Cracking of the serous coat of the intussuscipiens is apt to occur during the manipulations necessary to effect reduction of the invagination. These small cracks should be repaired at once by fine silk sutures.

Three cases of unusual complications following laparotomy were instructive. The first showed the formation of a fresh intussusception occurring three days after complete reduction of an ileo-cecal invagination. A baby girl, aged seven months, was admitted, under one of my colleagues, eighteen hours after commencement of attack. The usual symptoms presented: the tumour could be easily felt lying between the lower margin of the liver and the umbilicus. Laparotomy was performed. Several coils of collapsed bowel were delivered through the wound, followed by the invagination, which was easily reduced, except the last two inches. The mass was five inches in length, the cæcum much infiltrated and indurated. The variety was ileo-cecal. There was a long, free meso-colon. The baby did well for two days. On the third day vomiting started, the motions became slimy and tinged with blood. Restlessness increased, pulse 136, temperature 102. Three and a half days after the operation the abdomen was again opened. The small
A large tumour was felt below the liver, extending to the splenic flexure. This proved to be an invagination, and was easily reduced. There was much engorgement of the parts. The child now made an uneventful recovery.

The second case was a girl of six months, admitted to one of my beds four days after onset. The tumour was felt lying transversely across the upper part of the abdomen. Laparotomy was performed, and the tumour reduced, after much difficulty. The baby recovered well, and was discharged on the sixteenth day, apparently cured. She was admitted again on the twentieth day, suffering from constant vomiting and restlessness. Her condition rapidly became worse, and she collapsed and died. The cause of death, as revealed by the post mortem examination, was suppurating appendicitis. This unfortunate result I attribute to the injured appendix, which was noted at the time of operation to be extremely congested, being allowed to remain instead of being removed. Its vitality and power of resistance were evidently so lowered that the inflammation progressed to suppuration. Since that date I have several times in similar circumstances, removed the appendix after reducing the invagination, and with the best possible results.

The third case, a boy of eight months, was admitted twenty-two hours after inception of attack. The tumour was felt low down in the left iliac fossa, and projected about four inches beyond the anus. I performed laparotomy two hours later, and relieved the invagination. There was good recovery, although there had been some slight suppuration about the centre of the median incision. This had healed, and the child was ready to be sent home, when vomiting commenced on the nineteenth day. It soon became continuous, the bowels moved normally, but the baby rapidly became worse, and died. At the autopsy it was found that the anterior surface of the caecum was adherent to the abdominal scar, and there were two coils of small intestine (ileum) also adherent to the left side of the same scar. No acute obstruction was discovered, but the loops formed by the adherent coils of ileum contained other coils of collapsed, but not strangulated gut.
Intussusception.

Difficulties of reduction were chiefly due to oedema and swelling, which occurred particularly at the apex of the intussusceptum, this being the first portion to become strangulated. This is the part which always causes the most trouble in reduction, and is rarely more than one or two inches in length.

Adhesions are said by many authors to be the most potent cause of difficulty after the fourth day. I certainly agree to this statement; but in fourteen of my cases adhesions were found present within thirty-six hours. They were soft, and, in most cases, yielded to gentle manipulation. Although adhesions are obstacles to reduction, they are a safeguard against general peritonitis, due to gangrene of the intussusceptum.

There were eight cases in which it was quite impossible to reduce the invagination. In one, great swelling and thickening of the intestinal coats was accompanied by a twisting of the gut on its axis, that precluded all attempts at reduction when laparotomy was performed fifty hours after the onset. The child’s condition was so extreme that the abdomen was closed quickly, the child dying shortly after being put back to bed.

In a second case, in a child ill fifty-two hours, the ileo-cæcal invagination was reduced to the extent of eight inches, but the remaining larger portion was already gangrenous. The process had evidently begun at the apex, the ileo-cæcal valve being the part most decomposed. There were twenty-one inches of gut in the unreduced part, which I resected, a Murphy’s button being used. The baby died, and the post mortem showed the gangrene to have spread to the adjacent gut.

In the third case, admitted on the sixth day of illness, a somewhat similar condition was discovered, though less extensive. Here again resection was done, and a button used. The child died on the following day.

In the fourth case, admitted on the fifth day, gangrene was present, involving all the layers of the invagination. The intussuscipiens presented multiple ulcerations of the mucous membrane, leading to perforations of the wall of the sheath.

In the eighth case, gangrene appeared nineteen hours after onset, the shortest time I have seen recorded.
Gangrene is said to be less frequent in infants than in adults. This is probably due to the fact that gangrene of any part in infancy is rare, their tissues being soft, yielding, and abundantly supplied with blood.

Of the various operations recommended in cases where it is impossible to reduce the invagination, I have little to say, and that little is unsatisfactory, for I can record no instance of recovery after resection. The rule has been to perform complete resection, and end to end union by Murphy's button, as being the speediest method; but the result has been disaster every time. Clubbe has had one successful case, in a baby eleven months old, and two or three other recoveries in infants have taken place. In infants, where irreducibility of the tumour is found, demanding one or other of the methods of resection, the prospect of success is almost hopeless.

Of the one hundred and ten cases, seventy-nine were submitted to laparotomy. Of these, thirty-eight recovered, and forty-one died.

Of the forty-one who died, thirteen were admitted in a condition of collapse, and seven others had been repeatedly irrigated; two were markedly syphilitic, and fifteen were operated upon between the third and sixth days after the onset of the attack; and, finally, one child that had apparently recovered died three and a half weeks later of suppurating appendicitis.

Of the thirteen children admitted in a state of collapse, there were three who had general peritonitis, and in eight the invagination was irreducible.

In studying this mortality rate, and that of other recorded series, I find that death after laparotomy increases with every additional day, and that the large percentage of deaths is mainly due to the long delayed operations, and to operations performed where the invaginations cannot be reduced.

All records show that, while a simple laparotomy is well borne by infants, operations requiring partial or complete resection, entero-anastomosis, or the formation of an artificial anus, are nearly all attended by fatal results, for the conditions necessitating them are in themselves very fatal.
COMPARATIVE RESULTS OF TREATMENT BY IRRIGATION AND LAPAROTOMY.

**IRRIGATION.**

| | 12 successful | 28 cases | 16 unsuccessful |
| | (12 deaths) |
| Two were admitted collapsed; excluding these, therefore, as practically hopeless, there were:— |
| 26 cases | 12 successful | 14 unsuccessful |
| giving a percentage of 46.15 recoveries.

**LAPAROTOMY.**

| 79 cases | 38 successful |
| 41 unsuccessful |
| Thirteen were collapsed on admission, seven had been repeatedly irrigated, fifteen were operated upon between the third and sixth days after onset.
| Excluding the cases that offered little chance of recovery, there were:— |
| 52 apparently suitable cases for laparotomy, with |
| 38 successful, and |
| 14 unsuccessful results, |
| giving a percentage of 73 recoveries.

I am forced, therefore, to the conclusion that the treatment of intussusception is, *par excellence*, by abdominal section; and I quite understand the attitude of those surgeons who discard absolutely treatment by distension of the bowel, for as I have shown, even in cases treated by that method within twelve hours from the commencement of the illness, the successes were barely fifty per cent., whereas laparotomy, performed within that time limit, gave a percentage of eighty-three recoveries.

Personally, in the absence of symptoms such as I have described as contra-indicating the use of irrigation at any stage, I should use irrigation once, thoroughly, and under anaesthesia, if the intussusception had been in existence for not more than six hours. At the same time I should have everything ready for an immediate laparotomy to be performed, were I not sure, beyond all doubt, that complete reduction had been effected, as evidenced by total disappearance of the swelling where the tumour had been in existence.

**AFTER-TREATMENT.**

With regard to the after treatment of intussusception in infants, a subject which is barely mentioned by writers, different plans are followed by different men. To a certain extent each case must be a law unto itself.

The question of nourishment is most important, and involves special consideration. In those cases seen early, and operated upon shortly after the onset, I defer the administration of nourishment for a few hours, in order, theoretically, to allow time for the cause originally in operation to pass away, and so lessen the
risk of recurrence of the intussusception. The withholding of nourishment would postpone peristalsis. I have thought that some of the recurrences may have been due to peristaltic action being induced too soon after treatment.

In the majority of cases I put the baby to the breast as soon as it recovers from the anaesthetic, and, in the case of bottle-babies, give some liquid nourishment. Shock is lessened by this early administration of food. To obviate, as far as possible, the shock of operation, the urine is drawn off prior to the laparotomy, the baby wrapped in cotton wool, and laid on a hot water bag, other bags being applied to the sides of the trunk and limbs. An enema of coffee and brandy, or saline solution and brandy, is kept in readiness during the course of the operation. Chloroform is the anaesthetic generally used at the commencement, sparingly as possible, consistent with adequate anaesthesia. As shock becomes more manifest, chloroform is supplemented by ether, or ether used entirely.

On the baby's return to bed, which should be of warmed blankets, watch should be closely kept for the first half-hour. If at the end of that time there is no appreciable improvement in the pulse, or return of color to the face, an enema, consisting of brandy, two drachms, with coffee or saline solution, two ounces, at a temperature of 100 F., should be administered. A few minims of tincture of opium may be added where restlessness is present. It has a soothing effect, quietens peristalsis, and, in such small doses, acts as a heart stimulant. The child's condition improving, it may be put to the breast for three minutes, the application being repeated in an hour and a half. Sometimes a little of the first feeding is vomited. After three or four such feedings, the interval may be extended to two hours, and the time of application to five minutes. If, after twenty-four hours, progress is maintained, the breast milk may be given in the ordinary manner, say from ten to twenty minutes, every two and a half or three hours. If the child is weaned, nourishment, consisting of barley water, plasmon and water, egg albumen, peptonised or diluted milk, may be given in quantities appropriate to the age. It is better to err on the side of under feeding, as persistent vomiting may occur.
In the cases in which the baby seems unable to rally after the operation, free stimulation is indicated. Repeated enemata of coffee or saline solution and brandy, sips of champagne by the mouth, local stimulation in the form of heat, or mustard leaf applied to the precordium, lowering of the head, and the administration of the usual vascular stimulants hypodermically, as digitalin, camphor, strychnine, are the usual means I employ. With regard to strychnine, its special action on the unstriped muscular fibre of the intestine necessitates extreme care in its administration, otherwise the tendency to recurrence of the intussusception may be increased. The use of small doses of opium or morphine has already been mentioned as of much service in certain cases where the shock is profound.

In some infants a catarrhal condition of the intestine, at the site of the invagination, is apt to remain after reduction, and may prove troublesome. As a rule, however, it readily yields to suitable modification of the diet, with the judicious exhibition of bismuth carbonate for a few days.

After intussusception the bowels generally act naturally, the first one or two motions containing a little blood. Occasionally the bowels do not act soon after the reduction. In these cases it is wise treatment to delay the administration of a small aperient enema till the third day. On no account must purgatives be allowed.

**SUMMARY.**

Intussusception in infants is not so rare an affection as is stated by many authors. It occurred about once in every thousand babies brought to the Melbourne Children's Hospital during the past seven years. Ninety per cent. of the cases occurred in infants under one year of age.

Wiggin's statement, that cases left to nature are fatal ninety-eight times in every hundred, is borne out by these records, which show only two instances of spontaneous cure in one hundred and ten cases.

Predisposing factors in the production of intussusception in infants are the male sex, and, perhaps, to a slight extent, gastrointestinal disturbances, and family predisposition. The most
important, however, are congenital anomalies of the mesentery, such as I have described.

The question as to the origin of hernia, whether it be congenital or acquired, is causing much controversy, and there is a growing disposition on the part of many surgeons in favor of its congenital nature, especially in children. On a somewhat similar plane, I incline to place the origin of intussusception of the ileo-cæcal variety—the almost universal type in babyhood. In this variety the congenital defect is the persistence of an unusually long mesentery to the ascending colon—a portion of the gut which normally has none. In both hernia and intussusception there is probably some immediately antecedent condition which causes the descent of the bowel, in the one case into a pouch, in the other case into adjoining intestine.

The diagnosis is rarely doubtful in infants. Tumour exists, in my opinion, in almost all cases. Search for it should be made under anaesthesia, and by the conjoined bimanual examination of rectum and abdomen. Sudden onset, paroxysmal pain, vomiting, bloody discharges, absence of faecal matter, and the presence of tumour, leave no doubt for diagnosis even in cases where the baby is suffering from entero-colitis.

Purgatives aggravate the symptoms, and are inadmissible. Attempts at reduction of the invagination, by distension of the colon under water pressure, should be used only in cases that are of not more than six hours' duration. Irrigation should be performed slowly, thoroughly, and with the greatest care, the baby being anæsthetised.

Treatment by irrigation, even in these cases, involves shock, and possibly damage to the intestinal walls. It should not be repeated if done thoroughly.

The reasons for non-success are—(a) Very tight impaction, (b) much curving of the invagination, causing the axis of the tube to lie differently to that of the sheath, (c) great oedema of the apex of the intussusceptum.

The dangers of this treatment are—(a) Shock, (b) loss of time, (c) increase of the constriction, (d) rupture of the colon.

In every case where the complete disappearance of the tumour is in doubt, abdominal section should be at once performed.
Recurrence is frequent after irrigation, and rare after abdominal section. After one recurrence following irrigation, it is advisable to at once open the abdomen and disinvaginate.

In this record the results of laparotomy show the large mortality of fifty-two per cent.; but the reasons are not far to seek. In a great many cases the operation was done as a last resource, when the patients were in extremis, and often after other measures had been repeatedly tried. Prior to the year 1891 there had been only one recovery after laparotomy. Since that time the results have been increasingly good. In the favorable cases (where not more than forty-eight hours had elapsed since the onset) the record of recoveries was 72.5 per cent.; when done within twenty-four hours it was eighty-three per cent.

A simple laparotomy, gently and quickly done, is well borne by infants, but if it be performed after repeated attempts at reduction by distension of the colon, it is a very serious operation.

Operations demanding resection of gut, the formation of an artificial anus, etc., are badly borne, largely because the conditions rendering necessary such treatment are in themselves very fatal.

---

**A CASE OF INTUSSUSCEPTION IN AN INFANT.**

By G. F. SLEEMAN, M.B. Melb.

Surgeon to Creswick Hospital.

M. P., female, aged 5½ months, admitted to hospital on 10th November, 1904.

The history of the present illness, as given by the mother, was that the child, which was splendidly nourished and entirely breast-fed, had not met with any injury, and had not suffered from any bowel trouble, but had been quite well until 2 o'clock the previous afternoon, when she had suddenly commenced screaming, as though in violent pain, at the same time drawing the legs up on the abdomen. The screaming was followed in a few minutes by vomiting of the stomach contents. After screaming for about five minutes, the child dozed for twenty minutes, when she suddenly woke, and the screaming was resumed. On giving the breast, the milk was retained for a little over a minute, and then
rejected, vomiting only occurring after feeding. At first the milk was returned unaltered, but about four hours from the onset the rejected milk was tinted with bile. Considering that the screaming and vomiting were probably due to some intestinal irritant, the mother administered two drachms of castor oil at 7 p.m., and this was retained for about 3 minutes, and then rejected. At 11 o'clock the same night (i.e., 9 hours from the onset), the child passed about one ounce of a material which the mother described as resembling the reddish colour of stewed rhubarb, but containing no faeces. At 4 a.m., after a good deal of straining, the bowels acted again, this time about two ounces of bright blood being passed, and the mother now, for the first time, became alarmed at the condition of the child. The alternate dozing and screaming were continued up to the time of admission, which was 19 hours from the onset of symptoms.

On examination, the child was at once seen to be acutely ill. Temp., 96·6° in the groin; pulse, 120, small; respirations, 44, shallow and thoracic. The lungs and heart were clear. Abdomen not distended, and fairly flaccid. To the left of the umbilicus a tumour could be felt, but, owing to the crying of the child, it was not possible to determine its exact shape, so I administered chloroform, and then had no difficulty in detecting, about $2\frac{1}{4}$ in. to the left of the umbilicus, a sausage-shaped tumour, about $3\frac{3}{4}$ in. long, extending from the lower part of the left hypochondriac region to the region of the sigmoid flexure. The tumour was movable, and of a horseshoe shape, with the concavity towards the umbilicus. The "lack of resistance" in the right ilioc fossa was very marked under chloroform. Bimanually, per rectum, one could just feel the apex of the tumour, which was movable, and very closely resembled a rather soft cervix uteri. It was rather difficult to say whether the examining finger was actually in contact with the apex of the tumour, or whether the latter was felt through the wall of an adjoining piece of bowel.

The case was diagnosed as one of intussusception, and as the child was now in a state of profound shock, and had been ill for 19 hours, laparatomy was advised.

Some difficulty was experienced in convincing the mother that the case was one of intestinal obstruction, owing to the fact that
the bowels had "acted" twice, and she requested that operation be delayed for an hour or two, to see if there was any improve-
ment. From the time of admission up to operation, which took
place at 2 p.m. (24 hours from the onset), the vomiting after food
continued. There was never any faecal vomiting nor faecal
odour. The paroxysmal character of the intestinal colic was
very marked, the paroxysms recurring at intervals of 20 minutes
with almost clock-like regularity, and being accompanied by
violent straining. The bowels acted three times after admission,
each time about two ounces of blood-stained mucus being passed,
but no faeces.

At 2 p.m. I opened the abdomen by a median incision below
the umbilicus, and had no difficulty in discovering the intussus-
ception, which had extended into the lower part of the sigmoid
flexure. Reduction was effected fairly easily by expression,
the only difficulty experienced being at the splenic and hepatic
flexures, and I think the incision recommended by Dr. Cole, in
his recent admirable paper, would have been more suitable, and
would have facilitated manipulation of the transverse colon. In
reducing the last three inches, a little traction had to be combined
with the expression, and when reduced, the ileum, about 3 in.
from the ileo-caecal function, was stained by an annular mark,
about half an inch wide, of a dark plum colour, evidently from
pressure by the ileo-caecal valve. The peritoneal covering had,
however, not lost its lustre. The peritoneum was closed by a
continuous chromic gut suture, and the remaining tissues with
through and through sutures.

The child's bowels acted 8 hours after operation, the motion
containing a good deal of faecal matter mucus and a little blood.

Temperature on following day was 100°, and the motions for
three days after operation were of a dark greenish colour, and
contained a good deal of mucus. The subsequent history was
uneventful.
THE DICROTIC PULSE IN TYPHOID.

By H. CUMPSTON, M.B. Melb.

Medical Officer, Parkside Asylum.

While resident at the Melbourne Hospital, I undertook at Dr. Howard's request an investigation into the state of the pulse as regards dicrotism in the early stages of typhoid. The method adopted was as follows:—Whenever a case came in that at all resembled typhoid fever, or in which a diagnosis of typhoid had already been made by the practitioner who sent the case in, I took a pulse tracing as soon as possible. The previous history of the case was ascertained as accurately as possible from the patients or their friends. The same instrument was used throughout, and great care was taken to make the conditions in every case uniform. The observations extended over the "typhoid season" 1903-1904, and altogether included tracings from eighty-two individual cases. In some, tracings were taken at intervals throughout the illness, with the object of discovering how long the dicrotism lasted. In all, 115 separate records were obtained.

Dudgeon's sphygmograph was the instrument used, and in each case conditions were adjusted so that the excursion of the indicator was a maximum—the pressure of the excentric wheel, and of the cloth band, being adjusted to this end. All muscular movements were prevented.

A "dicrotic pulse" I have assumed to mean one in which the normal dicrotic wave is increased, and for greater accuracy have divided this type into two classes, a "fully dicrotic" pulse, in which the predicrotic notch reaches the base line on the tracing, and a "partial dicrotic" pulse, in which, while the dicrotic wave is enlarged, the predicrotic notch does not reach the base line. Thus—

Normal pulse. "Partial dicrotism." "Full dicrotism."

The majority of the "partially dicrotic" pulses were palpable to the finger as dicrotic pulses.

Pulse tracings of the eighty-two cases gave the following results:—Seven cases were pneumonia within three days of the onset, four showed fully dicrotic pulses, and three were normal.
Another seven were cases which were mistaken for typhoid, and all had been ill less than eight days. Of these, five had normal pulse tracings, one a slight alteration, and one a fully dicrotic pulse. These seven cases were in detail:—

(a) A case of appendicitis; ill five days, in which pain was not very marked and abscess only showed itself later; diagnosed as typhoid; no dicrotism.

(b) Acute rheumatism; ill five days; diagnosis originally typhoid; joint pains appeared seventh day; no dicrotism.

(c) A case of febrile character with anomalous symptoms, which showed a slightly dicrotic pulse; resolved in a week.

(d) Gastro-enteritis; ill eight days; diagnosis typhoid; resolved six days later; no dicrotism.

(e) Influenza, with gastro-enteric symptoms; ill three days; spleen enlarged; no dicrotism; recovery in a few days.

(f) This case showed the following symptoms:—Ill seven days; severe headache; pain in abdomen and limbs; slight cough; enlargement of splenic dulness; blood no reaction; spots appeared later; patient looked very like a case of typhoid, but the temperature was never high, and came down in another eight days to normal and stayed there. The previous duration of seven days was carefully ascertained to be correct. There was no alteration in the dicrotic wave.

(g) Influenza, followed by pneumonia—tracing taken after eight days' illness; pulse was fully dicrotic. Two days after tracing was taken the pneumonia appeared.

The other sixty-eight cases were undoubtedly typhoid. Of these, thirty-five showed a fully dicrotic pulse, seventeen a partially dicrotic, and fifteen a pulse free from this alteration. So that fifty-two of the sixty-eight had what is known as the "dicrotic pulse."

The ages of these patients were from 9 to 46, and a careful comparison shows no relation between the age and changes in the pulse. Nor was there any definite relationship between body temperature or pulse-rate and the occurrence of dicrotism.

The actual day of onset of the disease in all these cases was ascertained as accurately as possible. A table of the days of illness on which the tracings were taken, shows that from the second to the fourteenth day of illness, forty-three cases showed dicrotism, while only three showed it after the fourteenth day. In two
cases, in which the day of onset was definitely fixed, the
dicrotism was present on the second day. The remaining
six of the fifty-two were left out of this compilation, as the day of
onset was very uncertain. It must not be understood from the
above, that each of the forty-three cases showed dicrotism
throughout the period between the second and fourteenth days, but
that the day on which the tracing was taken was between those
days of the patient's illness.

The sixty-eight cases recorded above either showed on examina-
tion or had complained previously of the following symptoms and
signs. The number of cases in which the symptom was present is
given:—Headache 58, dicrotic pulse 52, enlarged spleen 34, pains
in the limbs 32, cough (not present before onset of typhoid) 22, epis-
taxis 21, spots 20.

I could only obtain the records of the result of Widal's test in 34
of the cases. In these, the result was:—Reaction 12, partial
reaction 5, no reaction 17.

The chief deductions from this series of figures are—
(1) That the dicrotic pulse was present in 76.4 per cent. of the
typhoid cases examined.
(2) That it was also present in five cases of pneumonia out of
eight examined in the first three days.
(3) That in the large majority of cases the dicrotism had dis-
appeared by the end of the second week.
(4) That it ranks next to headache in occurrence in the series of
symptoms during the first two weeks.

SOME OBSERVATIONS ON DYSPEPSIA.

By Alex. Lewers, M.R.C.S., L.R.C.P., D.P.H. Lond.

Physician to Out-patients, St. Vincent's Hospital, Melbourne.

The subject of indigestion can never be classed as an exciting
topic for discussion, but having regard to the importance that the
treatment of dyspeptic manifestations assumes in everyday practice,
it is at least a never-failing matter of interest. Of late years, more
particularly in Germany and America, various devices for direct
examination of the stomach contents have been advocated. Without
questioning the help that may be derived from such means in suit-
able cases, their employment in the everyday routine of practice is
neither necessary nor desirable. In the first place, they demand a considerable manipulative dexterity, and a very extensive experience before the deductions to be drawn possess any value. Secondly, a very appreciable armamentarium of apparatus and reagents must be available, and is rarely at hand in the stress of general work. Thirdly, and by no means of least importance as an objection, Anglo-Saxon patients, as a general rule, object to such physically and mentally displeasing sensations as are involved in the swallowing of a test meal, and the subsequent procedures necessary to bring it once more to light from the mysterious recesses of the gastric economy.

Looking back over a fairly extensive experience of lesser digestive ailments in private and hospital patients, the lesson appears to be that many failures in treating these minor dyspeptic conditions are due to the rule-of-thumb precepts that are applied in dealing with such cases. Both in the direction of dietetic guidance and the prescribing of drugs, a number of aphorisms seem to have grown up, which many of us go on repeating day after day without bringing any enquiry to bear upon their special or even their general application. To nine out of every ten persons in English-speaking communities, tea and potatoes are articles of diet, the lack of which deprives life of such of its enjoyment. While their abuse may contribute to dyspeptic manifestations, it is as to their use that the most illogical and slovenly directions are frequently given. There seems a very widespread notion that to substitute cocoa for tea, and to interdict potatoes entirely, are dietetic maxims of surpassing wisdom and importance. There is no hesitation in writing that, with certain limitations, tea may be allowed in almost every case of dyspepsia, and that there are few dyspeptic sufferers to whom cocoa should be allowed at all, except it be part of a fattening regimen.

Hutchison says cocoa is only fattening in the proportion of sugar and milk consumed, but, as in most cases this is a marked feature, it is one of importance. Potatoes, again, are mainly indigestible in proportion to the mode of preparation, and this is a matter of considerable import. If the available culinary artist is unequal to the lighter forms of potato cookery (and this is almost certain to be the case outside France), there is no household in which the potato may not be baked or boiled in its jacket until it becomes floury, and thereafter rubbed through a coarse sieve. In this form of light, feathery flakes, most patients will be able to take enough to
derive both pleasure and profit from the process. Notwithstanding that the carbohydrate intake is carefully cut off in the form of potatoes, it is customary to double and treble the total carbohydrate consumption by more or less riotous indulgence in semi-solid food-stuffs, ranging from Benger's food to boiled rice. The present purpose is not, however, concerned with dietetics, except to use the foregoing illustrations in order to emphasise the haphazard methods which too often underlie the scheme of gastronomic guidance. Similarly, in prescribing, the tendency is constantly towards routine, and the mental association of dyspepsia and bicarbonate of soda is the most difficult thing to overcome in the whole range of traditional therapeutics.

Perhaps the most common phase of chronic dyspepsia is that most frequently encountered in out-patient practice. The patient is generally a female, and the age limit is anything between sixteen or seventeen and middle age. These patients almost always begin by complaining of "pain in the left side." Sometimes it is described as "between the shoulders," or "under the left shoulder," but this is less frequent than referring the pain to the intercostal and infra-mammary regions. Not infrequently, palpitation is described in addition, and the immediate reason for seeking advice is to be assured that "the heart is all right." Many of these sufferers are mildly sceptical as to being the subjects of indigestion at all, and, in some instances, where no very prominent indication is otherwise present, the physician is himself dubious, and is content to place the complaint in that limbo of indefinite diagnosis classed as pleurodynia. The omission of a precise diagnosis is, in the majority of instances, unimportant; but it is well to be continually on the alert, for it may be necessary to distinguish between this dyspeptic trouble—a minor ailment—and gastric ulcer—a condition which, if overlooked, may mean a life endangered. The main points of difference are that in gastric ulcer the pain is nearly always referred more to the front, mainly occupying the epigastric region. There may be distinct tenderness, and sometimes acute pain, elicited by pressure just below the costo-sternal margin. The pain of gastric ulcer is almost always aggravated by food, while the reverse is often the case with this particular form of dyspeptic trouble. Vomiting, which is common with gastric ulcer, is rarely complained of by these patients. Dr. Sidney
Martin remarks that gastric ulcer responds much more quickly and satisfactorily to appropriate treatment than nervous dyspepsia.

Why women should suffer, particularly from this phase of nervous dyspepsia, is not quite clear, except it be that this is essentially the dyspepsia of constipation. The pain appears chiefly to be the result of distension, and in women distension would naturally produce more discomfort. Exercise appears often efficacious in dissipating the trouble, at all events for a time; and possibly for this reason, also, women are more affected. The treatment of these patients is generally sometimes completely, but more often only comparatively, satisfactory. It is difficult to discover the dietetic fault, and many of them are otherwise in such excellent health that they will not follow advice upon this point at all. Still, it is generally possible to eliminate the more obviously indigestible articles of food, and obviate the constipation, with beneficial results. It is in these cases that bicarbonate of soda and the other commonly employed alkalies are of signal service, and some variant of the time-honoured Haust. Gentian Alkalinus is almost certain to afford relief.

There are some common forms of nervous dyspepsia, however, in which the bicarbonate of soda and the other commonly employed alkalies afford little or no relief, notwithstanding that the symptoms are ascribed by both patient and practitioner to "acidity." One of these is the discomfort that comes in almost immediately after a meal, or even while it is in progress, and is more commonly met with in men than in women. The subject is usually of spare habits and unstable nervous energy. "Faddy" in some directions, carelessly self-indulgent in others. By the time he comes under observation, he has generally exhausted the possibilities of alkalies on his own initiative, or the advice of another medical man, and very often has views as to dieting himself. The discomfort may, or may not, amount to actual pain, and is generally accompanied by "acid" eructation. Whatever the acidity in the particular case, it is very rarely due to any excess of hydrochloric acid. Where butyric acid is present, the administration of an alkali will probably only aggravate the evil, for, according to Herter, butyric fermentation goes on best in a neutral or alkaline
medium. As is well known, these cases are benefited by hydrochloric acid, given before a meal, and the present writing is largely to advocate small doses of morphine in combination with it in intractable cases. Whatever the cause of the discomfort, be it excessive motility, or as most observers think, deficient motility, there is no doubt that a sedative gives more relief than anything else; and it seems that modern therapeutists have grown too unaccustomed to prescribe opium, or its derivatives, in such conditions. If there be any particular reason for avoiding morphine, codeina may be employed, and Brunton has credited it with specific action in intestinal pain; but it is not always reliable.

There is another aspect of this so-called "acidity," which appears towards the other extreme of the process of digestion, and renders itself unpleasantly prominent from two to three hours after the meal. Here an alkali is more often successful; hours after the meal. Here an alkali is more often successful; but the simplest and best remedy, as was long ago pointed out by Sir Thomas Watson, is a cup of hot, weak tea; or, if tea be anathema, from any real, or supposed, inability, the hot water may be unflavored. It probably acts by unlocking the pylorus and emptying the stomach. Where the patient has not access to this remedy, the alkaline lozenge of Roberts is often invaluable.

The last form of nervous dyspepsia, in which alkalies have often been prescribed with slender benefit, is that met with in stout, elderly women (though by no means confined to them), in which great and frequent belchings of wind render the patient's existence miserable, and are not infrequently accompanied by irregular cardiac action, that may become from time to time actually alarming.

These are the cases in which dieting and regimen are of most import, and of greatest difficulty, for most of the sufferers are hearty eaters, with palates that incline to dishes of strong savour, and tastes that do not lead them in the direction of active exercise. If there be any case of dyspepsia in which tea should be absolutely interdicted, it will probably be found somewhere under this category. Given the diet suitable to the particular case, and supposing the case to be otherwise uncomplicated, an occasional course of iodide of potassium, in moderate doses, is of empiric
benefit, and small doses of morphine with the usual anti-spasmodic remedies during the acute crises will certainly give most speedy relief. The customary alkali, with a bitter, in these cases, is not only useless, but makes matters worse. We require to allay appetite rather than excite it. Clifford Allbutt depreciates the elaboration of chronic dyspepsia into types; but the foregoing phases are so universal as scarcely to need any particular elaboration. Since the brilliant investigations of Pawlow, the dieting of dyspepsia has become at once easier, and more difficult. Easier, from the fact that many time-honored dicta have been exploded, and many dark ways made plain; more difficult, from the fact that we must recognise that hard and fast rules are no longer scientific, and that the means must be patiently adapted in every case to the individual end.

SYMPATHETIC OPHTHALMITIS DEVELOPING THIRTEEN DAYS AFTER EXCISION OF THE INJURED EYE.

By James W. Barrett, M.D., M.S., F.R.C.S. Eng., Surgeon to the Victorian Eye and Ear Hospital.

Lecturer on the Physiology of the Special Senses in the University of Melbourne.

And W. F. Orr, M.B., B.S., Surgeon to the Victorian Eye and Ear Hospital.

Master M., aged 7½ years. On July 8, patient ran against the prong of a garden fork, which injured his right eye. He complained of severe pains for a few minutes, shivered and vomited repeatedly for several days. Four days later, he saw Dr. Cowan, of Drouin, who sent him to Melbourne the next day. When he came under observation, five days after the injury, there was a large corneal wound, extending into the ciliary region, with protrusion of iris and ciliary body. The iris was very muddy; there was some effused lymph, and there was a hair lying across the iris in the anterior chamber. The lens appeared uninjured. Vision was fingers at 1 m. doubtfully. The eye was cleaned, and under a general anaesthetic an iridectomy was performed, and the lash removed. The iris broke away piecemeal, and left a ragged coloboma. The condition of the eye improved, and as the lens appeared to be uninjured,
there was considered to be some hope of recovery. About the beginning of August, the eye began to shrink, the tension to fall, and fresh lymph was effused. Immediate excision was then advised. Up to this time, examination of the left eye showed no lesion. On the day of the excision, the sound eye was a little irritable; there was a doubt as to whether any descemetitis could be made out in the left eye. The corneal epithelium was perhaps a little cloudy when examined with a +12 D lens. A day or two after excision this irritation disappeared. The eye was quiet and perfectly normal. The patient was sent home some days later.

On the evening of the thirteenth day, the eye became red. On examination next day, the fourteenth after excision, the pupil was found to be closed. Under atropin, all the adhesions gave way, leaving a ring of deposit on the capsule of the lens. There was descemetitis. The vision was $\frac{+4}{+6}$ partly. The irritation subsided, the media became clear, and the child was sent home after some weeks. Dr. Cowan states that the eye is at present perfectly quiet. Whatever may have been the cause of the irritation of the corneal epithelium at the time of excision, it is certain that there was no iritis on the twelfth day, and that there was on the fourteenth. Whilst we are fully aware, from experience, of the silent manner in which sympathetic inversion takes place, we do not think that there was any involvement of the iris or other evidence of disease on the twelfth day.

The excised eye was examined by Dr. Bull, who was requested by us to examine for organisms, as we were anxious to ascertain the cause of the destructive chronic iritis. His report, in the light of subsequent events, is interesting. As usual, no organisms were discoverable.

**Pathological Report by Dr. Bull.**

Master M. Eyeball removed 8th August, 1904. On section, some lymph on the iris in anterior chamber, and a little hæmorrhage behind the lens. Vitreous not thickened.

On microscopic examination, the site of the original perforating wound can be traced through corneal margin and ciliary body by a broad band of organising tissue. A little blood still remains in the post-chamber behind the damaged ciliary body, but the organising process is slowly extending into the old hæmorrhage. The lens at one part is adherent to the organising tissue. The iris is much
swollen, owing to the presence of large numbers of small round cells and fibroblasts, but without any marked vascular engorgement, indicating a condition of subacute or chronic iritis. The anterior chamber contains a little fibrillar fibrin and leucocytes. The cornea and sclera, for the most part, are normal, indicating a localised, rather than a generalised, ophthalmitis, and there is no infiltration of choroid or retina, and no detachment of the latter.

It is of interest to note the presence along the site of the old injury of a hair (probably an eyelash), which can be traced through consecutive sections embedded in the organising tissue and the superficial layers of the adjoining portion of iris lying in a radial position. In parts, little masses of conjunctival epithelium, which were carried in along with the hair, can be seen in contact with the latter. It may be that iritis has been due in part to the presence of such foreign body. (The hair referred to is not the one referred to in the clinical report. Two were evidently implanted, and the second was buried in the iris.)

By special staining methods, notably Gram's, carbol-thionin, carbol-fuchsin, I was unable to detect the presence of any microorganisms, either in the thickened iris or in the organising tissue and exudates.

---

We have received, by the courtesy of Dr. Ashburton Thompson, the Report of the Board of Health for 1903 on Leprosy in New South Wales. At the beginning of that year, ten persons were under detention at the Little Bay lazaret, and ten additional cases were admitted during the subsequent twelve months. Three deaths occurred, leaving seventeen cases under observation at the close of the year, of which nine were whites. The policy of the Board, that in suitable instances a leper might be allowed to live outside the lazaret under proper supervision, was made the subject of a debate in Parliament, and a Bill, which sought to make illegal the practice of segregating a leper anywhere but in the public lazaret, was carried by the Legislative Assembly, but thrown out by the Council. The experiment tried by the Board in this direction proved a failure,
owing to the facts of the case leaking out. The unfortunate patient was ultimately forced into the lazaret by a boycott of tradesmen and the public generally.

A tabular statement of all cases of leprosy registered in the Commonwealth from 1894 to 1903 is added. This would seem to show that the southern portion of the Continent is free, except for a few cases occurring in Chinese subjects. Northern New South Wales and Queensland continue to show a few instances in the white population, the precise source of infection of which cannot be traced. In the northern territory of South Australia, all the cases registered were in alien subjects or aboriginals. Of these latter, the assigned place of residence in each of the five instances, was Alligator River, and all were allowed to return to their people. We know not where Alligator River may be, but it seems a pity that direct investigation of these cases could not be followed out.

The Report as a whole is very complete, and includes clinical records of new cases, and the results of post-mortem examinations. It will furnish instructive information to anyone who is interested in the subject, and we congratulate those concerned in its compilation.

The Kronheimer Wing.

Some months ago we had occasion to comment on the ungracious attitude assumed by the Premier with respect to the Kronheimer gift to the Austin Hospital. Since that time, the Committee have not allowed grass to grow under their feet, and to-day the Kronheimer Wing stands completed, and ready to shelter a score of unfortunate sufferers who have been lightening their load of misery with the faint gleam of hope that help was soon to be at hand. Once again, however, the Premier has taken up a position in which childish obstinacy is strangely intermingled with the astuteness of the politician. It is idle to assert that the Committee had no permission to build the additional wing as they have done. The plans were submitted to the proper authorities, and in the absence of an official intimation that the building would not be approved when completed, the Committee were perfectly justified in assuming that their scheme was allowed. As a matter of fact, no objection on this score has been or can be seriously urged. The objections of the malcontents are merely sentimental. By a curious coincidence, Heidelberg forms an influential part of the constituency of the Minister for Public Health. The spectacle of a Government
deliberately obstructing charitable work in a spirit of political pique, is one that a healthy public opinion should not permit to be very prolonged.

SIR WILLIAM MACEWEN'S recent Huxley lecture on the "Function of the Cæcum and Appendix" comes most opportunely. The operation of appendicectomy has recently acquired a new danger—one that was quite unforeseen by the distinguished surgeon by whom it was first introduced—viz., that of being too frequently performed. The fact that many human subjects deprived of large portions of their abdominal anatomy, may still continue to live, and move, and have their being, has given rise to the hasty assumption that much of its structure is ornamental, and even without meaning of any kind. Such an assumption is merely illogical, but there is a real danger in assuming that portions of it are actually detrimental. The appendix vermiformis has of late been placed unreservedly in this category, and an uneasy feeling has arisen in the public mind that no time should be lost in applying to the nearest surgeon for its removal. It is a curious and somewhat melancholy reflection that, with so many intestinal operations which have as their deliberate object the alteration of natural conformation, we have such meagre knowledge of these patients after operation. Most of them recover from the actual surgical procedure, many of them live for considerable periods, but few indeed are the attempts that have been made to observe any one of them with completeness. Sir William MacEwen may be right or wrong in attributing an important digestive function to the appendix. There is no question that he is right in deprecating the assumption of many modern operators that the mere fact of its presence is a menace to health. The paper is the most important contribution that has been made to the subject since Treves opened up the question in the Hunterian lectures of 1885. Even though it is little more than suggestive, it is the utterance of a surgeon as distinguished from that of the surgical operator.

New Books. We have received a number of new books from various publishers, which will be fully noticed next month.
ORDINARY MONTHLY MEETING.

WEDNESDAY, DECEMBER 7, 1904.

(Hall of the Society, 8 p.m.)

The President (Dr. Howard) occupied the chair. There were 32 members present.

The minutes of the last meeting were read and confirmed.

The following gentlemen were elected Ordinary Members of the Society:

- Colin Gray, M.B. et Ch. B., Melb., of Maldon, proposed by C. H. Mollison, seconded by L. J. Balfour.

EXHIBITS.

Dr. Moore exhibited a patient who had suffered from severe haemoptysis.

Dr. Hewlett showed a case of popliteal aneurism after operation.

Dr. McCallum exhibited the following cases:—(a) Patient three years after removal of intussusception tumour, consisting of portion of ileum, whole of ascending colon, and half of transverse colon; (b) Hydatid of apex of right lung, with skiagram; (c) Patient after nephrectomy for renal calculus.

Dr. Moore expressed the gratitude of the Society to Dr. McCallum, that a member so far away as Geelong should come to Melbourne and induce his patients to show themselves before the Society. All the cases shown by Dr. McCallum were of great interest. With regard to the case of nephrectomy—if any attempt had been made to save the kidney, the probabilities were that furious hemorrhage would have occurred; or failing that, that the stone would have re-formed. The bowel case proved that a patient could exist in a state of good health for a considerable time after resection of a large portion of the bowel. Macewen had lately
expressed the opinion that a patient who had had his appendix removed was an injured man. If so, there were many injured men about.

The President also thanked Dr. McCallum. He congratulated him on his results. He was interested chiefly in the bowel case. The patient from whom Mr. Syme had removed from six to eight feet of bowel some months ago seemed to-day none the worse for its removal. It was interesting to watch the after-history of such cases. The case of hydatid of the lung showed the value of the X-rays in doubtful cases. The signs and symptoms were slight, but the X-ray picture was quite definite.

Dr. McCallum, in reply, stated that he was only too glad to show the cases and to have them criticised. The bowel case was interesting in connection with Macewen's statement with regard to the importance of the cæcum. His patient had now a slight "abdominal" countenance, but was without abdominal pain or symptoms. The symptoms in the hydatid case were slight, and out of all proportion to the opaqueness on the screen.

Dr. Mollison exhibited specimens of Pathological Anatomy.

Dr. McCallum showed—(a) Vesical calculus formed round portion of rubber catheter left in bladder for five months; (b) Skigram showing coin in œsophagus of child two and a half years old—removal after two months.

Obituary.

DAN ASTLEY GRESSWELL, M.A.; M.D. Oxon., M.R.C.S.

By the death, on December 10th, of Dan Astley Gresswell, M.A., M.D. Oxon., M.R.C.S., Chairman and Medical Inspector of the Board of Public Health of Victoria, the Medical Profession of the State has lost one of its most notable members, and Australia its most commanding figure in the sphere of Public Health work.

The immediate cause of death was a final attack in the course of a recurrent infective cholangitis, but he had been in indifferent health for more than eighteen months, and there can be no doubt that his zeal and anxiety to secure the consummation of his massive efforts to improve the legislative measures controlling the metropolitan milk supply, and the wholesomeness of food throughout the
State, had already taxed a system not fully restored from the severe illness of four months' duration from which he suffered early in the year. At the date of his death Dr. Gresswell was 51 years of age. The last fifteen years of his life were passed in the service of this State, and it may with safety be said that it will be many more before his name ceases to be a household word. His work will endure in many directions, not least in the shape of a quickened municipal health-conscience and a general public sense of the importance of public health activities, both central and local.

The son of a veterinary surgeon, Dr. Gresswell had himself no small knowledge of that branch of medicine—a knowledge which stood him in good stead in later life, affording, among other things, that breadth of view so essential to an appreciation of the wider branches of biological study, and enabling him readily to realise the importance of the theories of evolution in relation to medical science, a subject upon which he wrote on several occasions.

Matriculating at Balliol, Oxford, in 1871, he was afterwards awarded a scholarship in physical science, and obtained first-class honours in the School of Physical Science at Oxford, in 1874, subsequently took his degree in Arts, and later graduated as M.B. of the same University, and also as M.R.C.S. London. He obtained his M.D. by the presentation of a thesis on the Natural History of Scarlatina. This thesis, which was the first printed by the University, on account of its "exceptional excellence," well reveals the "infinite capacity for taking pains," so characteristic of the man. It sets forth, in detail, the results of his investigations during the London scarlatinal epidemic of 1887-8. He was, for a term, house surgeon at Bart.'s, and for several years was attached to the Local Government Board of England, and, in addition to valuable reports on obscure outbreaks of infectious disease furnished to that body, he published a paper in which he expressed to a somewhat unbelieving medical world his views on the Chronicity of Diphtheria, and its recrudescence. In 1889, when the Health Department of Victoria was re-organised, Dr. Gresswell was warmly recommended by the late Sir R. Thorne Thorne and Professor Corfield for the position of Medical Inspector then created. Arriving here in 1890, he at once manifested that ability and zeal which have ever since marked his work.

In 1894, the positions of Chairman of the Board of Health and permanent Head of the Department were conferred on him, and these
he occupied until his death. He was also President of the Victorian Health Society, and a member of the Council of St. John's Ambulance Association. He had also occupied the positions of President of the Victorian Medical Society and of the Victorian branch of the British Medical Association. In connection with his work in the Health Department, he wrote a large number of most valuable and exhaustive reports. Without doubt his extraordinary devotion to the duties of his office helped to shorten his days, if these are to be measured by mere length, and not as were, perhaps, more just, by the amount of work done. His enthusiasm and singleness of purpose lifted him far above mere routine and red tape, and his ideal of a healthy state, in which central and local authorities would know and realise the eradicable foes to health, and wherein every citizen would have engendered within him an alert health-conscience, is much nearer realisation to-day through his efforts and his adoption of the policy of the dispersal of insanitary conditions as far as possible by the forces of education in preference to the compulsion of the law. His efforts in preventing exotic disease from obtaining a footing in the State, were eminently successful. As with all pioneers, his path was not strewn with roses only; though these were not lacking in the shape of the sincere affection of his subordinate officers, the confidence of the Ministers under whom he served, and the Board over which he presided, as well as the unbounded confidence of the general public.

**Periscope.**

**Boric Acid in Food.**

The U.S. Dept. of Agriculture publishes a report of experiments last year in influence of boric acid on digestion. Twelve young men submitted themselves as subjects. "The report (Therap. Gazette) is thoroughly conservative. It makes no sensational charges that food is poisoned by borax. It admits that articles of only occasional use may be preserved with the aid of boric acid without harm, and it concedes that meat shipped raw, and not kept too long, may, without bad results, receive an external coating of the preservative. Nevertheless, it is emphatic in its warning against the habitual use of preserved
foods, and in its demand that such foods may be honestly labelled that the consumer may know what he is getting. It is not shown that boric acid has any deleterious effect upon the kidneys.

**Soap Solution (Hypodermically) for Cancer.**

Shaw-Mackenzie (Medical Press and Circular, Oct. 19, 1904) has an article on the treatment of inoperable cancer by hypodermic medication. He experimented with Chian turpentine, and with the soap solution advocated by Mr. J. Holden Webb, of Melbourne. Concerning the latter, he writes—"The notes of the cases treated by foregoing method will be detailed elsewhere, with a fuller description of Mr. Webb's work and treatment. Amelioration was obtained in all of them, chiefly in the direction of decrease of tumour, diminution of fetor and discharge, and cessation of pain." "In neither case is it possible to assert what the precise action is of Chian turpentine on the one hand, or of soap on the other; and—whether Mr. Webb is right or wrong in his theory—in neither case could it have any influence on the gratifying results which have, so far, been gained by these methods of treatment." He employed five minims of a 1% soap solution, increasing by five minims on alternate days to sixty minims every fourth day.

The same author, with Col. T. Ligertwood, reports a case in Journal of Royal Army Medical Corps. An old soldier, æt. 78, suffered for six months from cancer of tongue. Under similar dosage to above, marked cessation of all pain and fetor ensued, and the growth diminished from size of walnut to half filbert. Patient finally died of gangrene of left foot with toxæmia. Post-mortem, the appearance of tongue was almost normal, but sections, through a gland under ramus of jaw, demonstrated epitheliomata.

**Electricity in Skin Diseases.**

J. M. H. Macleod (Polyclinic, Oct., 1904) writes:—"For the removal of hairs, electrolysis, properly done, is our most reliable method at present. A series of exposures to X-rays will certainly cause a defluvium of hairs, but they almost certainly grow again. With regard to the port wine stain—the diffuse purple-red nævus—we have, at present, no satisfactory treatment.
Electrolysis is inadequate, and to destroy them with X-rays requires the greatest care, as it is necessary to produce reaction, and the scar which is liable to result might readily be more unsightly than the disease. X-rays are now used with excellent effect in treatment of rodent ulcer, lupus vulgaris, xanthoma, indurated acne, in some cases of superficial epitheliomata, and occasionally in lupus erythematosus. Finsen light maintains its place as a reliable method of removing a lupus patch without a scar. Its chief drawback is its slow action, but it is safer than X-rays.

"With regard to radium, its chief field of action is in treatment of small rodent ulcers, and lupus affecting the nasal mucous membrane. In both of these it is extremely valuable."

"High frequency currents have been much vaunted of late in the treatment of skin affections, but they are a poor substitute for X-rays. Light baths and heat baths, though much advertised, are of even less value in the treatment of skin diseases than high frequency currents, except as a means of imposing upon a too credulous public."

BACTERIOLOGICAL EXAMINATION OF ESTUARIAL WATER.

Houston (Journal of Hygiene, 1904) examined estuarial water and oysters for Royal Commission on Sewage Disposal. Inter alia, he concludes—"That the water of a tidal river, grossly polluted in its lower estuarial reaches, may, after a flow of twenty-five miles, become so far purified by sedimentation, dilution, and the operation, presumably, of bactericidal agencies, as to become seemingly as little objectionable, or, in some respects, less objectionable, bacteriologically, than certain of our water-supplies. (2) That the deposition in the sea of chemically precipitated sludge in enormous quantities need not result, necessarily, in the production of nuisance or serious pollution of surrounding water, and that such deposition may be thought of as an economical, and, seemingly, not unsatisfactory, means of disposing of this material. (3) There is a danger of hastily condemning waters and other materials, without a wider knowledge of comparative bacteriology and of the co-relation of bacteriology and epidemiology than is at present available."
AVULSION OF TONGUE, SELF-INFlicted.

Brouardel (Ann. de Hyg., Paris, 1904) records the following extraordinary case:—A Paris gendarme brought his wife to the Hôpital Tenon, along with her tongue, which he carried, wrapped up in a pocket-handkerchief. He stated that on his return home the previous day he found his wife up, and attending to her business. She informed him that during the day she had a violent attack of "nerves," and in order to obtain relief from a feeling of suffocation, she had put her hand down her throat and torn out her tongue. The organ was lying on the table at her side; only slight hæmorrhage had occurred. The doctor at the hospital who examined the wound found that it presented a regular surface, and that the whole tongue, from a plane posterior to the tonsils, and at the level of upper border of epiglottis, had been torn away. The patient made a good recovery.

Extracts from Foreign Current Medical Literature.


A great danger in operation about the bucco-nasal region is the risk of blood finding its way into the larynx and air passages, and surgeons try to guard against it by operating with the head hanging low, or by a previous tracheotomy, or even by ligature of the external carotid, all manœuvres not in themselves free from difficulties and dangers. The writer proposes to substitute for these intubation of the larynx, and connecting the laryngeal tube with a piece of india-rubber tubing, which passes through the nares, and serves for the passage of air and anaesthetic.

He first of all introduces the metallic laryngeal tube, then through one of the nares, passes a caoutchouc tube, armed at one extremity with an intermediary piece to fit the laryngeal tube. As soon as the latter becomes visible below the soft palate, it is seized with a laryngeal forceps, and adapted to the
intra-glottic tube. The air passages are now free from the danger of being flooded with blood during the operation, and it is as easy to administer the anaesthetic through the nasal tube as through a tube introduced into the trachea.

The procedure is interesting, and although, perhaps, easier to describe than to execute, worthy of trial.


In Bruns's Clinic, Trendelenburg's operation for varicose veins was performed 147 times—the first cases twelve years ago. Sixty-nine of these cases were examined afterwards personally. In only 19 of them (equal 27\% \%) was the result perfect, i.e., in addition to the permanent disappearance of varicose veins and ulcers, circulation in the saphena had not returned. In 4 cases anastomoses had formed with the small saphenous, and in one case with the external pudic. In 16 cases the collaterals had become enlarged. In 24 instances a convolution of veins had formed in the scar of the operation wound, consisting, probably, of newly-formed veins. In 2 cases the stem of the saphena had regenerated. But, in spite of these unsatisfactory objective results, the patients expressed themselves as much relieved by the operation. Of 69 lower extremities operated upon, 35 gave rise to no trouble whatever; 23 were considerably improved; and only 11 were not benefited at all. From the patients' point of view, 84 \% of the cases were satisfactory, and in only 16 \% was the operation a failure. Bruns considers, therefore, that, in spite of the objectively unsatisfactory results, the operation should not, for the present, be abandoned, and recommends that a fair piece of the vein be removed, and that the collaterals be included as much as possible.

C. A. Altmann.

New Books.


In his preface the author says—"In preparing this manual I have explored the by-ways as well as trodden the highways of coronial
law and literature." He has invited criticism from a wider standpoint than South Australia affords. In Victoria, much of the difficulty which surrounds coronial duties, when performed by an honorary Magistrate, is got rid of by the admirable article on inquests in Irvine's *Justices of the Peace* (2nd ed.), pp. 49 to 70 inclusive. Dr. Smith tells us truly, that coronial law is not to be learned from Acts of Parliament alone, and that the common law must be considered, and yet, he appears to have relied almost entirely upon Acts of Parliament when dealing with the procedure portion of his subject. He has gleaned haphazard from various Australian Acts of Parliament, the result being that his book is of very little use outside the State in which it was written.

The subject of the manual is both "abstruse and difficult," to quote Sir John Jervis, and exceedingly technical, and the measure of its usefulness is to be tested by the completeness, conciseness, clearness and reliability of the information it conveys. The author says—"No important point of law or of procedure has been omitted." Perhaps his sense of proportion is at fault. For example of want of clearness, vide p. 6.

Dr. Smith has quoted largely from "Instructions to Coroners," a Victorian production from some recondite source, and more honoured in the breach than the observance.

The book bears internal signs of hasty compilation, a fault which time will accentuate. It is to be regretted that, with the assistance at his command, Dr. Smith has not waited until practice and thought matured. One serious omission in the work is the lack of an index of cases, and another is the omission of typical forms of verdict for which MacNevin's little work is so useful to the coroner.

R. H. C.


The study of the various disorders of structure and function of the abdominal viscera form a large part of the practising physician's daily occupation, and any work which is likely to throw light on an important section of that study, should be very welcome, and of
great utility. The volume before us deals particularly with intestinal and peritoneal disease, and as showing the detail with which the subject is investigated, we may take into consideration that it contains no less than a thousand pages, in the well-known type and binding of the Nothnagel series.

The book opens with a very up-to-date account of the chemistry of intestinal digestion, and in this chapter we note the large amount of interpolation inserted by the editor, an Englishman familiar with the splendid work of English physiological chemists in this department. We question if any better résumé of the chemistry of the subject exists, than is to be found in this first chapter. The important part played by the bacterial action in the intestines is next dealt with, and not only does the discussion take in the utility of bacteria, but also the circumstances under which they may become pathogenic; and the chapter concludes with an account of the bacteriological examination of the faeces.

The movements of the intestine are illustrated by a series of plates, and then an excellent chapter on the clinical examination of the faeces, and the significance of various abnormalities, leads up to the first clinical subject—constipation.

The questions connected with etiology and symptomatology are fully dealt with, but we find little that is new in the matter of treatment. Stress is laid on dieting, and the combination of massage, Faradization, gymnastics, hydrotherapy, and regularity is recommended as giving the most favourable results.

The chapter on dyspepsia of the intestine, a condition too often overlooked, will be read with much interest, as also will the very full discussion of mucous colic and membranous catarrh.

A very important chapter is that on stenosis and occlusion of the intestine, which is illustrated by a series of some sixteen beautiful plates, showing the effect in the way of dilatation and peristalsis of obstructions at various parts of the intestinal tube. Many other subjects are dealt with more or less at length, and we can heartily recommend this volume as likely to help the puzzled practitioner to solve some of the difficulties connected with intestinal derangements.

The work concludes with a discussion of peritoneal diseases, a considerable space being given to appendicitis, with a very full discussion of the treatment, as between purely medical treatment and surgical interference. The author upholds the value of opium, maintaining that only good can come from its use, and that if cases...
are carefully watched, it does not so mask symptoms as to cause the opportunity for surgical interference to be lost; but the editor quotes, apparently approvingly, Osler's dictum—that there is no medical treatment for appendicitis.

One great feature of the Nothnagel series, and a feature well to the fore in the present volume, is the gathering together of many diverse opinions, with such criticisms by the editor and author, as is deemed necessary, the result being that the reader is placed in possession of a fund of information, from which he may readily draw his own conclusions, accepting what seems good, and rejecting such as does not appeal to his reason and judgment.

We consider the present volume one of great utility, and welcome it cordially as likely to be helpful in many a difficult case.

J. F. W.

A Treatise on Materia Medica and Therapeutics, including Pharmacy, Dispensing, Pharmacology, and Administration of Drugs.

By RAKHALDAS GHOSH, L.M.S., Calcutta University, Lecturer on Materia Medica, Medical School. Calcutta: Hilton & Co.

If it were possible, one would wish to give unstinted praise to this volume, partly because the author is dead, and partly because it was written by a native of India, who must have met with many difficulties in writing, in English, a work on the above subject. These difficulties have been largely overcome, and Dr. Rakhaldash Ghosh has shown that he possessed a sound knowledge of his subject, and has made very few mistakes of idiom. Nevertheless, the book is disappointing.

The work is largely a compilation, and general criticism cannot be applied to it; but there are many points in detail upon which remark can be made, and exception can also be taken to many of the author's statements. Thus, on p. 1, the statement is made that 'dispensing is not a part of pharmacy.' 'Therapeutics is the knowledge of remedial measures employed in the treatment of disease.' On p. 6, glucosides are described as being neutral bodies, whereas a large number of them are distinct acids. On p. 8 we have the curious statement that pure and genuine drugs can easily be obtained by paying reasonable prices. On p. 9 an absurd distinction is made between processes 'which belong to practical pharmacy,' and others which 'come within the range of chemistry,' distillation and crystal-
lization being, apparently, thus excluded from pharmaceutical operations.

A curious misapprehension of the meaning of a term is shown by the author on p. 11, when he speaks of a "wedge-wood mortar." On p. 38 "lemon oil" is said to be obtained by expression. This bald statement gives an entirely erroneous idea of the processes employed for obtaining it.

Such examples might be indefinitely extended in connection with the section of pharmacy and dispensing. Turning to administration of drugs, one finds, on p. 112, the surprising statement "that if we desire to obtain the full effects of cinchona, we can get them best by combining its extract, infusion, and tincture in one prescription." On p. 114 ferri cit. is allowed to mean either ferri et ammon. citras, or ferri et quininae citras.

Part IV. (Pharmacology) is, perhaps, the best of the volume; but, from its brevity, it can only serve as a convenient means by which students may grind up the subject.

The bulk of the volume is taken up by the part, Materia Medica and Therapeutics. This is such a pure and simple compilation that it eludes criticism; but one finds in it loose statements such as the following—"Chloroform should be freely diluted, say, with 95% of air"—p. 331. Digitalis leaves are said to be "4 to 12 m. long, 5 to 6 m. broad," thus giving the lowest dimensions as 4 m long and 5 broad, which is absurd, the absurdity being caused by the omission of the B.P. words, "sometimes as much as 5 to 6 m. broad." "The means of identification" of Filix Mas are somewhat vague, the author giving them as follow—"It bears no resemblance to any other drug. Its appearance is most peculiar." A curious constituent of oleum morrhuae is "12 smelling substances." Pulv. jalapae co. "is employed in drawing off water in dropsy," etc.

Here, again, such examples might be quoted indefinitely, but it must be admitted that the therapeutics of this part are treated, on the whole, accurately and well. Many mistakes in spelling occur, all of which, it is feared, cannot be laid at the printer's door. A few examples may be given—brochiectasis, quin. tar- tars, Burgundy pitch, caffeine, anatadic, sialagogue.

The work contains some useful information concerning Indian drugs, not generally used in other parts of the world; but beyond
this, there is nothing in the whole volume which can be interpreted as any addition to the information contained in existing publications.

S. P.

**New Editions.**

*Medical Electricity.* By H. Lewis Jones, M.A.; M.D., F.R.C.P.


This well-known manual, which forms one of Lewis' Practical Series, has achieved a fourth edition, and it need only be remarked that it has been thoroughly revised and brought up to the latest methods and opinions. Dr. Jones is one of the workers in this field who does not allow novelty to confuse his estimate of practical utility. His summary of the use of X-rays in the treatment of carcinoma is well balanced and refreshingly tonic, after the disordered mental condition produced by enthusiastic reporters in the various journals. "Half-a-dozen cases of unmistakable cure of undoubted cancer, if minutely reported, would be worth more just now than any number of vague statements about partial improvement, favourable effects, and the like."

Any practitioner looking for enlightenment in this new department of therapeutics cannot do better than follow the guidance of Dr. Jones, as expressed in this work.


Dr. Norman Walker's excellent little work has reached its third edition, and deserves its success. It is eminently practical, simple, and workmanlike. The present edition contains fuller references to radio-therapy, which extended experience has rendered advisable or necessary. Several new plates are added. As we reviewed this work so fully in a previous issue, there is no need to add more than that it quite maintains its place as the best work on skin diseases within the limits of the ground it covers.

From Messrs. Burroughs, Wellcome and Co., we have received samples of the following:—"Tabloid" Glycerophosphates Compound, dr. ½ (1.8 c.c.); "Soloid" Mercuric Potassium Iodide, gr. 4'37 (0'283 gm.); "Tabloid" Ophthalmic (D.D.) Zinc Sulphate, gr. 4 20 (0'00026 gm.); and Cocaine Hydrochloride, gr. 6 (0'00032 gm.)
2.58 per wife, including 9.30 per cent. childless. This table has been prepared to show the actual state of things during the intensity of the alleged restrictive period. In view of the fact that the average number of offspring to women under 45, who have been married for the mean period of 7½ years, is slightly over 2½, or an average of a child every three years, are the views of the expert statisticians of New South Wales, and the conclusions of the Commission, "that the practice of preventing conception by artificial means is common among all classes of the community, and in all parts of the State," justified by the figures in the tables of the New South Wales census? I think not.

In his work, "Fecundity, Fertility, and Sterility," Dr. Matthews Duncan (on page 158, Second Edition) gives a table showing the intensity of fertility in wives - mothers of different ages. The results were obtained from the registers of the births, numbering 16,593, in Edinburgh and Glasgow in 1855, and represent the total issue of married women who became mothers in that year, long before the period of the alleged restriction of families. An exact comparison can be made with Mr. Coghlan’s statistics of New South Wales for the years 1901 and 1902, when the births analysed numbered 70,490, and the results for the two countries are given in the following table:

<table>
<thead>
<tr>
<th>Mother's Age</th>
<th>Duration of Marriage</th>
<th>Scotland</th>
<th>New South Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>5 and under 5</td>
<td>1'128</td>
<td>1'209</td>
</tr>
<tr>
<td></td>
<td>5 and under 10</td>
<td>2'500</td>
<td>2'400</td>
</tr>
<tr>
<td></td>
<td>10 and under 15</td>
<td>3'300</td>
<td>3'283</td>
</tr>
<tr>
<td></td>
<td>15 and under 20</td>
<td>6'000</td>
<td>6'133</td>
</tr>
<tr>
<td></td>
<td>20 and under 25</td>
<td>7'000</td>
<td>9'250</td>
</tr>
<tr>
<td></td>
<td>25 and under 30</td>
<td>9'750</td>
<td>11'719</td>
</tr>
<tr>
<td></td>
<td>30 and under 35</td>
<td>13'000</td>
<td>13'467</td>
</tr>
</tbody>
</table>
It cannot be said, after an inspection of this table, that there is much difference between the two results. It must, however, be borne in mind that the figures are "gross" issue, not "net" or living. As both infantile and juvenile mortality are higher in Scotland than in New South Wales, and particularly so as far back as 1855, if the "net" issue had been taken, there can be no doubt that the New South Wales results would have been uniformly higher than the Scotch. Taking the total mothers as they stand, in Scotland the average issue was 3.70; in New South Wales it was 3.85. Dr. Duncan (page 116) says there can be no doubt that these 16,301 families are a fair sample of all the growing families in Edinburgh and Glasgow. Notwithstanding the decline of birthrate in New South Wales since the immigrant period, it is seen that the women are equally as prolific as those in Glasgow and Edinburgh years before the period of alleged restriction.

In commenting upon my remarks on infantile mortality, Mr. Trivett has utterly failed to understand what I wrote upon the subject, and has entirely misrepresented my views.

The table of birthrate and infantile mortality in New South Wales has been prepared by Mr. Trivett for the purpose of disproving the intimate association between the two rates, as affirmed by me. From my paper, it is evident that I was fully aware that New South Wales (being a new community) would not support my contention, inasmuch as the other factors in operation to bring about the decline in the crude rate per 1000 of population completely overshadowed the influence of infantile mortality. Moreover, Mr. Trivett utterly fails to offer any explanation of this intimate connection between birthrate and infantile mortality in old countries. He also considers that I have mistaken cause for effect. Whether high infantile mortality is the cause or the effect of high birthrate does not in the slightest degree affect the matter, so long as the association does exist. The first question that presented itself, when I realised this association, was, which was cause and which effect? After due consideration, and for reasons, some of which were advanced in my first paper, I concluded that infantile mortality was the cause, and not the effect, of high birthrate. In communities where indifference to preservation of infantile life exists, it can
Title: Intercolonial Medical Journal of Australasia 1904

Date: 1904

Persistent Link: http://hdl.handle.net/11343/23170

Terms and Conditions:
Articles from the Australian Medical Journal have been made available as permitted under the Copyright Act 1968. Any further reuse or reproduction is subject to the following: Copyright has expired: Where the author of an article died before 1 January 1955, copyright has expired under Australian copyright law and the material has passed into the public domain. Please note that this may not be the case in other jurisdictions, and it may be necessary to refer to the copyright law in your region when using this material. Articles still subject to copyright: Where the article is still protected by copyright, articles have been made available as permitted under section 200AB of the Copyright Act 1968. This material is subject to copyright and any further reproduction, communication, publication, performance, or adaptation is only permitted subject to copyright legislation in your jurisdiction.