Street,	1898
Biggar, H. F.,	Cleveland, 260 Euclid Avenue,	1867
Biggar, H. F., Jr.,	Cleveland, 260 Euclid Avenue,	1903
Bishop, H. D.,	Cleveland, 89 Euclid Avenue,	1894
Blackburn, W. J.,	Salem,	1895
Brenizer, N. O.,	Austin, Texas,	1888
Brickley, Laura C.,	Cincinnati, Cor. Chase and Hamilton Aves.,	1888
Bryant, Susannah L.,	Columbus, 859 Oak Street,	1903
Buck, Charles R.,	Cincinnati,	1904
Buck, J. D.,	Cincinnati, 605 Traction Building,	1869
Budde, Charles H.,	Dayton,	1904
Burnham, J. E.,	Prairie Depot,	1904

C

Cameron, G. D.,	Chagrin Falls,	1899
Canfield, Martha A.,	Cleveland, The Rose Building,	1877
Carpenter, W. B.,	Columbus, 657 North High Street,	1883
Carter, R. B.,	Akron,	1887
Chapman, E. K.,	Defiance,	1894
Chapman, Harriet B.,	Cleveland, 810 Rose Building,	1898
Cheatham, Elizabeth C.,	Marion,	1903
Childs, O. D.,	Akron,	1899
Church, T. T.,	Salem,	1886
Clark, G. E.,	Stillwater, Minn.,	1883
Claypool, Albert (Honorary),	Toledo, 711 Madison Street,	1877
Clemmer, J. W.,	Columbus, Parsons and Franklin Avenues,	1884
Coffeen, C. R.,	Piqua,	1882
Cook, J. H..	New Carlisle,	1892
Cooke, Clara E.,	Portsmouth,	1903
Cory, Kate Whipple,	Barberton,	1897
Crank, C. D.,	Cincinnati, 231 Auburn Avenue,	1877

NAME.	LOCATION.	ADMITTED.
Crismore, James M.,	Helena,	1886
Cummer, R. J.,	Cleveland, 531 Permanent Building,	1895
Curtis, H. M.,	Marietta,	1895
	D	
Darby, E. A.,	Northampton, Mass.,	1894
Dewey, W. A. (Honorary),	Ann Arbor, Mich.,	1898
Dudley, Mrs. Maurice,		
	E	
Eggleston, E. R.,	Mt. Vernon,	1877
Ehrmann, George B.,	Cincinnati, 28 East Seventh Street,	1898
Elliott, A. E.,	Lodi,	1900
Ellis, J. T.,	Waynesville,	1895
	F	
Faulder, H. B.,	Sidney,	1901
Fawcett, J. M.,	Wheeling, W. Va., Cor. Market and 7th Sts.,	1892
Ferris, Charles,	College Hill,	1896
Ferris, Jacob,	College Hill,	1889
Finke, F. W. D.,	Cleveland, 610 Rose Building,	1903
Fletcher, Sara E.,	Columbus, 338 East State Street,	1897
Forward, C. B.,	Cleveland, Williamson Building,	1895
Fowler, E.,	Cleveland, 1439 Broadway,	1868
Frost, W. A.,	Tecumseh, Mich.,	1881
	G	
Gaston, James E.,	Wilmington,	1904
Geiser, S. R.,	Cincinnati, Cor. Seventh and Race Streets,	1880
Geohegan, William A.,	Cincinnati, 918 Hawthorne Ave., Price Hill,	1889
Georgi, Sophia E.,	Cincinnati, 1634 Pullan Avenue,	1903
Gillard, Edwin,	Sandusky, 423 Columbus Avenue,	1875
Gillard, E. E.,	Rock Creek, Ashtabula County,	1898
Ginn, Curtiss,	Dayton,	1899
Grant, George D.,	Springfield,	1881
Graybill, J. D. (Honorary),		1882
Griggs, O. P.,	Ashtabula, 207 Main Street,	1885
	H	
Hadley, W. A. M.,	Springfield,	1903
Haggart, G. B.,	Alliance,	1901
Hall, Edward M.,	Delaware, 18 West Winter Street,	1873
Hastings, W. C.,	Seattle, Wash., Suite 28, Downs Block,	1887
Hatch, H. S.,	Madison, Ind.,	1892
Hershberger, J. P.,	Lancaster,	1887
Hetherington, Clark E.,	Piqua,	1903
Hills, H. B.,	Youngstown, 31 West Wood Street,	1889
Hinsdale, W. B.,	Ann Arbor, Mich.,	1890
Hodson, George S.,	Washington Court House,	1898
Horner, J. Richey,	Cleveland, 275 Prospect Street,	1898
House, R. B.,	Springfield, 108 East High Street,	1881
Howard, Elmira Y.,	Palmyra, Mo.,	1871
Hoyt, C.,	Chillicothe, 39 South Paint Street,	1882
Hoyt, William,	Hillsboro,	1871
Hughes, C. W.,		1897
Humphrey, W. A.,	Toledo,	1904
Hunt, Ella Grace,	Cincinnati, 608 West Eighth Street,	1899

NAME.	LOCATION.	ADMITTED.
Hunt, H. E.,	Newark,	1900
Hunt, J. S.,	Santa Monica, Cal.,	1896
Hunt, M. P.,	Columbus, 208 East State Street,	1881
Hurlburt, J. W.,	Uniopolis,	1900
	I	
Ireland, Charles L.,	Columbus, 942 North High Street,	1900
	J	
Jewitt, E. H.,	Cleveland, 484 The Arcade,	1887
Johnson, R. B.,	Riverside, Cal.,	1869
Jones, G. J.,	Cleveland, 5 Rockwell Street,	1873
Junkerman, C. F.,	Lancaster,	1903
	K	
Keiser, Romeo O.,	Columbus, 54 North Washington Avenue,	1901
Kilgour, P. T.,	College Hill,	1892
King, John C.,	Banning, Cal.,	1883
King, Julius,	New York, N. Y.,	1884
Kirk, Ellen M.,	Cincinnati, 169 West Seventh Street,	1880
Kraft, Frank,	Cleveland, 57 Bell Avenue,	1888
Kurt, Katherine,	Akron, 113 South Broadway,	1895
	L	
Laronge, L.,	Cleveland,, 197 Superior Street,	1894
Lee, Frank C.,	Fullertown,	1903
Lehman, F. P.,	Sandusky,	1900
Logee, H. M.,		1877
Loomis, F. R.,	Jefferson,	1886
Loy, E. N.,	Troy,	1901
Lunger, J. S.,	Prospect,	1894
Lyons, Matilda J.,	Cadiz,	1904
	M	
McCann, T. A.,	Dayton,	1896
McClure, S. D.,	Newark,	1901
McClure, W. B.,	Martin's Ferry,	1896
McCormick, A. L.,	Cincinnati, 3110 Woodburn Ave., Waln't Hills,	1885
McCleary J. R.,	Marietta,	1904
Maxwell, L. K.,	Toledo, 1615 Twenty-second Street,	1891
Mead, J. S.,	Lorain,	1900
Meade, C. C.,	Cincinnati, 4226 Hamilton Avenue,	1896
Meade, S. J. D.,	Cincinnati, 417 Everett Street,	1889
Meader, Lee Douglass,	265 Gilbert Avenue,	1895
Means, J. W.,	Troy,	1896
Miller, H. T.,	Springfield, 113 East High Street,	1895
Miller, John M.,	Springfield, 113 East High Street,	1882
Miller, W. T.,	Cleveland, 260 Euclid Avenue,	1879
Mitchell, J. A.,	Newark,	1898
Mohn, D. L.,	Ashland,	1896
Monroe, A. L. (Honorary),	Louisville, Ky.,	1889
Munns, C. O.,	Oxford,	1885
Murphy, Frank W.,	Dayton,	1899
	N	
Nelles, A. B.,	Columbus, 198 East State Street,	1896
Norris, J. C.,		1886