

## ***DIET IN TUBERCULOSIS,***

BY H. W. WILEY, M. D.

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I think it may be safely said at the beginning that there is no particular diet which may be regarded as curative or even prophylactic in respect of tuberculosis. In so far as diet, in any of its modifications, may give better health and thus better resistance power to the system it is useful as a prophylactic and as a remedy for tuberculosis. It is evident, however, that no form of diet, no matter how nutritious and digestible, could withstand the steady inroad upon health and vigor which the diminishing capacity of lung surface induces during the progress of the disease. The object of the physician in so far as diet is concerned therefore should be to suggest and recommend that menu which is best suited to each individual patient. There are some forms of nutriment, however, which have deservedly won a high place in the nutrition of those afflicted with this dread disease. Among the first of these may be mentioned the oils and especially cod liver-oil. A close second to cod liver oil is olive oil and in some cases I doubt not it would prove superior, especially in those cases where

cod liver oil is distasteful to the patient or produces any unpleasant consequences. In several cases of digestive inefficiency which have come under my own observation and where I have recommended the use of olive oil, very happy results have been secured. These, however, were not patients affected with tuberculosis but only incipient indigestion.

Oil of the class mentioned are chiefly useful by their faculty of being transformed into heat and energy. They have little or no nitrogenous elements and, therefore, are not suitable for the nourishment of any of the nitrogenous tissues of the body. They are, as a rule, quickly and easily digested and furnish an abundant amount of heat and energy: It is claimed for cod liver oil that it contains some of the most valuable medicinal agents known to man. Among these may be mentioned iodine which exists in very minute traces and can not be detected by incineration of the oil or by saponification and subsequent decomposition with acids, but only by saponification and incineration of the residual soap. These data show that iodine, if present at all in cod liver oil, is not in the free state nor as a metallic iodine, but probably in some organic combination. Bromine is also said to exist in small quantities in cod liver oil but the quantities which are found are extremely minute and probably would escape all ordinary methods of detection. Chlorine is present in quantities which can be estimated and probably amount to a little over 1/15 of one percent. The phosphoric acid which cod liver oil contains must be regarded as one of its most valuable constituents although it is present in minute quantities, probably not much over 0.05 of one percent. Both the phosphoric acid and sulphur which are found in cod liver oil probably exist chiefly in the organic state. It will be useless in this connection to try to enumerate all of the various constituents which it is alleged have been found in cod liver oil. I have before me an analysis of a cod liver oil in which 51

different substances are found. It must, of course, be admitted without question that this oil does contain a number of these organic compounds to which I have alluded and also many inorganic substances, and these, individually and as a whole, doubtless contribute much to the efficacy of this long used and highly valued food and remedy. The bulk of cod liver oil, as is recognized by every one, is ordinary olein which forms the bulk of the other edible oils, and it is to olein, therefore, that the chief food value of oil must be attributed. The effect of other constituents must be regarded solely as remedial. I think it would be advisable for physicians to try, more extensively, olive oil and other vegetable oils in disease of this kind. The other food material which has justly attained a high position as a nutriment for persons troubled with tuberculosis is alcohol. Alcohol is exhibited in a great many combinations, rarely as pure ethyl alcohol. More commonly it is used in the form of beer, wine, whisky and brandy. In the case of beer and wines there are other constituents which must not be neglected in regard to their food value, commonly known as extractive material. They consist largely of carbohydrate bodies and also contain a certain amount of albuminous constituents. Organic acids are also present either as free acid or as salts, and in wine this is especially true of tartaric acid and its salts. Tannin is also one of the essential constituents of wine and in beer the bitter principle derived from hops must be assigned a certain value.

When I speak of whisky I mean what is known as straight whisky, that is, the distillate from the fermented mash of cereals, stored in wood until properly aged. This again, according to general opinion, removes the greater part of so-called fusel oils, converting them into ethers and into aromatic substances which give to whisky its aroma and flavor. It is claimed by some that this oxidation of the higher alcohols does not take place during again, at

least not to the extent commonly supposed. In whisky, however, the chief element to be considered is ethylic alcohol. It has been shown that the human organism in a state of health is capable of oxidizing and converting into energy a considerable quantity of ethyl alcohol daily. In a debilitated state the quantity which could be absorbed and digested would be less. In many maladies whisky and brandy have apparently been used to great advantage and doubtless such is the case in tuberculosis. It may be stated in this connection that the alcohol, as is true of oil, is readily and quickly absorbed and before becoming oxidized into water and carbon dioxide, it produces a gentle stimulation which seems to favor the general metabolic process. It thus has a double value arising first, from stimulation, and second, from its food effects.

By brandy I mean the product of the distillation of wine, stored in wood, as in the case with whisky, until properly aged. Unfortunately, as we know, many of the brandies of commerce are anything but what they claim to be, just as whisky of commerce is often made artificially by means of mixing pure alcohol with essences, coloring matter, prune juice, straight whisky and other ingredients.

I do not want to make any invidious comparisons in this place between the two kinds of whisky and the two kinds of brandy mentioned above, only it seems but fair that the medical profession, in prescribing whisky or brandy, should be reasonably certain of the character of the material which patients are to use.

In the way of general diet for those afflicted with tuberculosis, little can be said. Every case must be studied particularly in this selection. Any single form of diet which might be prescribed, while useful to many, would perhaps be very distasteful to other patients. It seems to me that what the patient likes, if it be nutritious, is what

he should have. It does not appear to be essential to force a patient to eat an article of food which he positively dislikes. The mental attitude which he assumes in relation to such a food would certainly be unfavorable to its maximum good effect. Naturally those articles of food which are easily digested commend themselves most of all. Milk, eggs, rare cooked meats, soups, fruits, vegetables and wholesome bread, not excluding game, fish, oysters, ect., furnish a list from which the physician and the patient should be able to select a nutritious and palatable diet. I have little confidence in any set form of diet which could be applied in general, just as one formula for a fertilizer might be very suitable for one field and not for another. Good sense, good judgment and a knowledge of the character of material at hand will lead to the right results.

In this connection I beg to call attention to the fact that the adulteration of foods which are to be used by invalids is utterly reprehensible. The presence of antiseptics in such food might be very disastrous and artificial coloring matter and a cheaper substance added in place of a more expensive one are also extremely reprehensible. Every food product which a physician prescribes for his patient should be pure as well as wholesome.

The value of a correct diet is acknowledged by all. It may tide a patient over a crisis by giving strength to overcome the predatory character of the disease.

It is probably true that tuberculosis can not be cured, but the physician may so conduct affairs that the patient gets well and this is almost as good as curing the disease.

## **THE ACQUISITION**

OF SYPHILIS EXTRAGENITALLY BY MEDICAL MEN BY  
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The object of this paper is to present in as realistic a manner as possible a danger to which medical men are continually exposed, and to draw attention to the indifference they exhibit toward the terrible calamity of infection by syphilis.

I shall never forget the impression one of my friends made on me. I sent him a patient with epithelioma of the tongue, but warned him that the man was suffering from secondary syphilis with mucous patches in the mouth. He took the information so coolly that I said, "Are you not at all afraid to operate on such people?" He said in reply, that he would operate on a man with early syphilis as readily as on any other.

It was a charity case, yet this surgeon was willing to take the risk of being inoculated by the sputum or by a bite, not through conscientiousness, nor even from bravado, but because the possible consequences seemed not

to appeal to his imagination, and he was willing to run the risk of bringing to his family the malady that has more ways of tormenting the human race than any other in the round of medicine.

Not long before I had seen a very dear friend stricken down in the midst of an active surgical career, and in a couple of years transformed from a purposeful, decided operator into a palsied aged man, quickly to die.

The accidents strike medical men much more frequently than personal experience or statistical data indicate. By far the greatest number of infections would appear to occur in surgeons, especially in genito-urinary surgeons. It is the old story of handling edge tools, with, in addition, a most virulent poison awaiting a favorable point of inoculation. Next to surgeons come obstetricians and gynecologists, while the remaining infections are scattered promiscuously throughout the other branches of our profession.

The following list consists of seven cases. In two the virus was inoculated in cuts received while operating on patients suffering from syphilis.

The first was a physician, about 36 years of age, from one of the Middle States who while on a short visit to San Francisco, broke out with a severe rash. I found a macular syphilide of the trunk, limbs, face, palms and soles. Both epitrochlear lymphatic nodules in the left axel.

He then gave the following history: Seventy-two days previously while circumcising a man suffering with chancre of the foreskin, he slightly wounded himself on the outer side of the left forearm a little above the wrist. Sixteen days after the operation, an ulcer covered by a black scab appeared in the situation of the wound. This scab annoyed him while on the train by the edge of his cuff catching in it. The lymphatic nodules at the elbow and in

the left axel then began to swell, and the rash developed. in due course, When he called on me there was a dark red spot, the size of a nickle where the ulcer had been.

Another physician, a man thirty-one years of age, came to me on account of a widely spread papulo-roscolar rash. He said that three months before, while removing the breast of a woman of 47 years of age, for what was supposed to be a cancer, he stuck himself with a knife under the nail of the left ring finger. The finger afterwards had felt a little sore, but no serious trouble arose for about two weeks. He then got an atrocious pain under the nail, with swelling and redness, followed in a short time by terrific headaches, which endured up till the the time I saw him. The roseolar rash developed about six weeks after the operation.

Such experiences teach the value of thoroughly washing off and burning out every wound received while operating on any case where there is the least suspicion of the presence of syphillis.

The rending pain above referred to is a usual occurence in chancre involving the nail bed, and the doctor's conversation while under its stress could not be said to be without sin. Yet considering the provocation, one could say it was without reproach before men. Another acquaintance who inoculated himself while operating for phimosis, and whose chancre also involved the nail bed, stilled his pain by bathing the finger in a strong solution of carbolic acid. He never grew tired of reiterating the expression of the relief it gave him.

One of my patients was infected while attending the confinement of a woman who neither in her own person nor in that of her newly born infant showed the least sign of syphillis.

The physician in this case was a man of fifty years of



age, who came to me on account of an ulcer over the joint between the first and second phalanx on the radial side of the left index finger. This ulcer was crusted and had a dark red, raw ham colored, rolled, unfiltrated border. There was no enlargement of the epitrochlear lymphatic nodule, or of those in the axel. He said that fifty-seven days before, he had been bitten by a pet parrot, and that the wound had never healed. He was able to precisely fix the date of the bite by coincident events.

The discharge from the ulcer was examined for tubercle bacilli, but fruitlessly, and then our ingenuity was taxed in trying to guess out the nature of the lesion.

I did not then know that there could be a well developed chancre of the finger without demonstrable swelling of the epitrochlear lymphatic nodule or those in the axel. To further complicate the diagnosis, the next day after first seeing him, the doctor got swelling and redness of the entire back of the hand with streaks of lymphangitis running up the forearm.

Thirty days after I first saw him; a papulo-roseolar rash appeared on the free cutaneous surface with roseolar spots in the palms and soles, and a slight enlargement of the lymphatic nodules developed in the left axel. These symptoms of course cleared up the diagnosis. Shortly afterwards he got mucous patches in the mouth. The following history then came to light:

The doctor had been bitten, as he said, by a pet parrot and three days afterwards he was called to a confinement. The patient as before mentioned, showing no signs of syphilis. The doctor thought he had his wound perfectly sealed with collodion and cotton. The child born seemed perfectly healthy, but shortly after birth developed well marked symptoms of syphilis. As far as the mother and child are concerned, this absence of symptoms at the time

of confinement is not uncommon. It is one of the traps that a doctor may fall into.

This is a good demonstration of the ineffectiveness of the old method of protecting wounds on the hands with collodion and cotton. In all probability this infection would not have occurred in an equally careful practitioner if the present thin rubber finger cots had been available.

We can also draw another moral from the case, for it shows the danger a doctor runs in playing with pets. And how enticing it is! I, myself, can hardly refrain from playing with a kitten, although I have constantly present in mind the dangers arising from scratches on the hands.

According to the literature, obstetrical manipulations afford, as one would suppose they would, a favorable opportunity for infections of this sort. The woman is young and in the midst of her sexual life, and therefore if she is to have syphilis; will likely have it then. Two of the ten cases reported by Brandis were acquired while attending woman in confinement. In these two instances the fruit was born dead, and the mothers subsequently suffered from condylomata of the genitalia. (1)

In Prince A. Morrow's list of ten cases of professional syphilis, seven ascribed their infection to digital examinations or manipulations in obstetrical or gynecological work. (2)

Gynecologists, especially when examining the Pandoras that frequent the public clinics, continually run a considerable risk of acquiring syphilis. The following is a good example of this class of misfortune:

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(1) Syphilis Gravis in Medical Men by Dr. Brandis. Deut. med. Wochensch. 1891. No. 21, Abstr. in Brit. Journ. of Dermat. 1899, p. 210.

(2) Jour. of Cutaneous and Genito-Urinary Diseases 1896, p. 125.

A medical student, 25 years of age, asked my advice in regard to a dark red, lenticular, ten-cent-piece-sized, fairly firm lesion, situated on the dorsal surface of the web between the right index and middle fingers. This first appeared about two months before consulting me, as a flat dark papule. About forty days after this lesion was first noticed he became aware of three enlarged lymphatic nodules in the right axel, a large one and two small ones. Eighteen days after this a roseolar rash appeared on the arms, trunk and thighs.

He had examined a woman in the gynecological clinic, who was suffering from early constitutional syphilis, and the situation of the chanere was correspondent to the manner of inoculation.

Later he had mucnos patches in the mouth.

In such clinics there should always be an abundance of vaseline or some other heavy fat to thickly anoint the hands before examining a patient. Rubber gloves are, of course, too expensive to come into general use, and besides they interfere with the sense of touch. All wounds or scratches on the hands should be carefully guarded, and, of course, on the least suspicion no one having a fresh wound should examine a patient. But, as a matter of fact very few doctors and still less medical students, will refrain from making an examination through fear of contaminating themselves through a wound.

A number of medical men get chancres of the hands and fingers without being able to indicate any more precisely the mode of acquiring the disease than that they had attended a patient having syphilis. I have had three such cases.

A doctor, thirty-five years of age, consulted me for a papulo-squamous syphilide of the trunk and limbs. The site of the initial lesion could be easily made out, as a dark red macule toward the radial side of the dorsal aspect of

the lower third of the right forearm. Besides the rash, there was a universal adenopathy, and a slight sore throat. The doctor said that he had attended a patient having syphilis over four months previously, and that the lesion on the arm had manifested itself about two months previously, and that the lesion on the arm had manifested itself about two months after attending this patient. The dates could not be precisely given.

Another physician, twenty-six years of age, consulted me on account of a chancre of the left side of the lower lip. He said he had first noticed it in a "cold sore" about two weeks previously. Some time before he had been treating a patient who was suffering from what he thought to be chancroid, but which turned out to be a chancre. He probably infected his "cold sore" by thoughtlessly touching it after having handled the patient's lesion.

He showed a roseola of the trunk with papular syphilitides of the palms, soles and penis, and enlargement of the lymphatic nodules corresponding to the sore on the lip. He afterwards developed mucous patches in the mouth.

A physician, 29 years of age, consulted me on account of an ulcer, about the size of a nickle, showing profuse granulations and a dark red border, situated on the radial side of the terminal phalanx of the right index finger. There was no lymphatic engorgement, either at the elbow or in the axel.

He said that a swelling had appeared in this situation exactly one month before. Afterwards it broke down into an ulcer, and previous to coming to me it had been curetted. He also said that two months previous to consulting me, that is, one month before the appearance of the lesion, he had treated a patient with phimosis. In the absence of lymphatic engorgement, a diagnosis of chancre could not be made. Fifteen days after I first saw it, that is to say a month and a half after the appearance of the lesion, a

roseola broke out on the patient's belly. Two days afterwards a slight swelling of the right epitrochlear lymphatic nodule was noted, and for a few days he had a temperature running from 99 1-2 to 100.

Such cases show the value of always washing the hand after touching a patient so that the custom will harden down into an involuntary habit. A slight rinsing is usually sufficient. It is well not to make it too elaborate or it will not be done except on great occasions, and it is the apparently slight occasion that one has to be on one's guard about. A dilution of the syphilitic virus of 1 to 500 is enough to render it innocuous. (1)

Another excellent rule is to carry a couple of rubber finger cots in a little box in the vest pocket. Any of those little tin boxes that patent or proprietary medicine houses shower down on us will do admirably for the purpose. If you do not happen to like the advertisement on the back, scratch it off with your pen knife.

(1) Pospelow Arch. f.Derm. u. Syph. 1899. S. 92.

Pelizzari relates a case exactly in point. An aged male nurse while assisting a surgeon in removing some vegetations from a syphilitic woman, soiled his hand in the blood. He did not immediately wash, and acquired a chancre of the hand.

An. de Derm. et de Syph. Serie II Tome IV, page 14.

That such a washing may be ineffective goes without saying for we have to do with an extremely virulent poison. Fournier relates that he had seen five chancres of the eye in medical men caught from sputum ejected from the patient, three of them washed their face well after the accident, but this did not prevent the chancre appearing. He advises using, instead of water, bichloride of mercury solution, (1-1000).

Les Chancres Extragenitiaux, p. 194-195-196.

The objection to the routine use of strong antiseptic solutions is that one may run into the danger one attempts to escape, for, as pointed out by Taylor, their employment by causing eczema and fissures, exposes to the risk of infection.

R. W. Taylor Journal of Cut. and Genito-Urinary Diseases, 1898 p. 339.

In the above seven cases one of the chancres was situated on the lower lip, and the other six were on or near the hands where one would expect to find them. Of these six, three occurred at or near the index finger, and in all of these six cases the initial lesion was situated on the dorsal or lateral aspect, none on the palmar aspect of the extremity.

Chancres of the fingers are relatively rare, and they almost always occur in physicians. All of my cases except two of chancre in this situation were in medical men, and of forty-nine cases that Fournier has seen, thirty were practitioners of medicine. Twenty of them were in physicians and surgeons, three were in medical students, who were attending genito-urinary clinics, and the remaining seven were in obstetricians. (1)

According to the literature the index finger is the most frequently attacked (2). Next in order comes the middle finger. The thumb and the little finger seem to be the next most exposed, and the ring finger is rarely attacked. One of the dangers the middle finger seems to lie in its being allowed to rest on the lower lip while an instrument is being held in the mouth of a syphilitic patient (3), or on the external genitalia, when the index is inserted into the vaginal canal.

Cancre of the eyes is also a relatively rare affection, but the proportion of medical men getting it on patients

[1] Les Chancres Extra-Genitaux par A. Fournier page 447—450.

(2) In all of Brandis' ten cases the chancre was situated on either the index or medius. Syphilis Cravis in Medical Men, by Dr Brandis.

In a list of ten cases of professional syphilis given by Prince A. Morrow, five of the chancres were situated on the index finger. Journal of Cut, and Genito-urinary Diseases, 1896, y. 125.

(3) Whitehouse Journal of Cutaneous and Genito-urinary Diseases, 1898 p. 330.

belonging to other classes is as one to fifteen. (1) The infection is usually transmitted through sputum during the examination or treatment of syphilitic patients. Many of them are unable to resist a sudden attack of coughing, which sends out a spray of infected saliva into the doctor's face. Fournier has reported five such cases. (2) Debeck has reported six cases of chancre of the eye, three of whom were in midwives. They were infected either while cauterizing lesions in the mouth of their patients, or by inoculating themselves with their fingers after having handled specific lesions. (3)

Unless it is imperatively necessary to do so, a doctor should not stand or sit squarely in front of a patient while examining the mouth or throat.

Usually one can see the mouth and that part of the pharynx directly in view, by standing beside the patient and looking into the mouth as one would look around a corner. In such a position one can quickly dodge if the patient spits or coughs.

One rubs one's eyes several times a day, and this is usually done with the finger tips. A doctor, however, should train himself to rub his eyes with the knuckle of his index finger, as being less likely to be soiled with infectious material. Picking the nose should also be avoided by physicians as apt to convey infection.

We may here stop to speak of a most disagreeable habit that George Washington mentions in his rules on

(1) Les Chancres Extra-Genitaux par A. Fournier page 194, 195, 196.

(2) Idem.

(3) Chancres of the eye in Medical Men by Dr Debeck. Contributions from the Ophthal. Clinic, Medical College of Ohio, 1888. Abstr. In Annales de Derm. et de Syph. L. 11, t. VIII, p. 208.

conduct. Some people have a great desire to approach as near to you as possible while speaking, and their sputum often squirts and sputters into your face. I never yet have found that my shrinking back and half turning away had any effect on those confidential talkers, and the only means of penetrating their obtuseness is by a distinct reprimand

Several curious ways of doctors acquiring syphilis have been reported, as, for instance, holding between the lips a pen which had been soiled by the fingers after examining syphilitic ulcers. Otis mentions a case of a physician who got an initial lesion just within the right angle of the mouth, attributed to smoking a syphilitic friend's pipe. (1) This might be denoted as a case of unprofessional syphilis. Just think of a doctor using another man's pipe!

C. W. Allen mentions syphilis as being caught by performing insufflation on syphilitic newborn. (2) This is carrying life saving a trifle too far.

Three cases, in Dr Brandis' list of ten, previously mentioned, were attributed to digital exploration of the rectum, two followed wounds received while opening septic buboes, and one occurred after an operation in a case of necrosis of bone. (3)

Taylor has reported two cases and Matrow one where the infection was from the cadaver.

(1) Cullerier's Atlas of the Venereal Diseases, page 43. Translated by Bumstead.

(2) Prof. Bergh's brochure. Quoted by Dr C. W. Allen in a letter from abroad to the editor of the Journal of Cut. and Genito-urinary Diseases, 1888, p. 394 Fournier relates the case of a midwife who became infected in this way, and also cites a case reported by Wigglesworth. [Archives of Dermatology, 1879 p. 374] Where a physician got a chancre of the tonsil through performing insufflation.

Les Chancres Extra-génitiaux, par Alfred Fournier, p. 39.

(3) Syphilis Gravis in medical men, by Dr Brandis. Vide Supra.



Taylor first case was a young physician who infected himself while making a post mortem examination, held eight hours after death on the body of a patient who died from malignant syphilis. The chancre was located on the left middle finger. (1) Taylor's second case was of a physician, twenty-six years of age, who infected himself while making an autopsy nine hours after death, on the body of a prostitute. His chancre was located on the finger. (2)

Dr. Morrow's patient was a physician who got his chancre on the terminal phalanx of the left index finger. (3)

At one time it was a current belief that syphilis acquired extra-genitally was particularly severe in its subsequent manifestations. All of the men, the subject of the present paper, were in good health at the time of their infection, were from twenty-six to fifty years of age, and their syphilis, as it afterwards developed, appeared in no way to differ from that caught genitally. The doctor who came to me from The Middle States caught his disease from a patient who went on to have a most malignant syphilis, yet the doctor's infection ran a rather mild course. The doctor attributed the patient's severe syphilis to bad habits and a bad constitution. (4)

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(1) Some unusual modes of infection with Syphilis by R. W. Taylor *Journal of Cutaneous and Genito-Urinary Diseases*, June 1890.

[2] *Idem*.

[3] Prince A. Morrow, *Journal of Cutaneous and Genital-Urinary Diseases*, 1898 p. 541.

[4] Dr Brandis in reviewing ten cases of syphilis in medical men caught extragenitally, says that the subjects were all in robust health, from thirty to fifty years of age, and their syphilis ran the usual course. *Syphilis Gravis in medical men* by Dr Brandis. *Vide supra*.

These observations were made in Aix-la-Chapelle.

If this paper will cause any one man reading it to become more careful of himself in the handling of those dangerous cases, and so lead him to escape an infection that he otherwise might have had, it will have fulfilled its purpose.

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## **EXTRACTOS AZUCARADOS**

POR C. GILBERT WHEELER, DE CHICAGO.

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En los extractos azucarados se encuentra un nuevo sistema de medicación, que es seguro y preciso para los médicos, elegante y conveniente para los farmacéutas. Estas preparaciones contienen simplemente la sustancia extraída de la droga respectiva, triturada con azúcar de leche, en la proporción que un gramo del extracto corresponda á un gramo de la droga cruda.

### VENTAJAS DE ESTOS EXTRACTOS PARA LOS MÉDICOS.

El valor farmacéutico de un extracto fluido depende del extracto seco ó sólido que la solución contenga en relación con la droga cruda. Esta cantidad de extracto sólido depende de la proporción de agua que tenga la droga, de su naturaleza, de la más ó menos extracción completa, de la relación que la droga tenga con el vehículo que se haya empleado. En los extractos azucarados toda variación en el valor terapéutico está evitado por la evaporación en una temperatura bien regulada, anotando al mismo tiempo el por ciento del extracto sólido que haya resultado. Este

extracto sólido está después mezclado con suficiente cantidad de azúcar de leche para obtener un producto que deba pesar lo mismo que la droga empleada, para hacer el extracto líquido. La eficacia del azúcar de leche como agente para modificar el sabor amargo de varias medicinas, lo mismo que la acción preservativa é inofensiva de la misma, hace que el azúcar de leche sea considerado como uno de los mejores medios para la administración de las medicinas.

Para evitar la variación frecuente de los extractos que contienen principios activos (Aconito, Nux Vomica &c) se hace un ensayo para determinar los alcaloides ó principios activos que existen en los extractos azucarados y que deben tener una fuerza fija. Este ensayo se encuentra indicado en la etiqueta.

La preferencia que los extractos azucarados tienen entonces sobre los extractos fluidos, es clara, teniendo en cuenta su estabilidad, su uniformidad, calidad, su poco sabor, el no tener alcohol y la aplicación general á cualquier método de administración.

Estos extractos representan el valor total de la droga, con más exactitud que los mejores extractos fluidos. Porque en la manera de extraerlos, se continua la operación hasta no encontrar materia que deba ser extraída. La cantidad del excipiente no se limita como en los procedimientos oficiales de las distintas farmacopeas y por eso la solución que se obtiene siempre es completa.

En los extractos azucarados, los principios activos se hallan pulverizados y de este modo, no pueden precipitarse ó evaporarse, como suele suceder con los extractos fluidos, á la vez pueden conservarse mejor debido á la acción anti-séptica y preservativa del azúcar de leche.

De acuerdo con la opinión emitida por las autoridades más altas sobre la materia, los extractos fluidos son de

fuerza variable y con el tiempo perderán algo de su valor original.

En los extractos fluidos, las sustancias que entran en su composición á veces se precipitan y esta es la razón por que los extractos á veces pierden su eficacia. Debido á la manera de fabricación de los extractos azucarados, estos siempre representan la misma fuerza y calidad. No sucede lo mismo con los extractos fluidos, donde la fuerza varía por el deseo de obtener preparaciones más elegantes. El hecho es bien conocido entre los farmacéutas.

Los extractos azucarados poseen sobre la etiqueta no solamente el por ciento del extracto sólido, sino también los alcaloides presentes, de manera que el valor respectivo pueda ser comparado. La mayoría de estos extractos son solubles en agua, y aquellos otros que no lo son, debido á la materia resinosa que contiene en solución, quedan en suspensión, debido al azúcar de leche.

Estos extractos son muy recomendados para los países cálidos, donde los extractos se precipitan debido al calor.

## ***THE MEDICAL TREATMENT***

OF TUBERCULOSIS; BY JESSE SHOUP, M. D., WASHINGTON, D. C.

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A history of the medical treatment of tuberculosis from early medical practice to the present, would fill a most interesting volume. From tannin, which was early lauded as a specific, to tuberculin or the anti-tubercular era, the road-way is strewn with forgotten specifics and numerous monuments are erected by enthusiasts and admirers, upon most of which more recent travelers have inscribed as epitaphs; "Later experiments fail to confirm the earlier reports."

I am not so pessimistic as to say that drugs are useless in tuberculosis, nor so optimistic as to claim we have any real specific. I believe that we have in drugs a most useful aid and an ally we cannot despise. They are useful to stimulate exhausted functions, multiply the constructive power of the animal cell, and increase phagocytosis. They diminish the virulence of infection and decrease the destructive power of the bacilli. Iron, arsenic,

strychnin, phosphorus and vegetable tonics increase the number and rejuvenate the red blood-cells and fit them with the oxygen carrier, hemoglobin. Iron is indispensable in the anemic condition and should be given in the most easily assimilated form, organic iron. Arsenic stands second only to iron as a reconstructive agent, increasing the number of red blood-cells, and as a general nerve tonic. It has long been used for the fever, night-sweats and the general debility of tuberculous patients.

The new preparation of arsenic, cacodylic acid, has received a great deal of attention lately, much having been written of its efficacy in the treatment of tuberculosis.

Frassé and Gautier claim that in anemia and tuberculosis the treatment with cacodylic acid is always followed by a gain in weight and an increase in the amount of hemoglobin. Barbary reports lasting benefits from subcutaneous injections every other day of guaiacol cacodylate. Gilbert and others have used iron cacodylate, with resulting increase of body weight and lowering of temperature, disappearance of night-sweats and amelioration of general conditions. Dose, 1 to 1½ grains, hypodermically, and 3 to 6 grains by the mouth. Strychnin as a respiratory, heart and nerve stimulant has no superior, and should be given freely, as should also the various bitter and vegetable tonics, to increase the appetite and promote general nutrition.

Of those drugs used for their bactericidal action, creosote has long held an honored position. I prefer to give it in ascending doses, and furnish the patient capsules and creosote and let him fill his own capsules, increasing one drop each day until the tolerance of the stomach is ascertained, aiming to stop short of interference with degestion; or else give it in cod liver-oil or vaselin emulsions, increasing one drop a day. In this way the signs of poisoning from the drug can be looked for and its use discontinued before dangerous symptoms appear. There is no doubt

that creosote, given in this way lowers fever, lessens cough, changes the character of the sputum and often arrests the progress of the disease. Considerable has been written of the action of creosote in pulmonary tuberculosis and its efficacy is still debatable. Those who hold that its action is chiefly or wholly on the alimentary canal, give creosote in small doses for its local antifermentative effect, while those who believe it is eliminated by the lungs in sufficient quantity to be bactericidal, use the large doses. As a proof that creosote is only local in its action, it is claimed that animals infected with tuberculosis and treated with creosote die as soon as those not so treated. Sputum obtained postmortem from tuberculous patients who had been treated with creosote seem as virulent as that from those not so treated.

Creosote administered in other ways than by the mouth is much less efficacious. The strength of creosote present in the tissues can not, according to the laboratory experiments, have any destructive effects on tubercle bacilli. Against this it has been found (Cushny, Potter and others) that very dilute solutions of creosote reaching the blood and tissue cells tend to increase the activity of protoplasm. Dr. Potter claims, theoretically, that enough creosote may reach the tissues surrounding the tubercle to prohibit its growth. If this be true, a vital point is yielded in favor of creosote, for this alone may often enable the patient to tide over a critical period. In giving creosote by intunction, inhalation, or enema my experience has been that the odor is too disagreeable, and the irritation caused too painful for patients to endure it long; by inhalation it is too irritating and not more efficacious than the essential oils and other less irritating substances; by enema it soon becomes obnoxious to the patient, and he can not be prevailed upon to continue it in that way. By intratracheal injections it at times succeeds in checking the distressing cough and partially deodorizing and disinfecting



the sputum; beyond this no benefit is gained over administering it by the mouth. Guaiacol has to a great extent superseded creosote in the treatment of pulmonary tuberculosis on account of its being less disagreeable to the patient. It is not so liable to cause gastric distress, guaiacol carbonate is a favorite remedy with many physicians, and I prefer it to creosote. It should be given as creosote is given, in ascending doses, gradually pushed to the point of the stomach's tolerance, I have found guaiacol valerianate an admirable remedy, and large doses can be borne without causing gastric distress. I begin with ten drops in capsules, administered after meals, and gradually increase by drop additions to thirty and forty drops, three times a day, after meals. I have used thiocol, but found it inferior to guaiacol. Dr. Moritz Cohen claims the credit of first using ichthyol in pulmonary tuberculosis. He gives it mixed with equal parts of water, and administers four drops of this mixture, well diluted with water, three times a day, increasing one drop each day until the limit of the patients's endurance is reached. He claims it has distinct bactericidal qualities, and that in a series of 100 cases he had uniform good result. There was gain in weight; bacterial growth was hindered, fever was lowered, night-sweats and cough diminished, the sputum changing from purulent to mucous and frothy. Dr. Scarpa of Turin, has reported 150 cases of pulmonary tuberculosis in which the patients were treated with ichthyol, and considerable permanent improvement was noticed. He gave as high as 200 drops daily.

Dr. Edward Stubbert, of the Loomis Sanitarium, has reported good results from the use of ichthyol. He claims the best results are obtained from large doses. Schaefer, Spangler and others have reported favorably on the use of ichthyol. I have used ichthyol but comparatively little, discontinuing its use because of the disagreeable eructations and nausea resulting. Iodine and its compounds

have long been used with gratifying results in the treatment of pulmonary and other forms of tuberculosis. I prefer to give it in the form of the glycerole of iodine, from half to one drachm, painted daily over the diseased area. It does not blister, and is readily absorbed. It can be discontinued for a short while if it causes too much irritation.

Dr. Hessen noted that cinnamic acid given hypodermically was of benefit, while Fraenkel has noted no benefit. Dr. S. Mann reports good results from Landerer's method of intravenous injections, but concludes by saying that it is a difficult and troublesome treatment. Landerer claims that cinnamic acid increases the number of white blood corpuscles fully 50%, and that it cures by setting up an area of active inflammation around the tubercle. Others confirm this action of cinnamic acid. Dr. Harper was led to give urea for tuberculosis on the theory that carnivorous animals and animals excreting a large amount of urea were practically free from the disease. He claims that investigation will show that rheumatism and tuberculosis do not occur, or seldom occur, in the same families. He gives the urea in 20 to 60 grain doses three times daily either by the mouth or subcutaneously, and claims to have gratifying results.

Later reports do not confirm Harper's theory. So far, serum therapy in pulmonary tuberculosis has not accomplished all that was anticipated. Goetsch, in a series of 224 cases during the last 10 years, has had excellent results with tuberculin O and tuberculin R. He never gives it to a patient when there is the slightest rise in temperature and never increases the dose when the preceding dose produces any reaction whatever. To avoid reaction he advises the patient to remain in bed during the day of the injection and the succeeding day. He begins with 0001 mg. He increases the tuberculin O, until the

patient can take 1 mg. without reaction. Klehs considers tuberculin R almost a specific.

The danger of spreading the disease or lighting up the old foci from giving these small doses is practically *nil*, while the larger doses seem to have given better results in selected cases, all agree as to the positive element of danger to the patient from the administration of these large doses of tuberculin.

Favorable results continue to be recorded from the use of antitubercle serum. Dr. Baradat reports good results from the use of Bertin's and Picq's goat serum in doses of 2 cc. every other day. Dr. Baradat claims to get the same results from administering the serum by the mouth, but larger doses are required than when given hypodermically. Better results are obtained by giving the serum for two to three weeks and then giving the patient a rest of a week or two, when the same routine may be gone over. Streptococic serum is worthy a trial in cases of mixed infection. Dose 20 cc for the initial dose, and 10 cc daily, until improvement is shown by lowered temperature, freer expectoration and gain in patient's strength.

If, however, we have no specific in the antitubercle serums of Pacquin or Fish nor in the tuberculin O and tuberculin R. of Koch, I believe we have in them useful adjuncts when used with other medicines. My experience accords with that of those who claim that patients improve faster when the serums is added to other treatment. The time to give antitubercle serum, or tuberculin, is in the first stages of the disease. If we could diagnose the initial lesion with certainty before the bacilli have gained a foothold and administer the serum at this time, no doubt it would come nearer to being a specific.

Nearly all reports on new or old remedies contain a statement that the remedy is suitable to early apex cases or to the early stages of the disease. In the latent cases

the tubercle bacilli, with the assistance of the staphylococci and the streptococci, have long gained the ascendancy and have exhausted the leukocytes to such a degree that they are few in number and resist feebly.

If, then, the leukocytes are the antitoxin-producing element, how can we expect antitoxin to be formed in any great amount from weak, exhausted cells? Their power has already been expended.

Electricity has aroused renewed interest through the X-Ray. Excellent results are reported from the exposure of tuberculous glands to its light, and recently a good authority (Morton of New York) claims promising results in lung cases by previously administering a fluorescent substance until the system becomes practically saturated with the medicine when the X-Ray is turned on and the patient made into a sort of human glow-worm.

This has the advantage of being beautiful to look upon, at least, and since light is the great destroyer of tubercle bacilli, if we are able, by means of some substance, to increase the light effect of the X-Ray, without adding to its caustic effect, much good might be accomplished by lighting up the dark recesses of the lung and exposing the hidden bacilli.

Briefly the author's medical treatment of pulmonary tuberculosis generally consists in daily inhalations of the essential oils of thyme, cloves, cinnamon and eucalyptus with the addition of iodine and menthol with some bland oil as a vehicle. Administering guaiacol-valerianate in ascending doses, beginning with 10 m. and increasing to point of stomach tolerance, as much as 30 or 40 drops, three times a day where the patients stomach does not rebel against it; carefully watching the kidneys; daily applications to diseased area of one-half to one drachm of the gly-

cerole of iodine; treating symptoms as they arise. This is kept up indefinitely, with an occasional intermission for rest of patient's stomach, until sputum shows absence of bacilli, when the guaiacol-Valerianate may be gradually withdrawn.

## ***PSYCHO THERAPEUTICS***

BY ROBERT EDES, OF BOSTON, MASS.

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In the present revision and upsetting of therapeutic notions and the marvellous rapidity with which new drugs are being brought forward and urged upon an eager, not to say credulous, profession; among all the baths, radiations, lights, vibrations, and gymnastic methods, it is not perhaps strange that we find one of the oldest agents in the physicians armamentarium exploited in more or less legitimate fashion, as if it were a new discovery.

We have Mental Healing, Higher thought, Metaphysics and Christian Science and many others each phrase attached to some semireligious; semiphilosophic idea or ghost of an idea, reserving "Psychic Therapeutics" for the more sane scientific aspect of the same subject.

And yet, as we all know, psychic, mental, personal, influence is the oldest and least discredited therapeutic agent in the hands of the physician. There is no drug now in use that is so old. Medieval pharmacopoeias with their crude polypharmacy have become more curiosities and

have given place to the elegant collections of active principles and complicated synthetics, just as the pathologic systems, framed at the writing desk and not at the dissecting table and the bedside, have disappeared before the thermometer, the microscope, and the incubator. The vague guess is giving place to the exacter knowledge not so much because of more earnest search for truth or acuter intellects as because in the march of physical science new instruments of precision are being placed in our hands.

But, through it all, the physician, the man who uses these instruments crude or refined, has held his place, increasing in dignity and usefulness as a helper and healer without regard to his classifications or theories or his system of therapeutics provided always that he knows how and when to use this ancient weapon.

Has there been an advance in the practical use of psychic therapeutics corresponding to the somewhat greater precision in thinking about it?

I am inclined to think not, so far as any increase of mental influence over disease is concerned, but a great deal as regards the knowledge of when to rely upon it to the exclusion of other resources, just as the surgeon considers it a gain in his science if he is able to say more decisively that such and such a case is a suitable one for operation and such another should on no consideration be touched.

We know that a very large part of the morbid processes which go to make the difference between organic health and disease are beyond the control of psychic influences. Fever goes on unaltered, degenerations, intoxications, infections, atrophies go their destructive ways neither helped or hindered by the mental attitude of the patient or of the physician, except as they make him more amenable to other methods of treatment, or as they may help by supplementing the failing function with another

Even many of the most important mental conditions, where it might be supposed that mental influences would be all powerful, do not yield.

See for instance melancholia and other forms of insanity where the utmost encouragement that can be given is successful only in procuring some alleviation until even more mysterious organic processes shall have run their slower course.

Mental influences come in contact with the organic chiefly, so far as we know, through the vasomotor nerves. Trophic nerves have been long suspected but never satisfactorily demonstrated. Nervous influence upon the heart may affect its action sufficiently to kill in some rare cases and perhaps in the course of a long time to affect its structure. Secretions are undoubtedly under a good deal of mental influence as those of the stomach, kidneys. The control of mental states over the activity of the sexual organs and their reciprocal effect upon psychic conditions are well known.

It is through these channels that the more ordinary methods of psychic therapeutics, what we might call mind cure in repeated small doses, acts in chronic disease either helping to more vigor and tone in the function of the organs or simply carrying them along more comfortably while nature and time are restoring normal activity. Many claims are made for hypnotism for the control of morbid conditions in this way such for instance as insomnia, the desire for narcotics, and so on.

Undoubtedly good results have been thus accomplished and it can hardly be doubted that in some cases the mystic flavor, the hint at occultism, the idea of supernatural powers may do good, but it is not so certain that the same thing may not be accomplished without the hypnotic condition if the patient can be induced, to have the same con-



fidence based on more common place grounds of but equally firm, is by reason.

Statistics in such matters are obviously very untrustworthy.

A few years ago Mr. H. H. Goddard prepared for his graduation thesis at Clark University a paper upon this class of cures and was kind enough to show me some of the answers returned to him, some of them referring to patients who had been under my care. He came in contact with one man who had had a good deal of success in dealing with many cases of which a considerable proportion were evidently functional nervous, and who was willing to give information which Mr. Goddard believed to be full and candid. He was not a medical man and his diagnoses were consequently not very trustworthy but were probably honest. He was willing to speak frankly of the cases which were cured. This information Mr. Goddard compared with the published statistics of the celebrated medical hypnotists as representing the scientific side of the question. He found that in a general way the two sets of cases corresponded fairly well both as to percentages of cures and as to the class of cases benefitted.

“Dowie says, in certain issue of his paper: I pray and lay hands on 70,000 people in a year.’ At that rate he would have prayed with 175,000 in 2½ years. But in the 2½ years immediately preceding this statement, he reports only 700 even claimed cures. The conclusion is indisputable that only a small portion of those prayed with are cured.”

—Goddard.

When we came to the wonder cures, the miracle cures, the cases given up to their physicians restored to perfect health, the cancers disappearing without the aid of the knife, the organic diseases condemned to death by the

most eminent consultants, and so on it must be remarked in the first place that they will mostly call for a tremendous discount both in numbers and severity before they are received. They are very much less numerous than they appear. By a greater number when followed up lead one either to the plain lie or more frequently to exaggeration and misunderstanding. Others which appear at first able withstand criticism simple prove erroneous diagnoses honest or otherwise, and have nothing to do with organic disease.

From this point of view I doubt if there has been any advance.

There always have been and for a long time to come will be wonder cures wrought, and they are just as likely to be done (and a great deal more likely to be widely advertised when done) by the most shallow ignoramus as by the most skilful physician.

Such advances as have been made in the art of psychotherapeutics are to be attribute more to a general recognition of its importance and often the futility of other methods, except as adjuvants in building up strenght, removing local causes and so on, than to any special increase of knowledge or important discovery. As we have already remarked physicians have always practiced it but they have perhaps not always been aware that this branch of their art was of more efficacy than means which rests upon learning and tradition and which seemed to them more scientific.

The methods of psychotherapeutics are not easy to teach in a medical school or in formal lectures. They are the result of experience and may be, but seldom are learned by the student in the clinic. Certainly some of them may be put in practice with hospital patients in a way some of use may recollect that any hospitals do not teach. It is not the same with the cultivation of what our

English confreres talk about as a "good bedside manners." It consists in many cases as much as anything in putting one's self in the patient's place and thinking what would be the most the helpful not always the most agreeable thing that could be said. It is often more in the hands of the nurse than of the physician and it is not necessarily the trained nurse although if she has the one thing needful, tact and good feeling the training can only add to her efficiency. For the class of patients for whom psychotherapy is of the most consequence a nurse fitted by natural disposition is of much more use than one fitted only in the school.

As for the miracle cures it has already been intimated that the qualifications of the healer are matters which cannot be taught or defined. Experience shows that neither knowledge, good sense, sincerity, or honesty are of any value and lead to no more success than the densest ignorance and utter unscrupulousness, or the most fantastic pseudo philosophy.

Looking at the question from another point of view, that indeed where all therapeutic inquiry should begin is when to use psychotherapeutics or rather when it should be relied upon, the case is a different one.

One need not enquire too carefully when it may be applied for with a careful and well established diagnosis and an efficient plan of general and local treatment psychotherapeutics can hardly be misapplied. But this proviso is of the utmost importance.

Cousolation and encouragement to a patient who is known to have organic disease that can be relieved by the ordinary procedures of medicine and surgery offered to prevent or dangerously postpone the necessary treatment is at best but a ghastly mockery, perhaps kindly meant but none the less disastrous, while at the worst it approaches too closely the limits of criminal neglect.

Knowing as we do the conditions over which the action of the cortical centres has no control and those others where it can be considered and adjuvant we find left a region where psychotherapy is essential and supreme.

There are functional disturbances of great gravity arising in the very region whence we try to stimulate and organise the forces for their control. Even when we must acknowledge that organic changes are either hereditary or have taken place under observation agencies acting solely through the voluntary motor centres may be the only ones which bring the defective organism up its maximum possible efficiency. The employment and amusements and the judicious management now given to the insane are undoubtedly more efficient toward recovery, although not competent themselves to complete it, than any of the drugs which have been used.

The bringing of defective children up to the point of their greatest possible usefulness and comfort, as accomplished in the best training schools for that purpose, is a matter of psychotherapy, the training of the hand through the motor centres of the cortex and their reciprocated stimulation to the mental functions.

The supplementing of destroyed nervous tissue by the making use of other paths of conduction, as in tabes, is a distinct advance. In this case it is not so much the strengthening the muscles by exercise as in training them to act under the educated stimulus of other centres.

Of course it is in the condition or group of conditions many and various which we call hysteria of which we know so little of the essential underlying nervous disorder and so much of the manifestations that we can most firmly rely upon mental influences both for prophylaxis and treatment. There is little doubt that judicious education including as its most important and decisive part home training an example may have a most potent influence for

good in the case of children with any tendency to such an affection.

Temperament and hereditary tendencies cannot be totally reversed, but for many of the early years the surroundings can be made to modify and restrain the growing tendencies to nervous instability, selfishness and introspection.

Who that has watched the developments in recent years in the knowledge of these strange conditions and has seen or heard of the wonderful things done and said to be done by almost every agency known to therapeutics, scientific or fanciful, can fail to recognize that the real and active agent is not the drug or the ray or the current, but the person who uses it or the faith with which it is received by the patient?

The exact field covered by the word "hysteria" varies much according to the views of the particular writer who uses it. The "neuromimesis" of Sir James Paget well distinguishes a subclass which is quite distinct from the more popular idea of hysterics or from the extreme highly developed manifestations so carefully by the Salpêtrière school. The still more limited traumatic neurosis popularly and legally but often erroneously and which furnishes an important contingent to the number of cases of the kind we are considering supposed to be always curable by a verdict for damages is an instance of the apparent bodily damage which can be done by the "fixed idea" and sometimes the corresponding benefit which issues from suitable mental influence.

What observing physician can fail to see what a wide field is covered by purely functional affections of the psychic centres again had vastly important it is that this broad cloak should not be allowed to cover with its therapeutics the cases which are placed under it not by careful diagnosis but by mistake or carelessness.

## ***Pregnancy Following***

VENTRO-SUSPENSION OF THE UTERUS, BY HENRY T. WILLIAMS, M. D. ROCHESTER, N. Y., VISITING SURGEON OF ROCHESTER CITY HOSPITAL AND ST. MARY'S HOSPITAL, WITH

### REPORT OF CASES

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It has been claimed by many that ventro-suspension interferes with a future pregnancy. Many of the disadvantages urged are: the marked retraction of the scar, due to the dragging uterus; the failure of the anterior portion of the uterine body to expand, and the thinning of the posterior part of the uterus the production of abortion or premature labor, and the prolongation of the normal period of gestation. It is also claimed that the uterus may tear loose from its moorings and the consequent formation of a large hematoma at the point of rupture, and the uterus, itself, may be ruptured. It is also claimed that the difficulties during labor may result from the inability of the thinned out posterior wall of the uterus to expel the fetus. It is a well known fact that *ventro-*

*fixation* of the uterus is a frequent cause of dystocia, and that operation is now condemned by most eminent gynecologists, but I think that ventro-suspension is now considered by most authorities as quite satisfactory. In my own experience of twenty-eight cases of ventro-suspension in which pregnancy occurred afterwards, and which cases I have been able to follow difficult labor occurred in but one, and one case only miscarried at the third month, but in neither of these cases did I think that ventro-suspension was a factor. Cases have been reported where difficult labor has followed ventro-suspension and has been due to adhesion between the uterus and the abdominal wall, which have followed a more or less localized infection at the time of operation. I will mention but five cases: Mrs. R—, age twenty-seven, mother of two children, was operated upon by me September 1896. The right ovary and tube were diseased and were removed, and the uterus was held in place by ventro-suspension. Her health improved very much after this and she was relieved of the constant dragging sensations from which she had suffered previous to the operation. She became pregnant three years afterwards and labor occurred in April, 1900. It was perfectly normal in every respect, the labor from beginning to end only lasting about two and one-half hours. The uterus has remained in position ever since and has never given her any trouble.

Mrs. B—, age twenty-four; never pregnant; ventro-suspension performed March, 1899. The operation was followed in one week by a serious infection, the pus forming around the wound and along the sides of the uterus. She was seriously ill, with high temperature, for two or three weeks. She then recovered and was well afterwards. Two years later she became pregnant; went on to full term, and had a rather prolonged but otherwise normal labor. The uterus has remained in position ever since.

Mrs. M—, age twenty-eight; never pregnant; ventro-suspension performed September 1898, one year later she became pregnant and miscarried at the end of three months. Since then she has been delivered of a healthy child; labor was normal and she has been well since.

Mrs. H—, age thirty; two children; the youngest eighteen months old at the time of operation; operated upon December, 1900; left tube and ovary badly diseased and were removed; uterus held in position by ventro-suspension; patient was well afterwards. She became pregnant and labor took place in February, 1902. Her previous labors had both been slow and trying. The physician who attended her, reported to me that she had a very tedious labor; that the uterus did not seem to contract well and she seemed to have very little expulsive power. After she had been in labor twelve hours, he delivered her with forceps in the superior straight. The child was quite large. The uterus did not contract well after delivery and she had considerable hemorrhage. She recovered finally, and the uterus has remained in place since; and I understand she is quite well.

Mrs. R—, twenty-seven; one child three years previous. At the time of the birth of this child she had a slow, tedious labor. The child weighed a little over ten pounds; the cervix and perineum were extensively lacerated during birth. When she came under my observation, two years afterwards she was very much run down, pale and anemic; complained greatly of dragging sensations in the pelvis, and great irritability of the bladder. I found besides the extensive laceration of the cervix and perineum; a large retroverted uterus. After she was built up by tonics, fresh air, etc. and the condition of the cervix improved by douches and treatment, I repaired the lacerated cervix and perineum, also did a ventro-suspension, and resected the right ovary which was enlarged and cystic, taking out about two-thirds of the ovary.



She became pregnant 3 months afterwards. Her Labor was normal in every respect, pains beginning in the morning, and the child was born in the afternoon. Although the child weighed eleven and one-half pounds no instruments were required and there was no laceration following. Both she and the child have been very well ever since. Uterus remained in good position, and she has no trouble with her bladder. The operation that I have performed in all of these cases, has been a modified "Kelly" operation. I prefer to fix the uterus in only a slightly anteflexed position. If it is fixed too far forward it is apt to cause trouble from its pressure on the bladder, and also to be a cause of dysmenorrhoea. I make a small abdominal incision (never more than two inches, usually less) through the peritoneum. After scarifying with a scalpel the fundus of the uterus, and also that portion of the peritoneum to which I stitch the uterus, I then pass two silkworm gut sutures through the skin, muscles, fascia, and peritoneum, and about one-eighth of an inch deep through the fundus of the uterus, putting the sutures about an inch apart and about three-quarters of an inch either side of the incision in the abdomen; having an assistant hold these sutures, I stitch the peritoneum to the fundus of the uterus with medium size catgut sutures. I then sew up the abdominal incision in the usual way, generally with figure of eight silkworm gut sutures. I then draw up the fixation sutures and pass an ordinary bone button over the ends of each one and hold them in place by four shot run over the ends of the ligatures on to the buttons and clamp. I usually do not remove these sutures before two and one-half or three weeks. If a patient is examined a few months after this operation, the uterus will be found freely movable, held in position from the fundus only by ligamentous like bands.

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## ***THE OVER ZEALOUS***

TREATMENT OF CORNEAL AND CONJUNCTIVAL INFLAMMATIONS  
BY GEORGE F. SUKER, M. D., AND MARK D. STEVEN-  
SON, M. D., AKRON, OHIO, U. S. A.

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The enthusiasm manifested today by the ophthalmic practitioners in the employment of the many new pharmaceutical preparations—extolling this one as the sine qua non for this or that corneal or conjunctival inflammation—or vaunting this particular mechanical interference for any and all ulcerations of the cornea and conjunctiva, has been the impetus for this paper. It is not taking things for granted in presuming that this remark does not hit wide of the present status. It is an opportune time at this gathering of Pan American ophthalmologists to call especial attention to the fact that our brethren across the pond are the ones largely concerned in extolling this kaleidoscopic ocular pharmacy. On the other hand, we as Americans are likewise guilty of placing too much faith and confidence in the so called European clinical reports. In a measure we follow their experiments, but in truth, the

American Ophthalmologist is rather skeptical. Because of this mild skepticism, he is not prone to fly from one remedy to another in the treatment of corneal and conjunctival inflammation. Though for a moment, he may accede to the glowing reports of news remedies, yet, he readily falls back upon the tried and accepted ones. This marks one of the great differences between European and American practice. It is quite patent that the American practitioner seems to more fully realize the sensitiveness of the cornea and conjunctiva than any other, and therefore hesitates to employ such drastic measures as one frequently reads about. Through it is an accepted fact that an inflamed conjunctiva or cornea apparently tolerates stronger solutions than the healthy one, yet this is not a criterion that it is a good measure to follow

The over zealous practitioner seems to forget that it is not the application of any particular remedy that causes the cure, but it is the checking of bacterial life as a whole—and what it means---and the supporting of nature that causes a return to the normal condition. In other words, the idea of rendering the involved structures incapable of sustaining bacteria or their products on the one hand, and sustaining the repercutive powers of nature on the other, should be our aim. If this can be attained by the employment of mild and non-destructive procedures, it is our duty to do so. For the less we interfere with nature by our over-zealousness, no matter in what regard, the better. The ophthalmic surgeon is somewhat too strongly imbued with the idea that this or that disease of the cornea or conjunctiva can be aborted—if not aborted, then wonderfully cut short in its duration. But, how often is this a fallacy. Yet in order to accomplish this, he becomes guilty of meddling therapy. He above all other practitioners seems to forget that rest is a vital factor in curing any inflammation. Likewise, does he neglect to associate the

eye with the rest of the system and treats, therefore, often the part or the whole instead of the whole for the part. If we would become more imbued with some of the simple surgical principles and carry them out as faithfully as the surgeon does, when he treats corresponding conditions, we would never be guilty of over zealous treatments. A mere mentioning of these simple facts will suffice in order to vividly call before our minds that not only in the clinical practice, but in our own private duties, there has been a strong tendency to over do--ignoring simple things, discarding old and tried remedies and flittering about organo-therapy and synthetical chemical preparations. Far be it from me to detract one iota from the value of the above methods, yet a word of caution may not be amiss. The spirit of iconoclasm does not prevail with the writer, but rather the tentative feeling of conservatism is the paramount interest.

In order to more tersely bring the matter to a focus, we can advisedly pursue the following line of argument:

First.—Consider the treatment of the milder inflammations of the cornea and conjunctiva--either suppurative or non-suppurative.

Second.--In what regard can we be accused of over-zealousness.

In the simpler inflammations of the conjunctiva as phlyctenulosis, follicular inflammation, milder forms of trachoma, and the less virulent pneumococcal and staphylococcal infections, what need is there of cauterizing, cutting, or excising the follicles, the phlyctennules, or the isolated trachomatous granules, or applying the very strong solutions of the albuminates of silver, such as twenty five percent, or allow the more frequent applications of these than three times a day.

The end results following such measures are not near

as satisfactory as when milder ones are pursued. In the former, adjacent healthy structures are frequently implicated and undue irritations brought about which necessarily delay the recuperative powers of nature. It is better to sacrifice duration of the disease for the protection of the parts involved with their adjacent structures than to strive for the cutting short and sacrificing or rendering more evident the final end of all inflammatory reactions—namely cicaterization and partial or total loss of function. If these stronger solutions are irritating to the healthy conjunctiva they must necessarily be more irritating to one which is inflamed and wherein the nerve terminals are implicated. An undue hyperaemia and even a venous stasis follows the more drastic measures and invariably impedes the carrying away of these products, either of the metabolic or inflammatory type. The writer is not gainsaying any thing against the judicious employment of the more drastic measures in such conditions of the conjunctiva which are deep seated, rapidly progressive, and destructive in nature. How frequently in these conditions is the bandage abused, thinking that immobilization is achieved while the other eye remains uncovered. Any bandage other than that of simple exclusion of light is detrimental; for, every inflammatory reaction of the conjunctiva is accompanied by more or less discharge. This discharge is pent up by the bandage and simply aggravates the condition of affairs. Yet, how frequently do we see the bandage employed in the conditions just mentioned. Every bandage produces a certain amount of pressure and unless support is obligatory acts as an irritant because of producing greater friction between the contiguous surfaces. We are somewhat prone to forget that the eye is as well adapted for self preservation when the conjunctiva is affected as any organ of the body. Witness the lacrimal apparatus, the free surface, and the well adapted glandular supply and secretion.

As the majority of the bacteria which cause conjunctival inflammations, not including the Neisser or trachoma bacteria, are of rather low virulency they can readily be combated with the milder solutions of medicaments now in vogue. Bear in mind that quantity of bacteria is in all important factor in the maintainance of conjunctival inflammations.

Therefore, we ought not to employ such measures which have a tendency to destroy either the involved or non-involved conjunctiva because by doing so we would be simply adding fresh pabulum for their maintainance.

As the majority of bacterial infections of the conjunctiva are produced by non-sporing germs, therefore the need of employing the stronger bactericidal solutions is not very great. It is often the too frequent application and the employment of the more drastic measures which exercises a great tendency to destroy the protective epithelium that causes a prolongation of the disease rather than a shortening. This because of self evident facts. In our endeavor to mitigate the inflammation by employing the strong solutions we really set up a chemical irritation, and thus an inflammation, hence are adding but fuel to the fire.

So much for the views that the writer entertains regarding conjunctival inflammations and the over zealous treatment thereof. Now in reference to the corneal inflammations. Let us consider corneal abrasions, simple ulcers, phlyctenulosis, moderate infiltrations from either a parenchymatous or interstitial keratitis, and all such other conditions as would come under this broad classification what has been the custom with some of the ophthalmic surgeons. Has not the cautery and curette played in all too important factor in the treatment of these conditions? Not every simple ulcer either traumatic or idiopathic, primary or socondary, is bound to become indolent, infective, or rapidly progressive, thus involving the deeper structures

of the cornea, and thereby leaving great corneal opacities. Hence, what need of the cautery or curette when treating these conditions upon a simple surgical basis will yield better results though it may take a little longer.

In doing so, we do not jeopardize the adjacent healthy cornea and thus avoid producing larger corneal opacities. To prevent the latter and obviate progression should be the acme of our desire in the treatment. Yet, how often has our over-zealousness changed that apparently small corneal opacity into a visibly large one because of the drastic measures employed. Certain it is that if we are dealing with rapidly progressive and infective conditions of the cornea then the writer's argument is not very weighty. For, in order to limit the spreading fire deep furrows must be plowed and scars result in order to save the eye from total wreck and ruin.

In reference to parenchymatous and interstitial keratitis associated with or without pannus, from any cause whatsoever—constitutional, specific, or acquired—we often neglect the whole for the part. These conditions can be more readily combated by paying strict attention to the glandular system and employing but only mild supportive non-irritating local remedies to the eye. Our over-zealousness often leads us to prescribe such internal remedies as have a detrimental effect upon the vaso motor periphery producing a stasis or an undue diapedesis. Not only this but the prescribing of such internal agents in such large amounts so that they must be thrown off to a certain extent by the sudorific glands will act as an irritant to the ocular condition. It is important that the glandular system of the eye be stimulated in these conditions but it must not be brought about by the application of irritant remedies. If it were not our ultimate aim to preserve the transparency of the cornea then it would

matter little whether the agents employed were destructive or not to the surrounding healthy tissue.

It should be endeavor to only apply such local remedy as does not exercise a great tendency in causing or aggravating the vascularity of the cornea. The excrementitious products should be eliminated and disposed of by the lymph channels and not by the newly organized vascular net work. The latter when once formed are never absolutely obliterated while the former may be increased without detriment. Such strong agents which produce an infiltration when applied ought to be used sparingly. Therefore, one ought not to employ such strong solutions of the albuminates of silver or the like in inflammations of the cornea as in the conjunctiva. This is particularly true when the periphery of the cornea rather than the centre is involved in the reaction. Again, in this class of cases the naso-pharyngeal passages are often overlooked. The same may be said of the gastro-intestinal tract. We are quite prone to lose sight of a general auto intoxication with local manifestation in the treatment of interstitial and allied forms of keratitis, being carried away in our eagerness for local applications.

The old practice of trying to get rid of a chronic inflammation and its results by engendering upon it an acute variety may be good practice of general surgery and to a limited extent in conjunctival implications, yet it is to be deprecated when one deals with the cornea. The promiscuous canterization of simple corneal ulcers particularly when centrally located is a treatment out of all proportion to the severity of the condition present. The same is true for simple faceted ulcers and such as arise from impingement of the small foreign bodies. It is granted that now and then these measures are indicated and because glowing results are the consequence we become over zealous and promiscuously employ an agency when it ought



to be preserved for selected cases only. The writer does not refer or include such agents or applications as might be resorted to in the immediate surrounding ocular conjunctiva which may have an effect upon the corneal lesion. Our over-zealousness in the management of milder lesions of the cornea often lead to the production of cloudiness of the cornea which are scarcely perceptible by ordinary methods of examination. Yet they are sufficiently dense to produce blurring of vision out of all proportion to the resulting scar of the initial lesion.

The purport of this paper has been fairly well set forth and though much more may be said in regard to relative conditions of the conjunctiva and cornea, yet simple facts and illustrations have been adduced which clearly set forth that we are at times guilty of over-zealous treatments. The writer does not wish to impune any new advocated method, but desires to say that conservative considerations should enter in accepting or rejecting any of them. In other words, we should never lose sight of the prime principles of surgical therapy.

FIN DEL TOMO SEGUNDO

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eye with the rest of the system and treats, therefore, often the part or the whole instead of the whole for the part. If we would become more imbued with some of the simple surgical principles and carry them out as faithfully as the surgeon does when he treats corresponding conditions, we would never be guilty of over zealous treatments. A mere mentioning of these simple facts will suffice in order to vividly call before our minds that not only in the clinical practice, but in our own private duties there has been a strong tendency to over do—ignoring simple things, discarding old and tried remedies and flittering about organo therapy and synthetical chemical preparations. Far be it from me to detract one iota from the value of the above methods, yet a word of caution may not be amiss. The spirit of iconoclasm does not prevail with the writer, but rather the tentative feeling of conservatism is the paramount interest.

In order to more tersely bring the matter to a focus, we can advisedly pursue the following line of argument:

First.—Consider the treatment of the milder inflammations of the cornea and conjunctiva—either suppurative or non-suppurative.

Second.—In what regard can we be accused of over-zealousness.

In the simpler inflammations of the conjunctiva as phlyctenulosis, follicular inflammation, milder forms of trachoma, and the less virulent pneumococcal and staphylococcal infections, what need is there of cauterizing, curetting, or excising the follicles, the phlyctenules, or the isolated trachomatous granules, or applying the very strong solutions of the albuminates of silver, such as twenty five percent, or allow the more frequent applications of these than three times a day.

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as satisfactory as when milder ones are pursued. In the former, adjacent healthy structures are frequently implicated and undue irritations brought about which necessarily delay the recuperative powers of nature. It is better to sacrifice duration of the disease for the protection of the parts involved with their adjacent structures than to strive for the cutting short and sacrificing or rendering more evident the final end of all inflammatory reactions—namely cicaterization and partial or total loss of function. If these stronger solutions are irritating to the healthy conjunctiva they must necessarily be more irritating to one which is inflamed and wherein the nerve terminals are implicated. An undue hyperaemia and even a venous stasis follows the more drastic measures and invariably impedes the carrying away of these products, either of the metabolic or inflammatory type. The writer is not gainsaying any thing against the judicious employment of the more drastic measures in such conditions of the conjunctiva which are deep seated, rapidly progressive, and destructive in nature. How frequently in these conditions is the bandage abused, thinking that immobilization is achieved while the other eye remains uncovered. Any bandage other than that of simple exclusion of light is detrimental; for, every inflammatory reaction of the conjunctiva is accompanied by more or less discharge. This discharge is pent up by the bandage and simply aggravates the condition of affairs. Yet, how frequently do we see the bandage employed in the conditions just mentioned. Every bandage produces a certain amount of pressure and unless support is obligatory acts as an irritant because of producing greater friction between the contiguous surfaces. We are somewhat prone to forget that the eye is as well adapted for self preservation when the conjunctiva is affected as any organ of the body. Witness the lacrimal apparatus, the free surface, and the well adapted glandular supply and secretion.



As the majority of the bacteria which cause conjunctival inflammations, not including the Neisser or trachoma bacteria, are of rather low virulency they can readily be combated with the milder solutions of medicaments now in vogue. Bear in mind that quantity of bacteria is in all important factor in the maintainance of conjunctival inflammations.

Therefore, we ought not to employ such measures which have a tendency to destroy either the involved or non-involved conjunctiva because by doing so we would be simply adding fresh pabulum for their maintainance.

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So much for the views that the writer entertains regarding conjunctival inflammations and the over zealous treatment thereof. Now in reference to the corneal inflammations. Let us consider corneal abrasions, simple ulcers, phlyctenulosis, moderate infiltrations from either a parenchymatous or interstitial keratitis, and all such other conditions as would come under this broad classification what has been the custom with some of the ophthalmic surgeons. Has not the cautery and curette played in all too important factor in the treatment of these conditions? Not every simple ulcer either traumatic or idiopathic, primary or secondary, is bound to become indolent, infective, or rapidly progressive, thus involving the deeper structures

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